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State Health Access Data Assistance Center

# Evaluation of the Minnesota Community Application Agent (MNCAA) Program:
## A State Health Access Program Analysis for the Minnesota Department of Human Services

## Final Report

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***Prepared for***

Minnesota Department of Human Services (DHS), with funding from the Health Resources and Services Administration's (HRSA) State Health Access Program (SHAP)

***Submitted by***

State Health Access Data Assistance Center
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## Executive Summary

Established in 2008, the Minnesota Community Application Agent (MNCAA) program seeks to leverage public-private partnerships to address access issues for vulnerable populations. Unlike a traditional approach to making outreach grants to community organizations, the MNCAA program is a unique pay-for-performance initiative whereby certain community organizations receive a $25 bonus payment for every individual successfully enrolled in Minnesota Health Care Programs (MHCP). Another unique aspect of the program is that multiple levels of engagement are allowed—community organizations choose whether to offer direct assistance to individuals applying to MHCP ("Level 1 MNCAAs") or whether to provide outreach materials and assistance at a more basic level ("Level 2 and 3 community partners"). This tiered approach helps to focus resources on the partners most willing and able to offer direct assistance and foster a broad network of community organizations that promote access to health care in other ways.

An evaluation of the MNCAA program was conducted by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota under a contract with the Minnesota Department of Human Services (DHS) funded by the Health Services and Resources Administration's (HRSA) State Health Access Program (SHAP) grant. Through quantitative analysis using a tracking and payment database maintained by the MNCAA Resource Center, a DHS work team created to support the work of MNCAA organizations, and targeted interviews with key informants, "lessons learned" about the program emerged. These findings have important policy implications as Minnesota moves toward a more self-service environment with its health insurance exchange and defines the roles and responsibilities of program navigators under the Affordable Care Act.

### *Evaluation Findings*

- **The MNCAA program grew significantly in early years, but growth has tapered since**. The number of Level 1 MNCAA organizations has more than doubled in less than four years, but most of this growth occurred in the early years of the program. A combination of factors has contributed to the tapered growth and then decline in the number of MNCAAs submitting applications, the number of applications submitted through the program, and the number of applicants over time. Budget reductions, staffing changes, and other resource constraints impacted the strength of MNCAA recruitment efforts, especially in Greater Minnesota.

- **A small group of MNCAAs are responsible for the vast majority of applications**. The top 15 MNCAA organizations in terms of application volume account for almost 75 percent of total applications submitted during 2008-2012. As of June 2012, there were a total of 140 organizations classified as Level 1 MNCAAs. There is evidence that the expertise and capacity of a core group of organizations participating in the program has grown over time.

- **Roughly 70 percent of applications currently submitted via the MNCAA program come from health care organizations**. Since the first year of the program (2008), the mix of Level 1 MNCAAs has shifted away from human service organizations, for-profit businesses,

and legal service providers and toward health care organizations. Health care organizations are typically direct care providers such as hospitals or clinics that already have strong financial incentives to secure public health care coverage for individuals.

- **MNCAAs that have Data Share Agreements with DHS—Level 1 organizations that do not receive $25 bonus payments—now account for the majority of applications submitted through the program**. Faced with budget constraints, DHS worked with certain Level 1 MNCAAs (mostly health care organizations) to forgo bonus payments but retain access to the case status updates, performance reporting, and training provided by the MNCAA Resource Center. During 2011 and roughly the first half of 2012, around 60 percent of the applications submitted through the MNCAA program came from organizations that had Data Share Agreements with DHS; roughly 40 percent came from organizations that received $25 bonuses for successfully enrolling individuals in MHCP.

- **The vast majority of applicants submitting applications through the MNCAA program reside in the Twin Cities Metro Area, suggesting an underrepresentation of MNCAAs serving Greater Minnesota**. Over three-fourths of the applicants to MHCP via the MNCAA program between 2008 and 2012 live in the Twin Cities metro area. Yet just over half of the State's uninsured population in 2011 lives in the Twin Cities. This supports the notion that generally speaking, the MNCAA program has been a more successful outreach strategy in the Twin Cities.

- **Only 13 percent of applicants assisted by MNCAA organizations during 2008-2012 were new to Minnesota Health Care Programs**. This measure is a meaningful indicator of how the MNCAA program is doing in terms of reaching underserved populations that have difficulties accessing public health care programs. There is considerable variability in this measure among high application volume MNCAAs.

- **Enrollment statistics are positive overall, but long waits continue—both for clients as their applications are processed and for MNCAAs receiving bonus payments**. From 2008 to 2011, 65 percent of MHCP applicants applying through the MNCAA program were successfully enrolled in Medical Assistance, MinnesotaCare and General Assistance Medical Care programs. The percent of applicants successfully enrolled, however, varies greatly by MNCAA. In addition, there continues to be a long wait for clients waiting as applications are processed and for MNCAAs receiving bonus payments. From 2008 to 2011, an average of 18 weeks elapsed between the time MNCAAs submitted their clients' applications and the time they received bonus payments associated with these applications. For the most part, this time lag is not due the time it takes to process MNCAA bonus payments. Rather, it is indicative of systemic resource shortages in eligibility processing infrastructure at the State and county level.

- **MNCAA organizations place the highest value on access to case status updates**. This evaluation included interviews with staff and/or directors from five MNCAA organizations. When asked what they valued most about the program, a clear and common response from

everyone was "access to data and information". Staff from MNCAA organizations place a very high value on their ability to call the MNCAA Resource Center for individual case status updates, often on a daily basis, and their ability to receive case status updates for many individuals at once by submitting forms to DHS periodically. In general, MNCAA organizations felt that getting questions answered through the MNCAA Resource Center was much easier and expeditious than working through the counties or MinnesotaCare.

- **Most individuals interviewed believed that a $25 bonus per enrollee is an insufficient incentive if the goal is to truly engage a broader spectrum of community organizations in this effort**. Staff from MNCAAs that continue to receive the $25 bonus payment relayed that the additional funding is helpful, but that it does not come close to covering the cost of doing this type of work. Most rely on other sources of funding (e.g., from the federal government, foundations, health care providers) to maintain their operations. It follows that to recruit and increase the participation of smaller organizations and/or organizations with different core missions that have strong connections with underserved populations, a larger investment will likely be needed.

### *Policy Implications and Conclusions*

The MNCAA program was implemented in an effort to break down barriers to access to public health care programs for vulnerable populations through pay-for-performance partnerships with community organizations. In just over four years, the program can point to many laudable results. For one, the program's reach has grown substantially. The number of Level I MNCAA organizations submitting applications has doubled, and the number of applications and number of individuals applying to MHCP through the MNCAA program has more than doubled. Importantly, despite long waits related to statewide infrastructure needs, almost two-thirds of those applying through the MNCAA program have successfully enrolled in MHCP. A core group of community partners with significant expertise and capacity to do outreach work has emerged, due in part to the resources, training, and technical assistance provided by the MNCAA program. And finally, in the face of several rounds of program budget cuts, the MNCAA Resource Center has been strategic in developing new partnership agreements (i.e., data share agreements) where possible so that pay-for-performance funding is available for expanding its network of community partnerships.

At the same time, questions remain about how the MNCAA program fits into the State's public health care outreach strategies and navigator program that will accompany the new health insurance exchange under the Affordable Care Act. As this report is being written, the details of these strategies are being contemplated by various State advisory task forces and workgroups. The most valuable takeaways from this evaluation are the lessons learned from the MNCAA program that should inform these broader decisions being made:

- **Significant expertise on reaching and enrolling individuals in public health care programs already exists within a core group of community organizations.** This expertise should be leveraged as the State defines the roles and responsibilities of health insurance exchange navigators. Many of these partners are organizations that have the capacity

and resources to broaden the scope of their outreach and application assistance work beyond public health care programs, and could probably serve as resource and training "hubs" for a network of less experienced community partners, much like the role the MNCAA Resource Center has played thus far.

- **To be successful, outreach providers, application assisters (and navigators, however defined) need timely access to the most current case information on their clients.** The strength of the MNCAA model comes down to the fact that through the MNCAA Resource Center, community organizations are able to access timely case status information for their clients, where in the past they have had to negotiate within an already overburdened system. The MNCAA program serves an "express-lane" of sorts, allowing outreach staff to get questions answered quickly so they can do proper follow-up with clients. This access to timely data is so crucial that to date, 37 MNCAAs have elected to participate as Data Share Organizations, foregoing bonus payments altogether. Admittedly, this finding opens up a whole new set of questions about the role of the State, the role of counties, and the role of community partners in the enrollment process. With proper controls, certification, and training, it is possible to envision a network of community partners who have real-time access to the State's eligibility and enrollment system, and who work collaboratively with the State and counties to ensure program integrity.

- **Implementing outreach, application assistance, and enrollment navigation activities may be most challenging in parts of Greater Minnesota.** The MNCAA program was designed with the goal of reaching individuals who are uninsured but eligible for MHCP from geographic areas in the State that have been traditionally underserved. While there has been a large increase in the number of Level 2 and 3 partners from Greater Minnesota in the last four years—due in large part to the outreach and recruitment efforts of the MNCAA Resource Center—applicants to MHCP via Level 1 MNCAAs come disproportionately from the Twin Cities. And only a few MNCAAs with significant application volume and expertise are located outside of the metro area. Regardless of the policy and program decisions made in connection with Minnesota's navigator program and health insurance exchange, targeted strategies to reach individuals in underserved counties in Greater Minnesota will be imperative.

- **It takes more than an innovative, pay-for-performance model to leverage the capacity of organizations who serve hard-to-reach populations.** While early, more intensive recruitment efforts by the MNCAA Resource Center had an initial impact, budget reductions and human resource constraints meant that over time, very minimal MNCAA Resource Center staff time could be spent working with Level 1 organizations that submitted fewer applications and Level 2 and Level 3 community partners. In addition, most organizations appear to view the pay-for-performance incentives associated with the MNCAA program ($25 for each individual successfully enrolled) as helpful, but inadequate. As a result, the vast majority applications submitted via the MNCAA program now come from health care organizations that have strong financial incentives to enroll individuals in public health care programs without the bonus payments. If the goal is to reach disparate groups who do not normally access the health

care system, a "higher-touch" approach to recruiting and training new organizations through more substantial investments in human resources and financial incentives will be required.

# I. Background on this Evaluation

Established in 2008, the Minnesota Community Application Agent (MNCAA) program offers incentive payments and technical assistance to a network of community partner organizations that assist individuals in applying for coverage in Minnesota Health Care Programs (MHCP). The goals of the MNCAA program include: improving access to care by reaching hard-to-reach populations who are eligible but not enrolled in MHCP; increasing the efficiency of application process for clients, counties, and State; and increasing the expertise of community partners by supporting their efforts in the enrollment process.

The MNCAA program seeks to leverage public-private partnerships to address access issues for vulnerable populations. Unlike a traditional approach to making outreach grants to community organizations, the MNCAA program is a unique pay-for-performance initiative whereby organizations receive a $25 bonus payment for every individual successfully enrolled in MHCP. This adds an element of accountability to outreach work in that organizations are paid for specific results. Another unique aspect of the program is that multiple levels of organizational engagement are allowed. A tiered approach where community organizations choose their level of engagement focuses resources on the partners most willing and able to offer direct application assistance and fosters a broad network of community organizations interested in helping in other ways.

This evaluation, conducted by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota under a contract with the Minnesota Department of Human Services (DHS) funded by the Health Services and Resources Administration's (HRSA) State Health Access Program (SHAP) grant, was included in SHAP activities for two main reasons. First, while DHS collects and monitors application volume and enrollment data on a monthly and quarterly basis, a synthesis of program outcomes has not been completed since the annual report in 2008, the first full year of the program. Now, with more than four years of complete data, a more comprehensive evaluation of this outreach program is possible. Second, as Minnesota develops its own health insurance exchange, questions remain about how to successfully break down barriers to coverage for those who are eligible, but not enrolled, in MHCP. An evaluation of "lessons learned" from the MNCAA program—such as how to partner effectively with community organizations that can assist in the enrollment process—could also have important policy implications under the Affordable Care Act (ACA) as Minnesota moves toward a more self-service environment with its health insurance exchange and defines the roles and responsibilities of program navigators.

## *Evaluation Approach*

The core of SHADAC's evaluation approach built on the extensive data collection and monitoring activities DHS already performs. We began with a quantitative analysis using an application status and payment database that the MNCAA Resource Center, a DHS work team created to support the work of MNCAA organizations, maintains. Through our quantitative analysis, we were able to establish overall trends in application volume and enrollment that helped to frame what has been accomplished over time—namely, how effective the program has been in enrolling hard-to-reach populations. Next,

we examined whether factors like MNCAA organization type, DHS contract type, or application volume helped to explain overall program trends.

The data analysis described above was supplemented with 15 key informant interviews. The design of the qualitative analysis, including the identification of key stakeholder groups and the content of interview protocols, was done in consultation with MNCAA program staff and SHAP leadership at DHS. Interviews with MNCAA Resource Center staff, past program directors, county officials, and staff from MNCAA organizations helped to: validate findings from our quantitative analysis, identify how stakeholders view and value the program, and expand our understanding of lessons learned. Discussions with officials developing the health insurance exchange and navigator program helped to determine the relevance of our findings to this broader effort. Please see Appendices A and B of this report for a listing of key informants interviewed for this evaluation as well as the discussion guide used to conduct interviews.

### *Key Evaluation Questions*

Specific evaluation questions fell under one of three areas of inquiry: (1) effectiveness in reaching disparate populations; (2) improvements in efficiency of application process; and (3) overall program value and cost-effectiveness.

1. Effectiveness in Reaching Disparate Populations
    - How has the number of community partners submitting applications changed over time?
    - Has the composition of community partners changed over time?
    - How has the number of applications submitted by community partners and individuals applying changed over time?
    - How does the location of applicants align with major geographic areas of health disparity within the state?
    - Which organizations (or organization types) are responsible for most of the growth in application volume?
    - What percentage of individuals assisted successfully enroll in MHCP? Into which programs do they enroll?
    - Which organizations are most successful in enrolling individuals assisted?
    - What is the ethnic and racial background of individuals applying for coverage through the MNCAA program? Has this composition changed over time?
    - What age groups are prevalent? Has this composition changed over time?
    - What percentage of individuals applying for coverage through the MNCAA program are considered new to MHCP?

2. Improvements in Efficiency of Application Process
    - How many MNCAA organizations submit applications directly to counties/MinnesotaCare and how many continue to rely on the Resource Center?
    - What percent of applications submitted by MNCAA's are complete with the documentation needed to determine eligibility?

- Which organizations are most successful in submitting complete applications?
- Do select State and county officials believe that the MNCAA program and Resource Center create efficiencies in the MHCP enrollment process?

3. Overall Program Value and Cost-Effectiveness
   - How long on average do MNCAA organizations wait to receive incentive payments?
   - Is the $25 pay-for-performance bonus an adequate incentive?
   - What is the value of the program to MNCAA organizations?
   - Has the training and technical assistance (policy clarification, case information, reporting) provided by the State increased the expertise of MNCAA organizations participating in the MHCP enrollment process?

## II. MNCAA Program Summary

The MNCAA Resource Center, a work team staffed by DHS employees within the Department's Health Care Eligibility and Access Division (HCEA), was created to support the work of community partners at the three different levels of participation provided for in the tiered structure of the MNCAA program. Level 1 organizations – referred to hereafter as "MNCAAs" or "MNCAA organizations"– offer direct assistance to individuals applying to MHCP. Some Level 1 organizations have contracts with DHS and receive a $25 bonus payment for each applicant successfully enrolled, and other organizations have Data Sharing Agreements with DHS and assist applicants without payment. Through the Resource Center, all Level 1 MNCAAs receive day-to-day call center support, access to case status information, orientation, and on-going training. Please see Appendix C of this report for a listing of Level 1 MNCAAs by location and organization type.

Level 2 and level 3 organizations do not hold agreements with DHS, but may provide individuals with materials about MHCP, referrals to MNCAA organization application sites, or assistance with health care applications at a very basic level. Level 2 and 3 organizations currently receive key MHCP information on a quarterly basis and have access to the MNCAA website, but due to resource constraints, have very limited call center support from the Resource Center.

### *MNCAA Community Partners*

As of June 2012, 944 organizations were participating in the MNCAA program: 140 Level 1 MNCAA organizations (15%), 227 Level 2 community partners (24%), and 577 Level 3 community partners (61%). The program's reach has clearly grown substantially since the end of its first year, 2008, when there were a total of 130 organizations participating. As shown below, most of this growth has been in the number of Level 2 and 3 partners participating in the program. Still, the number of Level 1 MNCAA organizations has more than doubled in less than four years.

**Table 1. Number of MNCAA community partners by participation level**

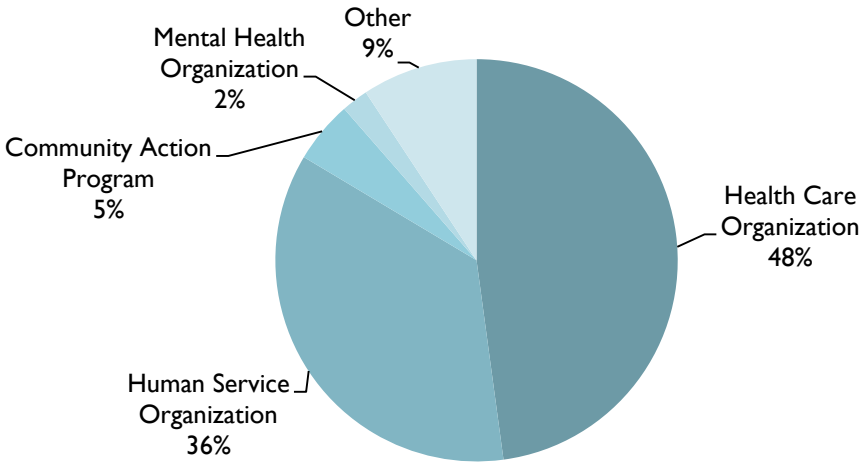
| Participation Level | December 2008* | June 2012 |
|---|---|---|
| Level 1 | 66 | 140 |
| Level 2 | 59 | 227 |
| Level 3 | 5 | 577 |
| **Total** | **130** | **944** |

**See "MNCAA Program Annual Report (January 1 to December 2008)", prepared by Sarah Kelsea, Minnesota Department of Human Services.*

As shown in Figure 1, the vast majority of Level 1 MNCAAs participating as of June 2012 are classified as health care or human service organizations. This has remained the case since the first year of the program. MNCAAs classified as health care organizations are typically direct care providers such as hospitals or clinics (e.g., Hennepin County Medical Center and Hennepin County Medical Center clinics). Human service organizations participating vary, ranging from health care outreach and coverage assisters to immigrant social service providers to food shelves to counseling centers to Minnesota AIDS projects in different communities. Community Action Programs, mental health organizations, for-profit

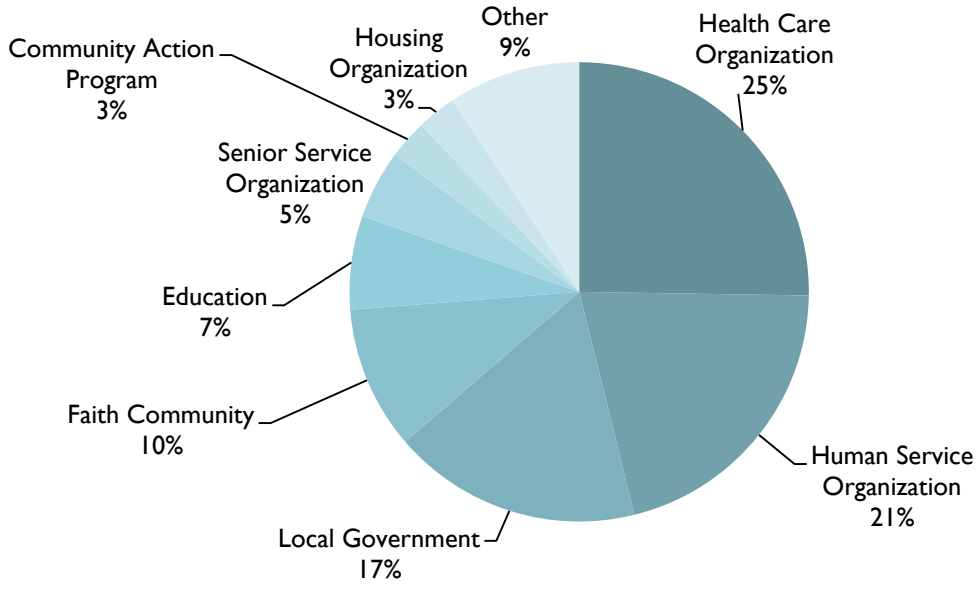
businesses, local government agencies, public schools, and youth, senior service, housing, and legal service organizations are also represented among Level 1 MNCAAs, albeit in smaller numbers.

**Figure 1. Distribution of Level 1 MNCAAs by organization type as of June 2012 (total number of organizations = 140)**




As Figure 2 illustrates, Level 2 and 3 community partners are more diverse than Level 1 MNCAAs in terms of organization type and by extension, mission. One of the unique features of the MNCAA program as designed was that it allowed for flexible levels of engagement in public health care outreach depending on an organization's mission, capacity and interest. It makes intuitive sense that the organizations interested in a more modest level of participation in outreach efforts would be more diverse than those investing resources to offer individualized application assistance.

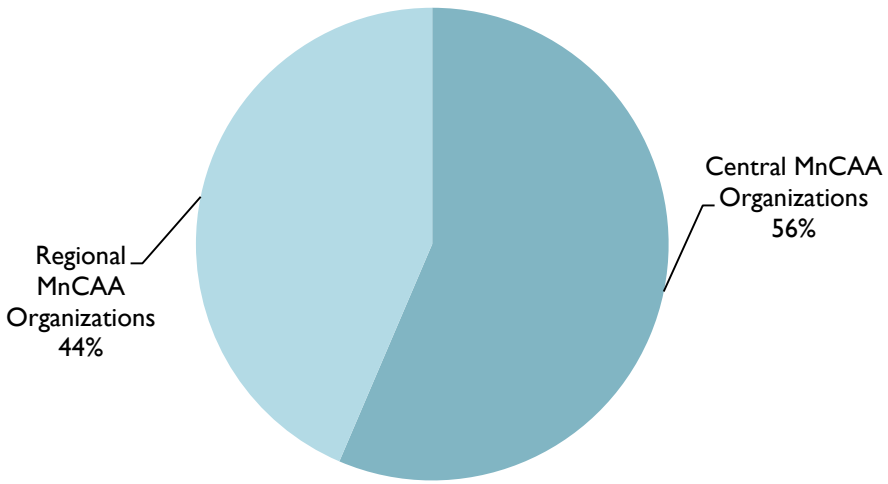
**Figure 2. Distribution of Level 2 and 3 community partners by organization type as of June 2012 (total number of organizations = 804)**



Currently, 56 percent of Level 1 MNCAA organizations assisting individuals with MHCP applications are classified as "central" organizations, meaning that they submit applications to the MNCAA Resource Center for screening before they are forwarded to the county or to MinnesotaCare. Most MNCAA organizations are required to use this process when they begin the program and then graduate to regional status as their expertise and volume of applications grows. As of June 2012, 44 percent Level 1 MNCAAs were certified as "regional" organizations, meaning they are able to submit MHCP applications directly to the county or MinnesotaCare. Regional organizations continue to submit minimal information about every application to the Resource Center for tracking purposes. See Appendix D for a DHS diagram of the MNCAA process for central organizations (i.e., "MNCAA Resource Center Process") and regional organizations (i.e., "County Graduated Process").

In October 2008, the first year of the program, only 9 organizations were submitting applications directly to the county or MinnesotaCare. This suggests that not only has the number of MNCAA partners grown, but the expertise and capacity of the organizations participating has grown as well.

**Figure 3. Level 1 MNCAAs by central or regional status as of June 2012 (total number of organizations = 140)**




### *The MNCAA Resource Center*

In general, the MNCAA Resource Center housed within DHS provides Level 1 MNCAA organizations with:

- timely case status updates, eligibility information and policy clarification, and other day-to-day technical assistance;
- quarterly performance reporting; and
- periodic training opportunities.

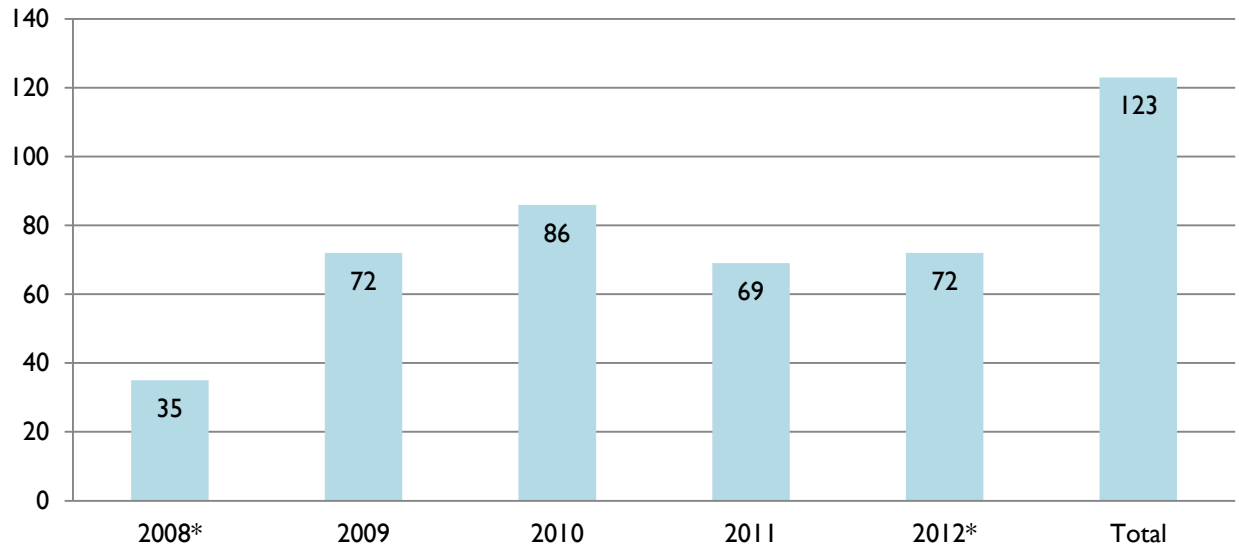
The Resource Center also assesses and tracks application completeness. A complete application, by MNCAA program standards, would be one that has all questions answered and commonly required verifications attached (e.g., income, assets, citizenship, identity, pregnancy, information release). Finally, the Resource Center maintains an application status and bonus payment database in Microsoft Access (the "DHS Outreach Agency Database"), manages the contracting process, and recruits and trains new community partners. Currently, seven DHS employees devote all or a meaningful portion of their time to the MNCAA Resource Center.

## III. Evaluation Findings

### *The MNCAA Program Grew Significantly in Early Years, but Growth Has Tapered Since*

The MNCAA program began accepting applications from Level 1 MNCAAs in March of 2008. Thirty-five organizations submitted applications through the program in its first year. Due in part to strong early recruitment efforts by the MNCAA Resource Center including targeted mailings and staff presentations in both the metro area and in Greater Minnesota, that number had more than doubled by the end of 2009. This growth in the number of organizations submitting applications began tapering in 2010. As of the writing of this report in mid-2012[1], it appears that participation in the program in terms of those organizations offering full application assistance is roughly the same as it was in 2009. Over the life of the program (2008-2012), 123 unique organizations have submitted applications.

**Figure 4. Number of unique Level 1 MNCAAs submitting applications per year**




**Represents number of unique MNCAAs submitting applications for a partial year.*

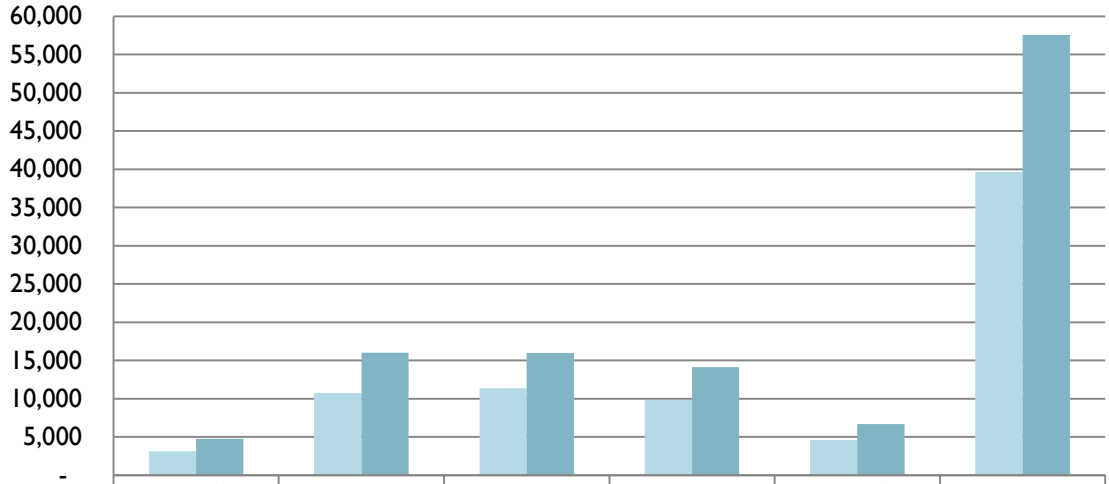
This same basic pattern is evident in MNCAA application and applicant volume over time. Tremendous growth in 2009 in both the number of applications submitted through the MNCAA program and the number of MHCP applicants is followed by more even results in 2010, and then an actual decline in application and applicant volume in 2011. Data for the first five months of 2012 suggests that MNCAA application and applicant volume is roughly on track to mirror 2011 results by the end of 2012.

A combination of factors have likely contributed to the tapered growth and then decline in the number of MNCAAs submitting applications, the number of applications submitted, and the number of applicants over time. First, underlying economic and public health care program enrollment trends have probably had some impact, but the extent of the this impact is unknown. It is important to note that caseloads for MHCP during this time period have been growing, generally speaking. Also, through unallotment and

[1] Data was available through June 8th, 2012.

subsequent budget bills, the funding for this program was reduced significantly from original levels beginning in FY 2010 (July 2009-June 2010). According to State staff interviewed for this evaluation, by early in calendar year 2010, the Resource Center had stopped adding new Level 1 MNCAAs because there was not enough funding available to provide additional bonus payments. Finally, staffing changes, resource constraints, and travel restrictions within DHS during this same time period likely impacted the strength of MNCAA recruitment efforts, especially in Greater Minnesota.

**Figure 5. Level 1 MNCAA application and applicant volume per year**




| | 2008* | 2009 | 2010 | 2011 | 2012* | Total |
|---|---|---|---|---|---|---|
| Applications | 3,135 | 10,733 | 11,382 | 9,801 | 4,593 | 39,644 |
| Applicants | 4,766 | 16,001 | 15,972 | 14,115 | 6,693 | 57,547 |

** Represents number of unique MNCAAs submitting applications for a partial year.*

### *A Small Group of MNCAAs Are Responsible For the Vast Majority of Applications*

The top MNCAA organizations in terms of application volume have remained fairly consistent since the inception of the program. Portico Healthnet, MedEligible, HCMC's Whittier and Richfield Clinics, Lake Superior Community Health Clinic, Children's Hospitals and Clinics (Minneapolis and St. Paul), St. Cloud Area Legal Services, and Southside Medical Clinic have all been consistently among the top MNCAAs in terms of application volume. Organizations now responsible for a significant number of applications but joining the program after 2008 include Cardon Outreach (2010), La Clinica (2009), Cardon Outreach Duluth (2010), Hennepin County Medical Center (2012), and Fond du Lac Human Services Division (2011). Table 2 provides the top 15 MNCAAs by percent of application volume (denoted by red figures) for each year of the program as well as during 2008-2012 overall.

As shown below, the top 15 MNCAA organizations account for almost 75 percent of total applications submitted during 2008-2012 (in other words, over the entire life of the program). In 2008, the top 15 organizations accounted for 96 percent of the total application volume, while in 2012, the top 15 organizations accounted for 70 percent. This demonstrates that although a small number of organizations are responsible for the vast majority of applications, more and more MNCAAs have become contributors to overall application volume over time.

**Table 2. Percent of total applications submitted by top 15 MNCAA organizations**

| Figures for top 15 MNCAAs denoted in red | 2008 | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|---|
| Portico Healthnet | 39% | 19% | 10% | 8% | 10% | 14% |
| MedEligible | 15% | 12% | 7% | 9% | 4% | 9% |
| HCMC Whittier Clinic | 5% | 11% | 9% | 3% | 2% | 7% |
| Cardon Outreach | 0% | 0% | 7% | 15% | 9% | 7% |
| Lake Superior Community Health Clinic | 13% | 6% | 4% | 5% | 5% | 6% |
| Children's Hospitals and Clinics of MN (Mpls) | 3% | 7% | 6% | 4% | 4% | 5% |
| St. Cloud Area Legal Services | 10% | 4% | 3% | 3% | 1% | 4% |
| HCMC Richfield Clinic | 1% | 3% | 4% | 4% | 3% | 3% |
| HCMC East Lake Clinic | 2% | 5% | 4% | 2% | 0% | 3% |
| Children's Hospitals and Clinics of MN (St. Paul) | 1% | 3% | 3% | 3% | 3% | 3% |
| La Clinica (West Side Community Health Services) | 0% | 3% | 3% | 3% | 3% | 3% |
| Cardon Outreach – Duluth | 0% | 0% | 4% | 4% | 5% | 3% |
| Southside Medical Clinic | 1% | 4% | 3% | 1% | 3% | 3% |
| Park Nicollet Methodist Hospital | 0% | 0% | 7% | 1% | 0% | 2% |
| Indian Health Board | 1% | 3% | 2% | 2% | 1% | 2% |
| Vietnamese Social Services of MN | 1% | 2% | 2% | 1% | 2% | 2% |
| East Side Family Clinic | 0% | 2% | 2% | 2% | 1% | 2% |
| Southside Community Health Services | 1% | 1% | 2% | 3% | 0% | 2% |
| HCMC - Hennepin County Medical Center | 0% | 0% | 0% | 0% | 10% | 1% |
| Cardon Outreach - St. Cloud Hospital | 0% | 0% | 1% | 2% | 2% | 1% |
| HCMC Brooklyn Park Clinic | 0% | 0% | 0% | 3% | 2% | 1% |
| Native American Community Clinic | 1% | 1% | 1% | 1% | 1% | 1% |
| Cardon Outreach - Austin Medical Center | 0% | 0% | 0% | 2% | 2% | 1% |
| Fond du Lac Human Services Division | 0% | 0% | 0% | 2% | 4% | 1% |
| Cardon Outreach – Hibbing | 0% | 0% | 2% | 1% | 0% | 1% |
| HCMC Brooklyn Center Clinic | 1% | 2% | 1% | 0% | 0% | 1% |
| Olmsted Community Action Program | 1% | 1% | 0% | 0% | 1% | 1% |
| Face to Face Health and Counseling Service, Inc. | 1% | 0% | 1% | 0% | 0% | 1% |
| **Subtotal** | **97%** | **90%** | **87%** | **86%** | **81%** | **88%** |
| **Subtotal, top 15 MNCAAs** | **96%** | **86%** | **77%** | **73%** | **70%** | **74%** |
| *Total number of applications* | *3,135* | *10,733* | *11,382* | *9,801* | *4,593* | *39,644* |

Another way to look at which community partners have been responsible for the most application volume is to look at MNCAA parent organizations. MNCAA parent organizations are typically the

organizations with which DHS contracts, and may have several different locations. For example, DHS contracts with HCMC's Whittier Clinic as a parent organization, and HCMC and HCMC's Richfield, East Lake, Brooklyn Park, Brooklyn Center clinics participate as MNCAAs under this umbrella.

Table 3 shows the top 10 MNCAA parent organizations—and 20 affiliated MNCAAs—by percent of total applications each year. Again, one can see that a small number of contracted partners have been responsible for the vast majority of applications over the life of the MNCAA program. During 2008-2012, these top 10 MNCAA parent organizations and 20 affiliated MNCAAs account for 84 percent of the total application volume. This means that the remaining 93 MNCAAs submitting applications during 2008-2012 represent just 16 percent of the total application volume during that time.

**Table 3. Percent of total applications submitted by top 10 MNCAA parent organizations and affiliated MNCAAs**

| *Denotes MNCAA parent organization | 2008 | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|---|
| **HCMC** | **9%** | **21%** | **17%** | **12%** | **19%** | **17%** |
| HCMC Whittier Clinic* | 5% | 11% | 9% | 3% | 2% | 7% |
| HCMC Richfield Clinic | 1% | 3% | 4% | 4% | 3% | 3% |
| HCMC East Lake Clinic | 2% | 5% | 4% | 2% | 0% | 3% |
| HCMC | 0% | 0% | 0% | 0% | 10% | 1% |
| HCMC Brooklyn Park Clinic | 0% | 0% | 0% | 3% | 2% | 1% |
| HCMC Brooklyn Center Clinic | 1% | 2% | 1% | 0% | 0% | 1% |
| HCMC FY 2012 Grant | 0% | 0% | 0% | 0% | 1% | 0% |
| **Portico Healthnet*** | **39%** | **19%** | **10%** | **8%** | **10%** | **14%** |
| **Cardon Outreach** | **0%** | **0%** | **17%** | **27%** | **19%** | **14%** |
| Cardon Outreach* | 0% | 0% | 7% | 15% | 9% | 7% |
| Cardon Outreach – Duluth | 0% | 0% | 4% | 4% | 5% | 3% |
| Cardon Outreach - St. Cloud Hospital | 0% | 0% | 1% | 2% | 2% | 1% |
| Cardon Outreach - Austin Medical Center | 0% | 0% | 0% | 2% | 2% | 1% |
| Cardon Outreach – Hibbing | 0% | 0% | 2% | 1% | 0% | 1% |
| Cardon Outreach - Albert Lea Medical Center | 0% | 0% | 1% | 1% | 0% | 1% |
| Cardon Outreach - North Country Health Services – Bemidji | 0% | 0% | 1% | 1% | 1% | 1% |
| Cardon Outreach – Rochester | 0% | 0% | 0% | 0% | 0% | 0% |
| **MedEligible*** | **15%** | **12%** | **7%** | **9%** | **4%** | **9%** |
| **Children's Hospitals and Clinics of MN** | **4%** | **10%** | **9%** | **8%** | **7%** | **8%** |
| Minneapolis* | 3% | 7% | 6% | 4% | 4% | 5% |
| St. Paul | 1% | 3% | 3% | 3% | 3% | 3% |
| **Lake Superior Community Health Clinic*** | **13%** | **6%** | **4%** | **5%** | **5%** | **6%** |

| *Denotes MNCAA parent organization | 2008 | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|---|
| **La Clinica and Affiliated Clinics** | **0%** | **6%** | **5%** | **5%** | **5%** | **5%** |
| La Clinica (West Side Community Health Svcs.)* | 0% | 3% | 3% | 3% | 3% | 3% |
| East Side Family Clinic | 0% | 2% | 2% | 2% | 1% | 2% |
| McDonough Homes Clinic | 0% | 0% | 0% | 0% | 0% | 0% |
| Healthcare for the Homeless | 0% | 0% | 0% | 0% | 0% | 0% |
| **Southside Clinics** | **2%** | **5%** | **5%** | **4%** | **4%** | **4%** |
| Southside Medical Clinic* | 1% | 4% | 3% | 1% | 3% | 3% |
| Southside Community Health Services | 1% | 1% | 2% | 3% | 0% | 2% |
| Southside Dental Clinic | 0% | 0% | 0% | 0% | 1% | 0% |
| St. Croix Family Medical Clinic | 0% | 0% | 0% | 0% | 0% | 0% |
| **St. Cloud Area Legal Services*** | **10%** | **4%** | **3%** | **3%** | **1%** | **4%** |
| **Park Nicollet** | **0%** | **0%** | **8%** | **3%** | **2%** | **3%** |
| Park Nicollet Methodist Hospital | 0% | 0% | 7% | 1% | 0% | 2% |
| Park Nicollet Health Services* | 0% | 0% | 1% | 1% | 2% | 1% |
| **Subtotal** | **92%** | **83%** | **86%** | **84%** | **77%** | **84%** |
| *Total number of applications* | *3,135* | *10,733* | *11,382* | *9,801* | *4,593* | *39,644* |

### *Roughly 70 Percent of Applications Currently Submitted Via the MNCAA Program Come from Health Care Organizations*

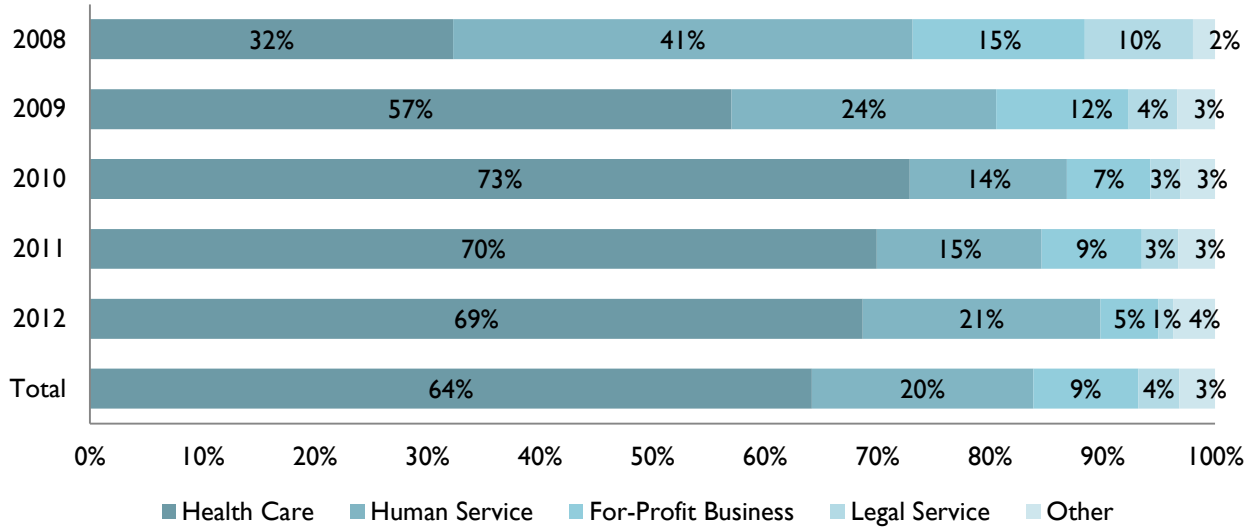
During the first year of the program, 41 percent of the applications submitted came from human service organizations (e.g., Portico Healthnet), 32 percent came from health care organizations (e.g., Lake Superior Community Health Clinic), 15 percent came from for-profit businesses (e.g., MedEligible), 10 percent came from legal service organizations (e.g., St. Cloud Area Legal Services), and 2 percent came from all other partners.

Since that time, the mix has shifted toward health care organizations, and away from human service organizations, for-profit businesses, and legal service providers. In 2011, for example, the last year of complete data, health care organizations accounted for 70 percent of the applications submitted, human service organizations accounted for 15 percent, for-profit businesses accounted for 9 percent, and legal service organizations accounted for 3 percent.

Much of this shift can be explained by two factors. First, Cardon Outreach, a for-profit eligibility assistance and revenue recovery company affiliated with various hospitals in the State began participating in the MNCAA program in 2010, submitting 27 percent of all MNCAA applications by 2011. The MNCAA database maintained by the Resource Center classifies Cardon Outreach as a health care organization, which has a notable impact on the distribution by organization type over time. Newer health care MNCAAs like La Clinica, East Side Family Clinic, and Park Nicollet Methodist Hospital and Health Services, and higher MNCAA application volume from Children's Hospitals and Clinics and Southside Clinics, also contribute to this shift toward health care organizations.

Second, one MNCAA partner classified as a human service organization that was responsible for a significant portion of applications in 2008–Portico Healthnet, a non-profit health care application and coverage assistance organization—began receiving federal Children's Health Insurance Program Reauthorization Act (CHIPRA) outreach grants beginning in 2010. Funding could not be claimed from both the State and federal governments for the same activities, so while overall outreach activities for Portico Healthnet increased, applications directed specifically toward the MNCAA program tapered during the same time.

**Figure 6. Percent of total applications by MNCAA organization type**




| | 2008 | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|---|
| *Total number of applications* | *3,135* | *10,733* | *11,382* | *9,801* | *4,593* | *39,644* |

## *The Vast Majority of Applications from Health Care Organizations Come from MNCAAs Operating Under Data Share Agreements*

As mentioned earlier in this report, through unallotment and subsequent budget bills, the funding for the MNCAA program was reduced significantly from original levels beginning in FY 2010. By early in calendar year 2010, the Resource Center had stopped adding new Level 1 MNCAAs because there was not enough funding available to provide additional bonus payments. At the same time, there continued to be significant interest from Level 2 and 3 partners on how to participate as Level 1 MNCAAs, begin offering application assistance to community members, and receive bonus payments for successful enrollments.

Faced with resource constraints, the MNCAA Resource Center began exploring alternate strategies. Certain Level 1 MNCAAs—most notably health care providers that have a strong financial interest in securing public health care coverage for individuals—were willing to forgo the $25 bonus payments if they were able to retain access to the data provided by the Resource Center (most importantly, case status updates). This would free up resources so other community partners could join as Level 1

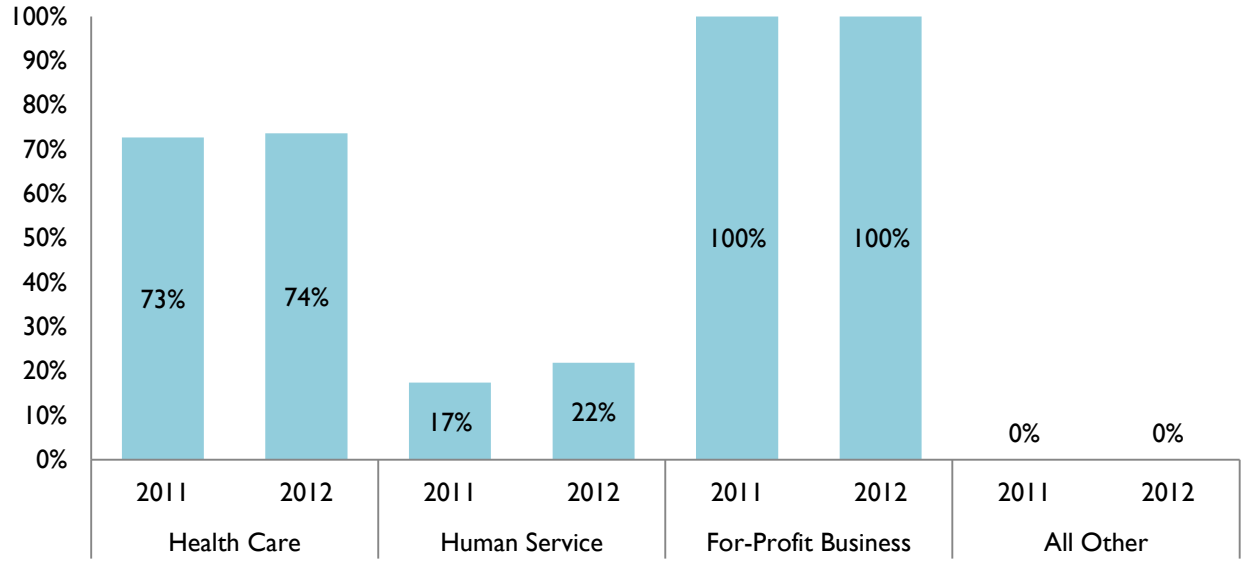
MNCAAs and receive bonus payments. By December of 2010, the Resource Center had entered into Data Sharing Agreements with 22 Level 1 MNCAA organizations. A list of the 37 current Data Share Organizations is provided below.

**Table 4. MNCAA Level 1 Data Share Organizations as of June 5, 2012**

| | |
|---|---|
| Allina Health System – Unity Hospital | HCMC – Whittier Clinic |
| Altegra Health | HCMC – FY12 Grant |
| Bois Forte Reservation Health Services | LakeWood Health Center |
| Cardon Outreach | MedEligible |
| Cardon Outreach – Albert Lea Medical Center | Park Nicollet Health Services |
| Cardon Outreach – Austin Medical Center | Park Nicollet Methodist Hospital |
| Cardon Outreach – Duluth | PrimeWest Health |
| Cardon Outreach – Hibbing | Rainy Lake Medical Center |
| Cardon Outreach – North Country Health Services Bemidji | Red Lake IHS Hospital |
| Cardon Outreach – Rochester | Regina Medical Center |
| Cardon Outreach – St. Cloud Hospital | Riverwood Healthcare Center |
| Children's Hospitals and Clinics of MN (Mpls) | St. Joseph's Area Health Services |
| Children's Hospitals and Clinics of MN (St. Paul) | U of M Physicians – PFS |
| Fond du Lac Human Services Division | UMP – Bethesda Clinic |
| HCMC – Hennepin County Medical Center | UMP – Broadway Family Medicine |
| HCMC – Brooklyn Center Clinic | UMP – Phalen Village Clinic |
| HCMC – Brooklyn Park Clinic | UMP – Smiley's Clinic |
| HCMC – East Lake Clinic | University of Minnesota Physicians – Family Medicine Clinic |
| HCMC – Richfield Clinic | |

Interestingly, Figure 7 shows that the vast majority of applications (73-74 percent) submitted through the MNCAA program by health care organizations and all of the applications from for-profit businesses were submitted under Data Share Agreements in 2011 and 2012.

**Figure 7. Percent of total applications submitted under DHS Data Share Agreements by MNCAA organization type**



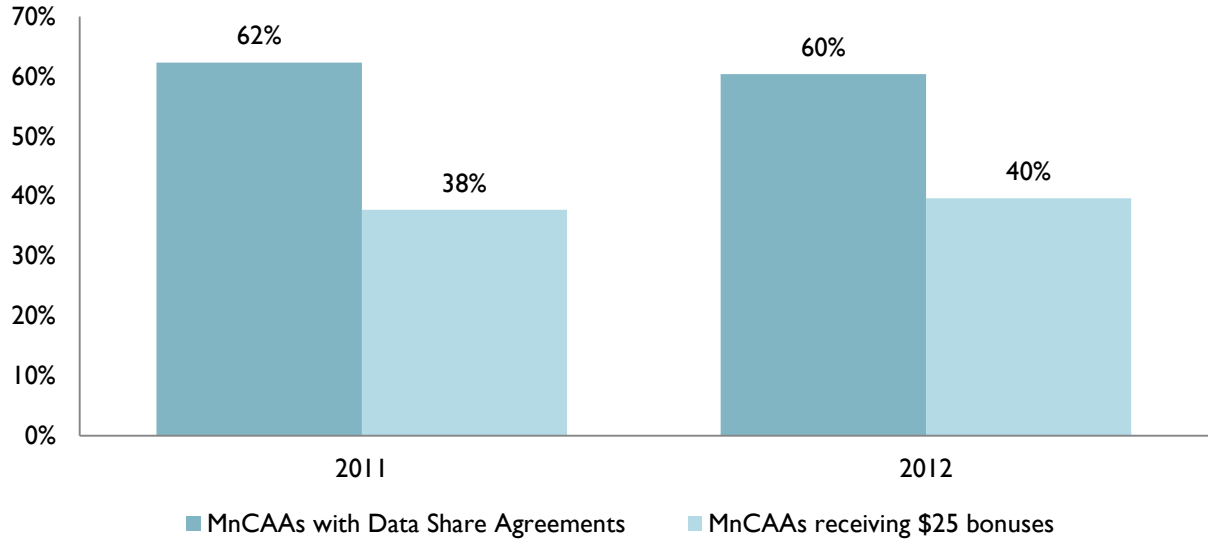

| | *Total Number of Applications* | | | |
|---|---|---|---|---|
| | *Health Care* | *Human Service* | *For-Profit Business* | *All Other* |
| *2011* | *6,855* | *1,434* | *873* | *639* |
| *2012* | *3,155* | *970* | *237* | *231* |

### *MNCAAs that Have Data Share Agreements with DHS Now Account for the Majority of Applications Submitted Through the Program*

Given that most of the applications submitted by MNCAAs come from health care organizations, and that the vast majority of these organizations now operate under Data Share Agreements and do not receive $25 bonus payments, it is not surprising that most MNCAA program activity now occurs under Data Share Agreements versus pay-for-performance contracts.

As illustrated in Figure 8 below, during 2011 and roughly the first half of 2012, around 60 percent of the applications submitted through the MNCAA program came from MNCAAs that had Data Share Agreements with DHS; roughly 40 percent came from MNCAAs that were receiving $25 bonuses for successfully enrolling individuals in MHCP.

**Figure 8. Percent of total applications from MNCAAs with Data Share Agreements and those receiving $25 bonus payments**




| | *2011* | *2012* |
|---|---|---|
| *Total number of applications* | *9,801* | *4,593* |

### *Regional MNCAAs Now Account for Almost All of the Applications Submitted Through the Program*

As of June 2012, 56 percent of Level 1 MNCAA organizations were classified as central organizations, meaning they submit applications to the MNCAA Resource Center for screening before they are forwarded to the county or to MinnesotaCare. Thus, 44 percent Level 1 MNCAAs had graduated to regional organization status and submit MHCP applications to the county or MinnesotaCare directly. While the MNCAA outreach database does not include information on when MNCAAs graduated from central to regional status, looking at application volume in 2011 and 2012 should provide a fairly accurate picture of the current proportion of applications being submitted to the MNCAA Resource Center first, and the proportion being submitted to the county or MinnesotaCare directly.

The majority of MNCAAs submitting applications in 2011 (70 percent) and in 2012 (61 percent) are regional organizations going directly to counties or to MinnesotaCare for eligibility decisions. Figure 5 illustrates that the percent of applications being submitted directly to counties or MinnesotaCare is now extremely high: roughly 98 percent in 2011, and 92 percent in 2012.

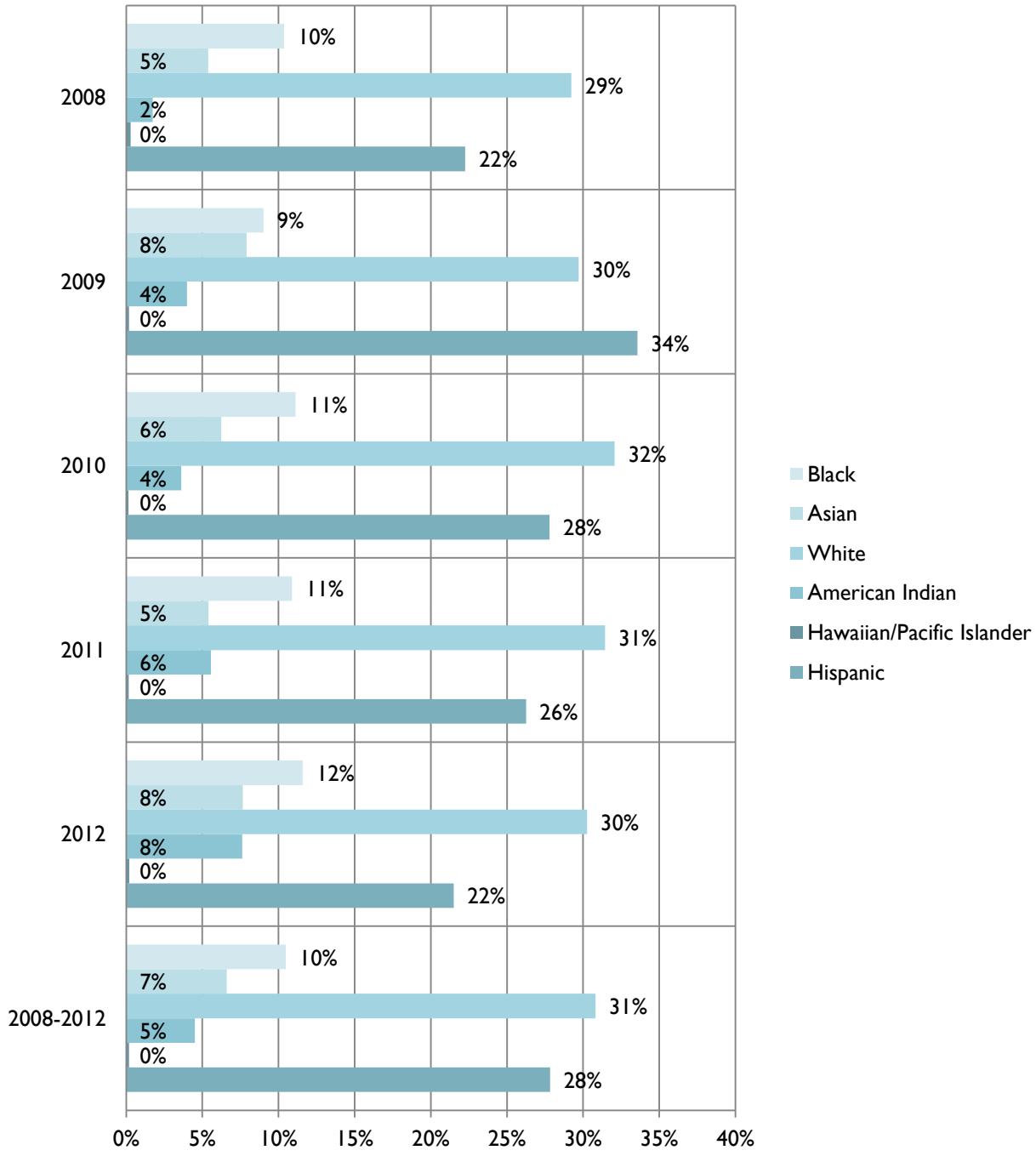
**Table 5. Number and percent of total applications by central and regional MNCAAs**

| | Number of Applications | Percent of Total Applications |
|---|---|---|
| **2011** | | |
| Central | 224 | 2% |
| Regional | 9,577 | 98% |
| **2012** | | |
| Central | 348 | 8% |
| Regional | 4,245 | 92% |

### *The MNCAA Program Has Targeted Population Groups Known to Face Health Care Disparities*

Of all applicants to MHCP assisted by the MNCAA program identifying their race or ethnicity between 2008 and 2012, 43 percent identified themselves as Black, American Indian, or Hispanic, while 31 percent identified themselves as White. This result has been very consistent except for in the first year of the program, 2008, when the proportion of clients identifying themselves as Black, American Indian, or Hispanic was somewhat lower (34 percent). All in all, the demographic information provided below suggests that the MNCAA program has been successful in targeting population groups that are known to face disparities in accessing public health care programs.

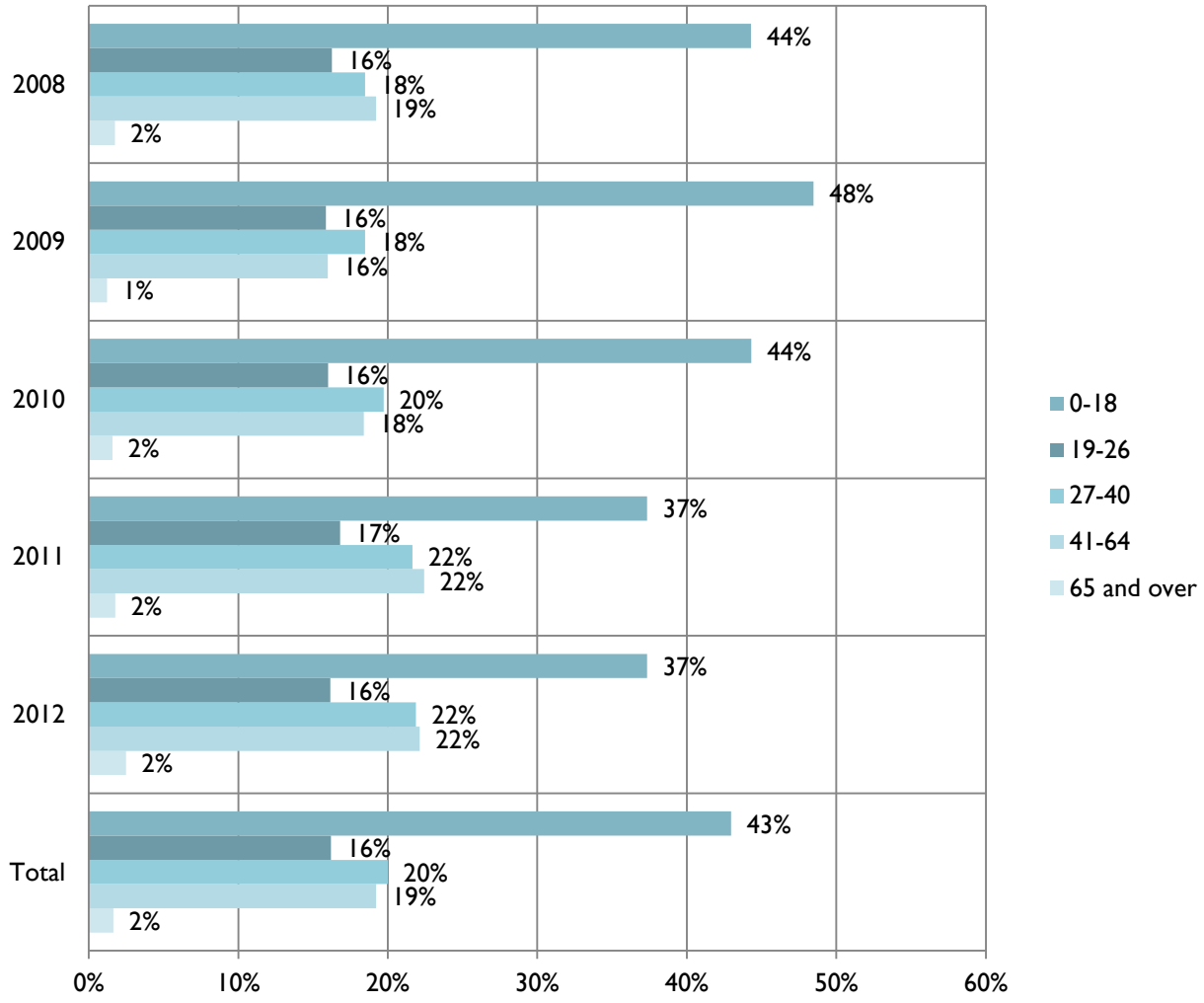
**Figure 9. Percent of total applicants submitting applications through the MNCAA program reporting race and ethnicity**




| | *2008* | *2009* | *2010* | *2011* | *2012* | *Total* |
|---|---|---|---|---|---|---|
| *Total number of applicants* | *4,766* | *16,001* | *15,972* | *14,115* | *6,693* | *57,547* |

In addition to race and ethnicity, understanding the age of applicants submitting applications through the program can provide insights about whether at-risk populations like children have been served by MNCAA organizations. The distribution of applicants served by age cohort has been very consistent across the years, with children under the age of 18 representing the largest percentage of individuals served by the MNCAA program (43 percent across 2008-2012). Adults 19-26, 27-40, and 41-64 are also a significant portion of the population served (16 percent, 20 percent, and 19 percent, respectively). A very small proportion of elderly individuals (over 65) applied to MHCP through the MNCAA program over the life of the program.

**Figure 10. Percent of total applicants submitting applications through the MNCAA program by age cohort**

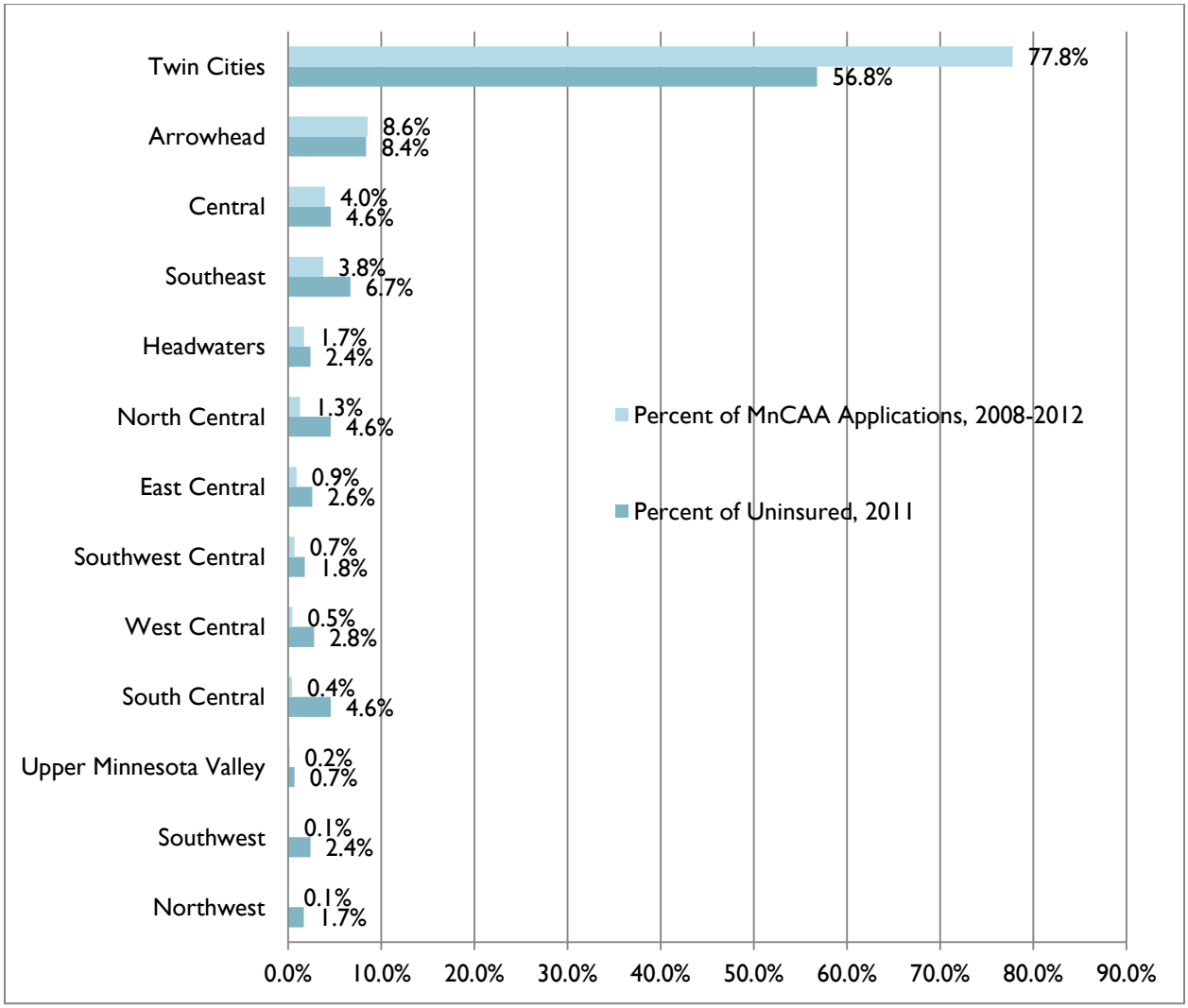



| | 2008 | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|---|
| *Total number of applicants* | *4,766* | *16,001* | *15,972* | *14,115* | *6,693* | *57,547* |

### *The Vast Majority of Applicants Submitting Applications through the MNCAA Program Reside in the Twin Cities Metro Area, Suggesting an Underrepresentation of MNCAAs Serving Greater Minnesota*

Over three-fourths of the applicants to MHCP via the MNCAA program between 2008 and 2012 live in the Twin Cities metro area. Yet just over half of the State's uninsured population in 2011 lives in the Twin Cities. While certainly not conclusive, this supports the notion that to date, the MNCAA program has been a more successful outreach strategy in the Twin Cities than it has been in Greater Minnesota, generally speaking. The Arrowhead and Central regions of the State stand out as exceptions to this rule.

**Figure 11. Distribution of total applicants submitting applications through the MNCAA program versus distribution of Minnesota's uninsured by economic development region**



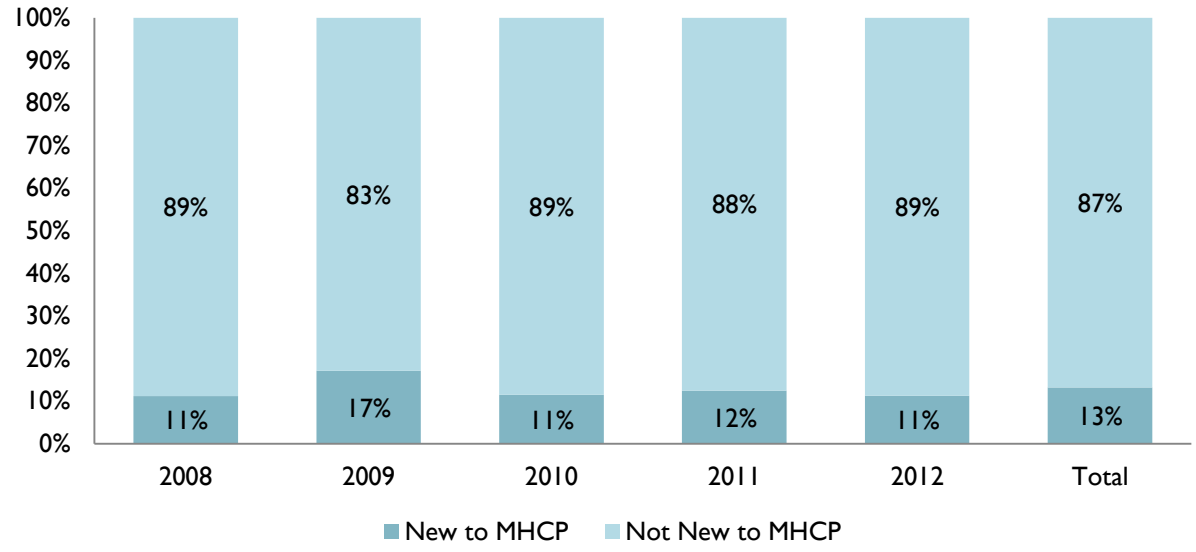

*Source for percent of Minnesota's uninsured by region, 2011: MDH Health Economics Program and University of Minnesota School of Public Health, Minnesota Health Access Surveys. Last updated 01112/2011. See separate map with regional definitions at http://www.health.state.mn.us/divs/hpsc/hasurvey/regions.pdf.*

### *Thirteen Percent of Applicants Assisted by MNCAA Organizations Are New to Minnesota Health Care Programs*

One helpful feature of the MNCAA database is that through periodic data reconciliation with DHS' health care payment system, MMIS, the Resource Center is able to track whether or not individuals assisted by the MNCAA program were new to MHCP. This measure is a meaningful indicator of how the MNCAA program is doing in terms of outreach to underserved populations that have difficulties accessing public health care programs.

As shown below, only 13 percent of applicants assisted by MNCAA organizations over the life of the program have been new to MHCP. This measure has ranged from a low of 11 percent to a high of 17 percent from 2008 to 2012. It is also important to note that this measure actually overstates the outreach effort to individuals new to MHCP through December 2010 because it includes a population of enrollees called "auto-newborns". Auto-newborns are automatically enrolled in MHCP when their mothers are enrolled and up until this point, the MNCAA program paid bonuses for these newborns and tracked them as new to MHCP. Technically speaking, auto-newborns are new to MHCP, but they probably should not be included in a measure intending to isolate the outreach effort.

**Figure 12. Percent of total applicants submitting applications through the MNCAA program who were new to MHCP**

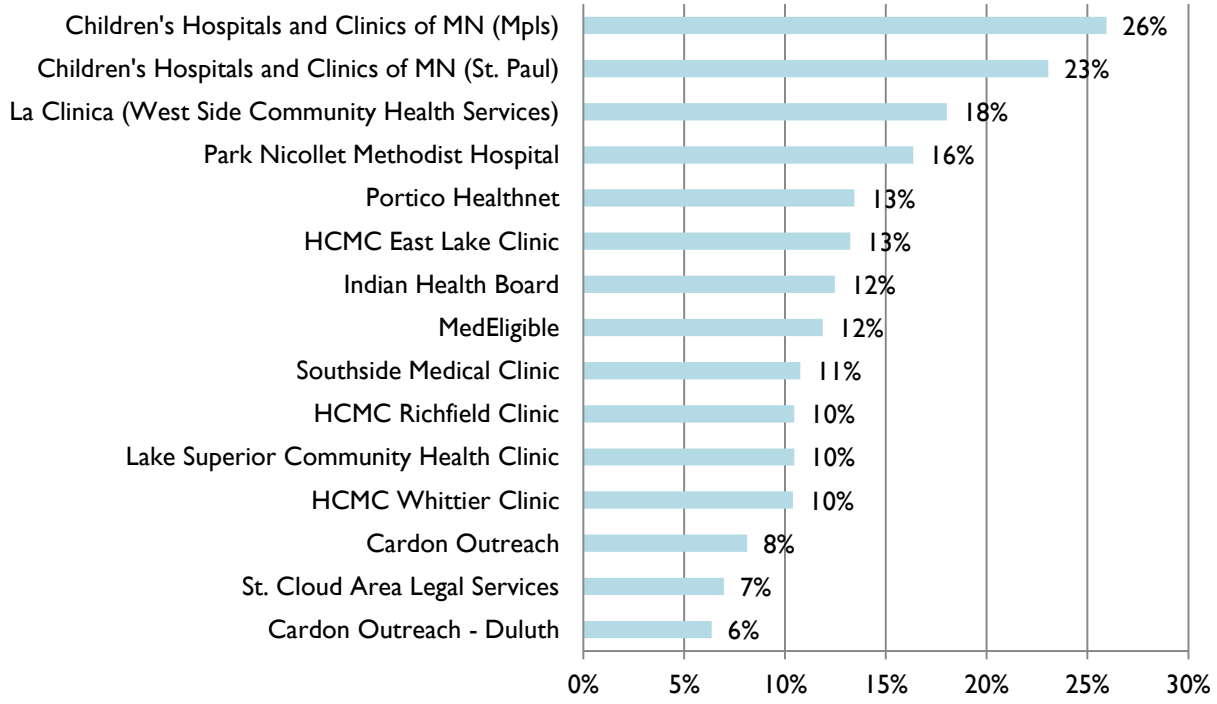



| | *2008* | *2009* | *2010* | *2011* | *2012* | *Total* |
|---|---|---|---|---|---|---|
| *Total number of applicants* | *4,766* | *16,001* | *15,972* | *14,115* | *6,693* | *57,547* |

Among the top 15 MNCAAs in terms of total application volume over 2008-2012, there is wide variability in the percent of applicants new to MHCP. Children's Hospitals and Clinics, both Minneapolis and St. Paul locations, have the highest percentage of applicants submitting applications through the MNCAA program during 2008-2012 who are new to MHCP, at 26 and 23 percent respectively. La Clinica and Park Nicollet Methodist Hospital are also above average when it comes to targeting

individuals who have not had attachments to the public health care system in the recent past. Within this group, Cardon Outreach, Cardon Outreach Duluth, and St. Cloud Area Legal Services appear to have the lowest percentage of applicants who are new to MHCP.

**Figure 13. Percent of applicants new to MHCP for top 15 MNCAAs (in terms of application volume), 2008-2012**




### *MNCAAs Initially Submit Complete Applications over Half the Time*

One of the main goals of the MNCAA program was for trained community partners to submit applications to the MNCAA Resource Center, counties, or MinnesotaCare with all questions answered and commonly required verifications attached (e.g., income, assets, citizenship, identity, pregnancy, information release). When applications are submitted with all verifications, applicants are more likely to be successfully enrolled in MHCP.

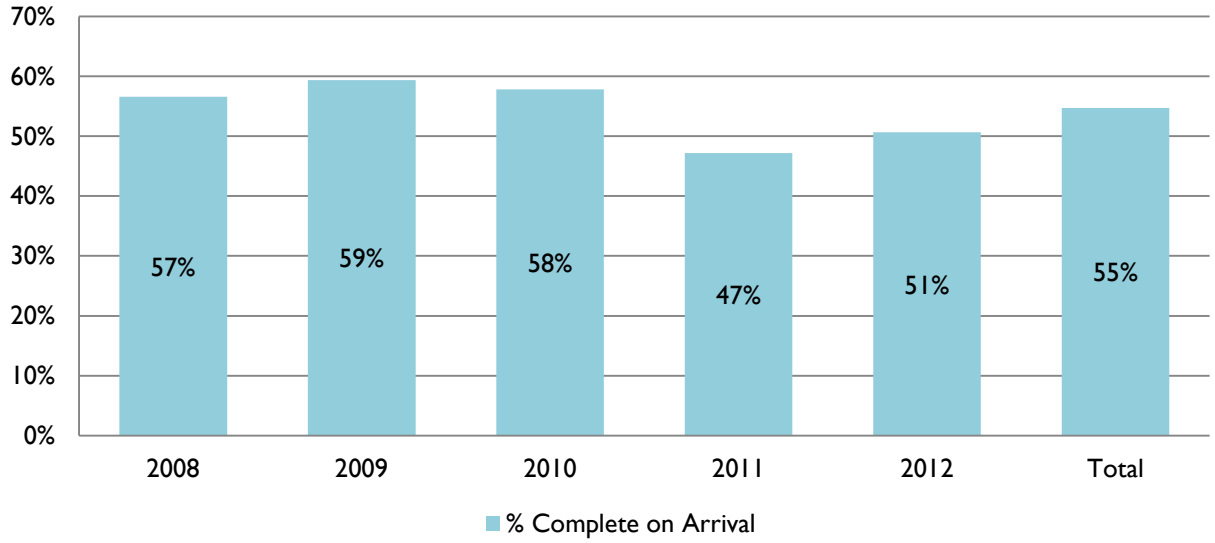
For the purposes of the MNCAA program, an application is considered "complete on arrival" if all required information for the applicant is provided to the Resource Center, counties, or MinnesotaCare upon initial submission. If not, the application goes into pending status. When remaining verifications are submitted for an applicant who has a pending application, the individual's application is considered "complete on follow-up".

Central MNCAA organizations submit applications to the MNCAA Resource Center for review before they are forwarded to counties or MinnesotaCare. At that time, MNCAA Resource Center staff determine and track whether an application is "complete on arrival" or not. If additional verifications

are received for a pending application, staff change the status of the application to "complete on follow-up". Regional MNCAA organizations submit applications directly to counties or to MinnesotaCare, but they still submit an application cover sheet to the MNCAA Resource Center indicating whether all necessary documentation has been provided to the service location upon initial submission. If it has, staff track the application as "complete on arrival". If it has not, staff do not mark the application as complete. A "complete on follow-up" designation is not used for applications submitted by regional MNCAAs.

Because of the discrepancy in process for applications submitted by central versus regional organizations, the best measure of application completeness available is the "complete on arrival" indicator. As shown below, applications submitted have been complete on arrival by MNCAA program standards 55 percent of the time over the life of the program (2008-2012). During this same time period, applications were complete on follow-up around 7 percent of the time, but again, it is not clear that this is a reliable figure given how differently applications from central and regional MNCAAs are processed and how application status is tracked.

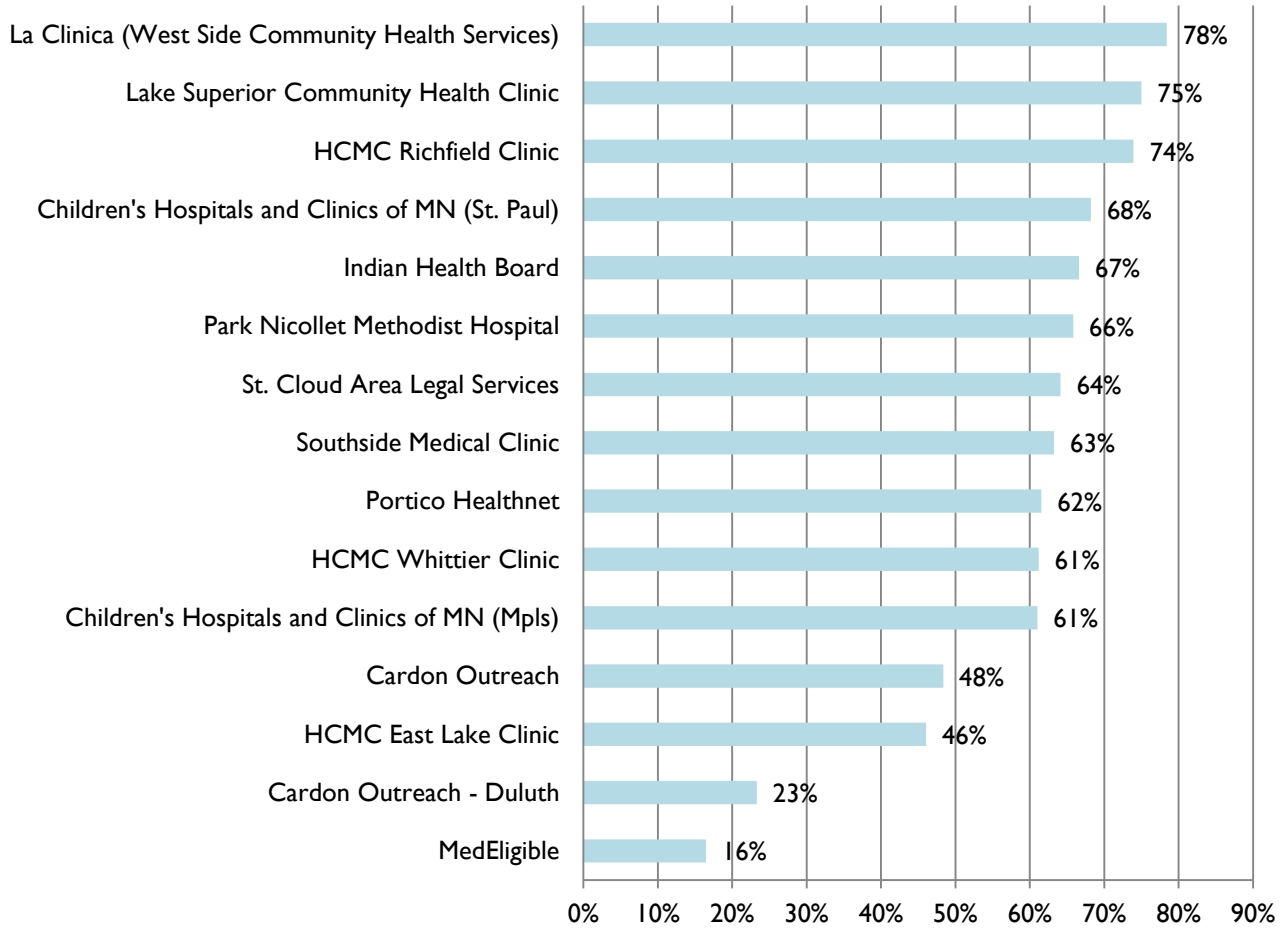
**Figure 14. Percent of total applicants with applications submitted through the MNCAA program considered complete on arrival**




| | *2008* | *2009* | *2010* | *2011* | *2012* | *Total* |
|---|---|---|---|---|---|---|
| *Total number of applicants* | *4,766* | *16,001* | *15,972* | *14,115* | *6,693* | *57,547* |

Among the top 15 MNCAAs in terms of total application volume over 2008-2012, there is wide variability in the percent of applicants with applications considered complete on arrival, ranging from 16 percent (MedEligible) to 78 percent (LaClinica). Eleven of the top 15 MNCAAs have application completion rates above the average rate of 55 percent for the program across 2008-2012.

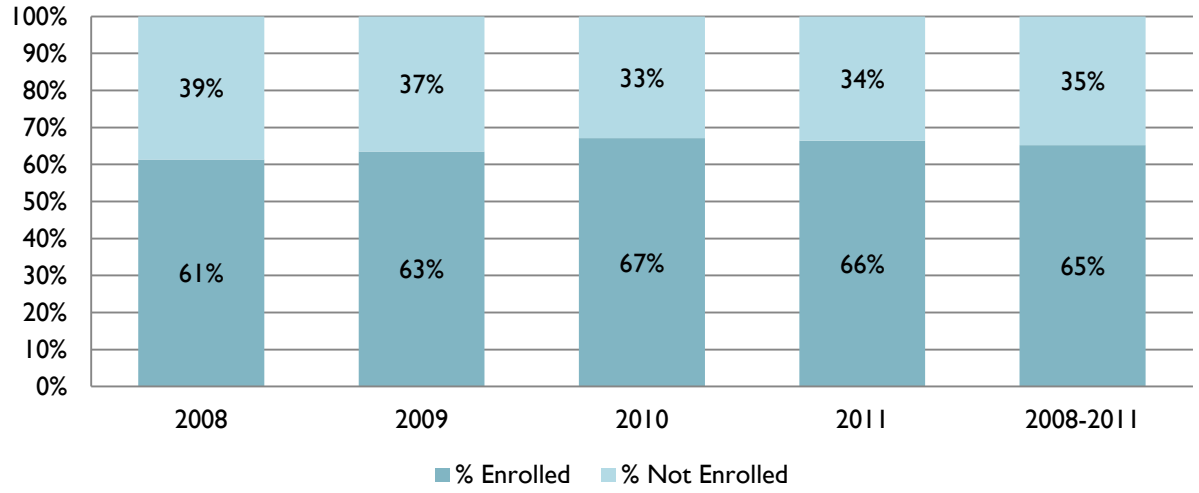
**Figure 15. Percent of applicants with applications considered complete on arrival for top 15 MNCAA organizations (in terms of application volume), 2008-2012**




### *Almost Two-Thirds of Applicants Applying for MHCP through the MNCAA Program Were Successfully Enrolled*

As shown in Figure 16, from 2008 to 2011, 65 percent of MHCP applicants applying through the MNCAA program were successfully enrolled. The percent of applicants successfully enrolled each year varied from 61 to 67 percent. Figure 17 illustrates that the vast majority of enrollees over the years were enrolled in the Medical Assistance program (79 percent across 2008-2011). Clients were also enrolled in MinnesotaCare and General Assistance Medical Care (GAMC) rograms (when GAMC was still in operation).

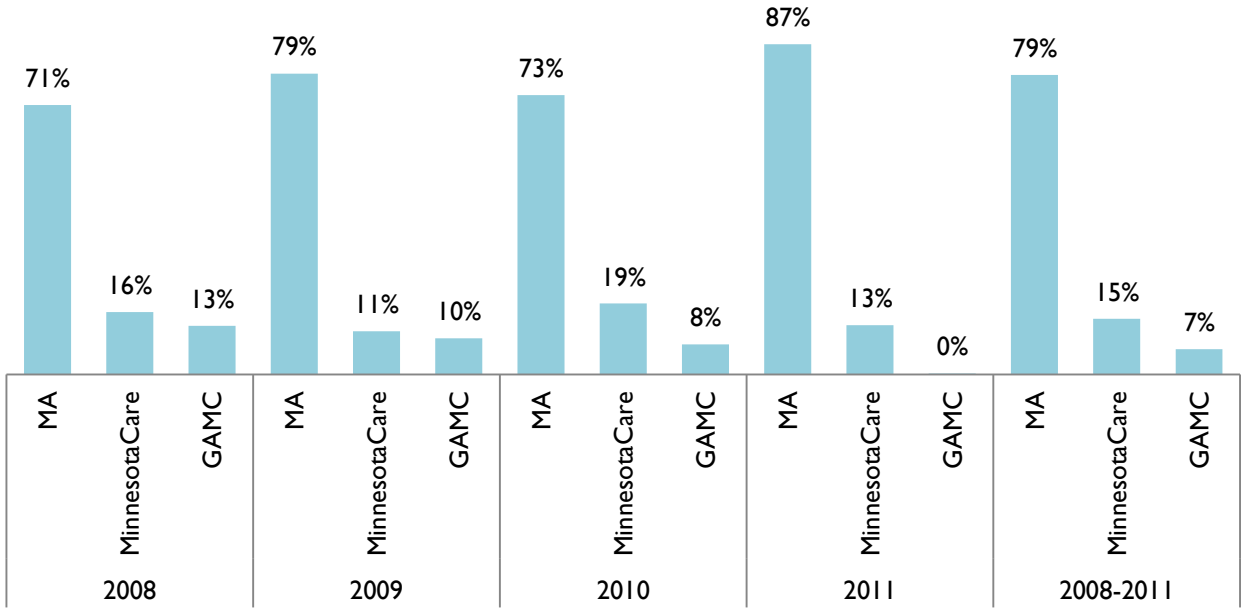
**Figure 16. Percent of total applicants submitting applications through the MNCAA program successfully enrolled in MHCP**




** 2012 is not included because current year enrollment data are not yet complete.*

| | *2008* | *2009* | *2010* | *2011* | *2008-2011* |
|---|---|---|---|---|---|
| *Total number of applicants* | *4,766* | *16,001* | *15,972* | *14,115* | *50,854* |

**Figure 17. Percent of successfully enrolled applicants by major program**

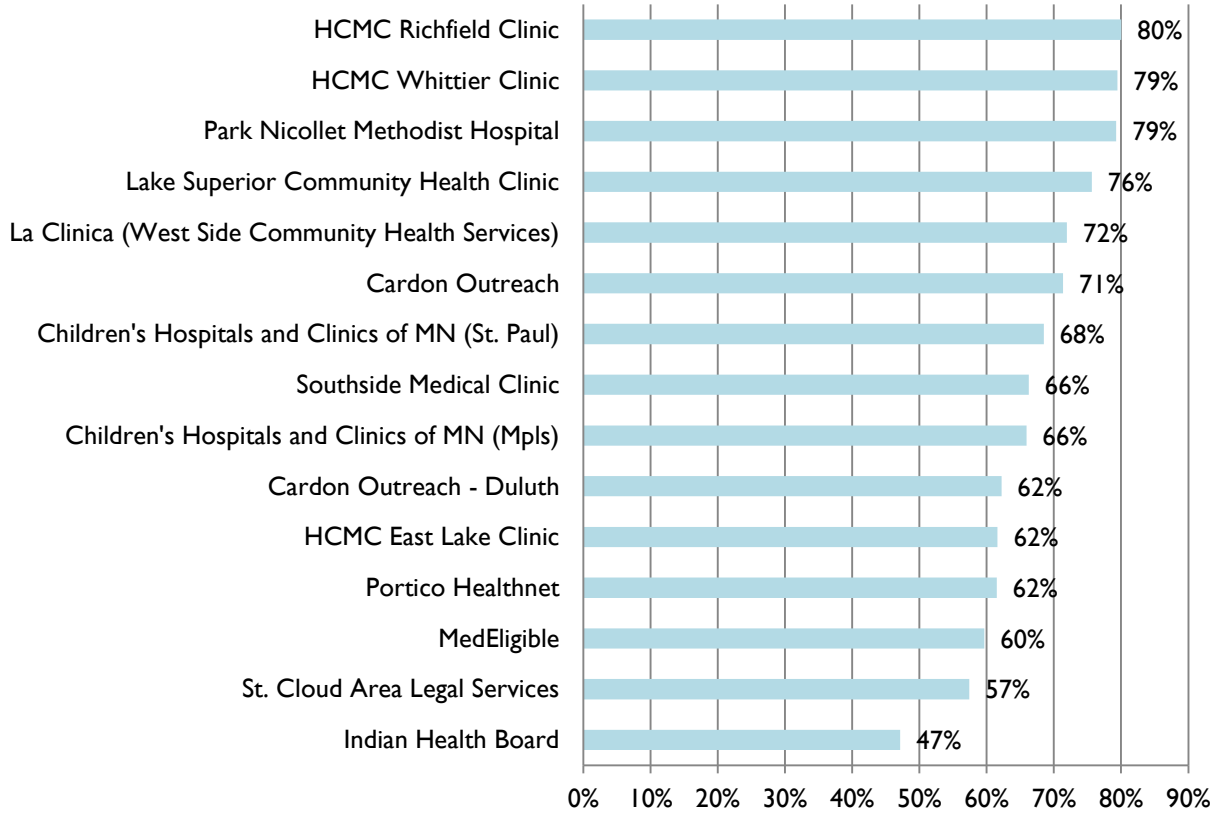



** 2012 is not included because current year enrollment data are not yet complete.*

| | *2008* | *2009* | *2010* | *2011* | *2008-2011* |
|---|---|---|---|---|---|
| *Total number of enrolled applicants* | *2,924* | *10,157* | *10,713* | *9,378* | *33,172* |

Among the top 15 MNCAAs in terms of total application volume over 2008-2012, there is wide variability in the percent of applicants who are successfully enrolled in MHCP, ranging from a low of 47 percent (Indian Health Board) to a high of 80 percent (HCMC's Richfield Clinic). Nine of the top 15 MNCAAs have applicant enrollment rates above the average enrollment rate of 65% for the program across 2008-2011.

**Figure 18. Percent of applicants successfully enrolled in MHCP for top 15 MNCAAs (in terms of application volume), 2008-2011**




** 2012 is not included because enrollment data are not yet complete.*

### *Enrollment Statistics are Positive Overall, But Long Waits Continue—for Clients as Their Applications are Processed and for MNCAAs Receiving Bonus Payments*

The MNCAA Resource Center pays eligible organizations their $25 bonus payments after receiving information from MMIS (via a weekly data match process) that applicants have been successfully enrolled in a public health care program. As Table 6 illustrates, however, there continues to be a long wait for clients waiting for applications to be processed and thus for MNCAAs receiving their bonus payments. Across 2008 to 2011, an average of 18 weeks elapsed between the time MNCAAs submitted clients' applications and the time they got their bonus payments associated with these applications.

According to interviews with State staff, this time lag is not due, for the most part, to MNCAA bonus payment processing time. Rather, it is indicative of systemic resource shortages in eligibility processing infrastructure at both county and State levels. While the county and MinnesotaCare representatives we interviewed acknowledged that the time spent by MNCAA outreach workers on the front end of the process often helped to increase the completion rate of applications submitted, it did not necessarily expedite the overall MHCP enrollment process due to the sheer volume of cases being processed in the order they are received and resource constraints.

**Table 6. Average number of weeks for MNCAAs to receive bonus payments after submitting client applications**

| Year | Average Number of Weeks* |
|---|---|
| 2008 | 17 |
| 2009 | 16 |
| 2010 | 21 |
| 2011 | 15 |
| **2008-2011** | **18** |

**Reflects the average difference between the date bonuses were paid and the date applications were received. 2012 is not included because enrollment and payment data are not yet complete.*

### *MNCAA Organizations Place Highest Value on Access to Case Status Updates*

This evaluation included interviews with outreach workers, managers, and directors from five MNCAA organizations. When asked what they valued most about the program, a clear and common response from everyone was "access to data and information". MNCAA organizations place a high value on their ability to call the MNCAA Resource Center for individual case status updates, often on a daily basis, and their ability receive the case status of many individuals at once by submitting forms to DHS periodically. This information is crucial to MNCAAs as they determine whether their clients need to submit additional verifications to successfully enroll in MHCP. In general, MNCAA organizations felt that getting questions answered through the MNCAA Resource Center was much easier and expeditious than working through the counties or MinnesotaCare.

While the MNCAA organizations we spoke to all seemed to value the training, reporting, and MHCP policy updates provided by the Resource Center to some degree (some to a limited degree), access to timely case status data seemed to be much more important. When asked whether the policy clarification provided by the Resource Center had increased their expertise on health care eligibility matters, most of individuals interviewed expressed their opinion that MNCAA staff had as much expertise (if not more expertise) as the individuals working in the Resource Center.

### *Most Individuals Interviewed Believed That the $25 Bonus per Enrollee Is an Insufficient Incentive if the Goal Is to Truly Engage a Broader Spectrum of Community Organizations in This Effort*

As mentioned earlier, certain Level 1 MNCAAs were willing to forgo the $25 bonus pay-for-performance incentives if they were able to retain access to the data provided by the Resource Center (most importantly, case status updates). By December of 2010, the Resource Center had entered into Data Share Agreements with 22 Level 1 MNCAA organizations. And during 2011 and roughly the first half of 2012, around 60 percent of the applications submitted through the MNCAA program came from MNCAAs that had Data Share Agreements with DHS. It appears that MNCAAs that already have some financial interest in securing public health care coverage for individuals—such as those affiliated with hospitals or clinics—are motivated to assist individuals with applications without the $25 pay-for-performance bonus.

The MNCAAs interviewed that continue to receive the bonus relayed that the $25 bonus certainly helps somewhat from a financial standpoint, but does not come close to covering the cost of doing this type of work. Most rely on other sources of funding (e.g., from the federal government, foundations, health care providers) to maintain their operations. It follows that to recruit and increase the participation of smaller organizations and/or organizations with different core missions that have connections with underserved populations, a higher financial incentive will likely be needed.

## IV. Policy Implications & Conclusions

The MNCAA program was implemented in an effort to rethink how to break down barriers to access to public health care programs for vulnerable populations through pay-for-performance partnerships with community organizations. A tiered approach to engagement was envisioned so that outreach funding could be targeted on community partners most willing and able to offer direct application assistance and a broad network of community organizations interested in helping in other ways could be fostered at the same time.

In just over four years, the program can point to many laudable results. For one, the program's reach has grown substantially. The number of Level 1 MNCAA organizations submitting applications has doubled, and the number of applications and number of individuals applying to MHCP through the MNCAA program has more than doubled. Importantly, despite long waits related to statewide infrastructure needs, almost two-thirds of those applying through the MNCAA program have successfully enrolled in MHCP. A core group of community partners with significant expertise and capacity to do outreach work has emerged, due in part to the resources, training, and technical assistance provided by the MNCAA program. And finally, in the face of several rounds of program budget cuts, the MNCAA Resource Center has been strategic in developing new partnership agreements (i.e., data share agreements) where possible so that pay-for-performance funding is available for expanding its network of community partnerships.

At the same time, questions remain about how the MNCAA program fits into the State's public health care outreach strategies and navigator program that will accompany the new health insurance exchange under the Affordable Care Act. As this report is being written, the details of these strategies are being contemplated by various State advisory task forces and workgroups. The most valuable takeaways from this evaluation are the lessons learned from the MNCAA program that should inform these broader decisions being made:

- **Significant expertise on reaching and enrolling individuals in public health care programs already exists within a core group of community organizations.** This expertise should be leveraged as the State defines the roles and responsibilities of health insurance exchange navigators. Many of these partners are organizations that have the capacity and resources to broaden the scope of their outreach and application assistance work beyond public health care programs, and could probably serve as resource and training "hubs" for a network of less experienced community partners, much like the role the MNCAA Resource Center has played thus far.

- **To be successful, outreach providers, application assisters (and navigators, however defined) need timely access to the most current case information on their clients.** The strength of the MNCAA model comes down to the fact that through the MNCAA Resource Center, community organizations are able to access timely case status information for their clients, where in the past they have had to negotiate within an already overburdened system. The MNCAA program serves an "express-lane" of sorts, allowing outreach staff to get

questions answered quickly so they can do proper follow-up with clients. This access to timely data is so crucial that to date, 37 MNCAAs have elected to participate as Data Share Organizations, foregoing bonus payments altogether. Admittedly, this finding opens up a whole new set of questions about the role of the State, the role of counties, and the role of community partners in the enrollment process. With proper controls, certification, and training, it is possible to envision a network of community partners who have real-time access to the State's eligibility and enrollment system, and who work collaboratively with the State and counties to ensure program integrity.

- **Implementing outreach, application assistance, and enrollment navigation activities may be most challenging in parts of Greater Minnesota.** The MNCAA program was designed with the goal of reaching individuals who are uninsured but eligible for MHCP from geographic areas in the State that have been traditionally underserved. While there has been a large increase in the number of Level 2 and 3 partners from Greater Minnesota in the last four years—due in large part to the outreach and recruitment efforts of the MNCAA Resource Center—applicants to MHCP via Level 1 MNCAAs come disproportionately from the Twin Cities. And only a few MNCAAs with significant application volume and expertise are located outside of the metro area. Regardless of the policy and program decisions made in connection with Minnesota's navigator program and health insurance exchange, targeted strategies to reach individuals in underserved counties in Greater Minnesota will be imperative.

- **It takes more than an innovative, pay-for-performance model to leverage the capacity of organizations who serve hard-to-reach populations.** While early, more intensive recruitment efforts by the MNCAA Resource Center had an initial impact, budget reductions and human resource constraints meant that over time, very minimal MNCAA Resource Center staff time could be spent working with Level 1 organizations that submitted fewer applications and Level 2 and Level 3 community partners. In addition, most organizations appear to view the pay-for-performance incentives associated with the MNCAA program ($25 for each individual successfully enrolled) as helpful, but inadequate. As a result, the vast majority applications submitted via the MNCAA program now come from health care organizations that have strong financial incentives to enroll individuals in public health care programs without the bonus payments. If the goal is to reach disparate groups who do not normally access the health care system, a "higher-touch" approach to recruiting and training new organizations through more substantial investments in human resources and financial incentives will be required.

## Appendix A: Key Informants Interviewed for MNCAA Program Evaluation

| Name | Organization |
|---|---|
| Jessica Crowley | Lake Superior Community Health Clinic (MNCAA) |
| Denise Denny | DHS (MinnesotaCare) |
| Jennifer Ditlevson | DHS (MNCAA Resource Center) |
| Susan Hammersten | DHS (Health Care Reform) |
| Connie Harju | Bois Forte Indian Health (MNCAA) |
| Laura Fonnier | HCMC Richfield Clinic (MNCAA) |
| Deb Holmgren and Leigh Grauman | Portico Healthnet (MNCAA) |
| Sarah Kelsea | AARP New Hampshire (Previously with DHS) |
| Sue Krey | Dakota County Human Services |
| Ralonda Mason | St. Cloud Area Legal Services (MNCAA) |
| Bob Paulsen | Minnesota Department of Commerce (Exchange Office) |
| Marcos Perez | DHS (MNCAA Resource Center) |
| Stephanie Radtke | Dakota County Human Services (Previously with DHS) |
| David Van Sant | DHS (Previously with MNCAA Resource Center) |
| Deb Waldriff | St. Louis County Public Health and Human Services |

## Appendix B: Discussion Guide for Key Informant Interviews

### DHS/MNCAA Resource Center Staff

- Briefly, what is your role at the Resource Center and what are your main responsibilities?
- What is the most valuable thing the Resource Center offers to MNCAAs?
- Have you noticed changes in the composition of community partners submitting applications (either geographic locations or organization types) over time?
- Have you noticed changes in the types of requests or questions you are getting from MNCAA organizations over time?
- What lessons have you learned along the way?
- In your opinion, would you say that the MNCAA program is in a phase of gaining momentum (adding new contracts, more applications, more efficiencies) or losing momentum?
- In general, on a scale of 1 to 10 (lowest to highest), how valuable do you think the Resource Center's training and technical assistance activities are?
- In general, on a scale of 1 to 10 (lowest to highest), how valuable do you think the Resource Center's data collection and monitoring activities are?
- What data or information do you use most often in providing technical assistance to MNCAAs or in program operations?
- Do you believe the training and technical assistance (policy clarification, case information, reporting) provided by the Resource Center has increased the expertise of MNCAA organizations participating in the MHCP enrollment process?
- Do you believe that the MNCAA organizations you work with are devoting more resources to assisting individuals with their applications than they would without the program and $25 bonus incentive?
- What changes would you suggest—to program design, financing, or administration—to reach more clients or increase the efficiency of the application process?
- Are there other questions that you wish I had asked about the MNCAA program?
- Do you have any other feedback on the MNCAA program to offer at this time?

### Individuals with Past Program Experience

- Briefly, what was your role at the Resource Center and what were your main responsibilities? When were you involved with this program?
- If you were involved in the start-up of the program, talk briefly about what the original goals of the program were and why the program was designed the way it was.

- Were there initial roadblocks and how were these overcome?
- How would you characterize the initial outcomes of the program?
- Do you believe that the MNCAA organizations you worked with were devoting more resources to assisting individuals with their applications than they would have without the program and $25 bonus incentive?
- If you are still knowledgeable about or involved with the program, would you say that the MNCAA program is in a phase of gaining momentum (adding new contracts, more applications, more efficiencies) or losing momentum?
- In general, on a scale of 1 to 10 (lowest to highest), how valuable do you think the Resource Center's training and technical assistance activities are?
- In general, on a scale of 1 to 10 (lowest to highest), how valuable do you think the Resource Center's data collection and monitoring activities are?
- What changes would you suggest—to program design, financing, or administration—to reach more clients or increase the efficiency of the application process?
- Are you aware of other interesting state models of investing in community partnerships to improve access to care?
- Are there other questions that you wish I had asked about the MNCAA program?
- Do you have any other feedback on the MNCAA program to offer at this time?

**County/MinnesotaCare Officials**

- Briefly, what is your role at the County/MinnesotaCare and what are your main responsibilities?
- How are you involved with the MNCAA program? How long have you been involved?
- Do you believe that the MNCAA program and DHS Resource Center create efficiencies in the MHCP enrollment process? If so, why?
- From your perspective, what is the most valuable thing about the MNCAA program or the work that the DHS Resource Center performs?
- In your opinion, would you say that the MNCAA program is in a phase of gaining momentum (adding new contracts, more applications, more efficiencies) or losing momentum?
- Do you think the size of the program is about right? Are the outcomes of the program significant in the grand scheme of MHCPs?
- Do you believe that the MNCAA organizations you work with are devoting more resources to assisting individuals with their applications than they would without the program and $25 bonus incentive?
- What changes would you suggest—to program design, financing, or administration—to reach more clients or increase the efficiency of the application process?

- Are you aware of other interesting state models of investing in community partnerships to improve access to care?
- Are there other questions that you wish I had asked about the MNCAA program?
- Do you have any other feedback on the MNCAA program to offer at this time?

**MNCAA Organization Staff**

- Briefly, what is your role within your organization and what are your main responsibilities?
- How are you involved with the MNCAA program? How long have you been involved?
- What is the value of the MNCAA program to your organization? What do you value the most?
- In general, on a scale of 1 to 10 (lowest to highest), how important do you think the Resource Center's training and technical assistance activities are?
- In general, on a scale of 1 to 10 (lowest to highest), how important do you think the Resource Center's data collection and reporting activities are?
- Do you believe the training and technical assistance (policy clarification, case information, reporting) provided by the Resource Center has increased the expertise of your organization as it helps individuals access needed health care services?
- Do you believe that your organization is able to devote more resources to assisting individuals with their applications than it would without the program and the $25 bonus incentive?
- In your opinion, would you say that your organization is in a phase of gaining momentum or losing momentum with respect to reaching underserved populations and helping them successfully navigate the application process?
- What changes would you suggest—to the design, financing, or administration of the program—to reach more clients or to increase the efficiency of the application process?
- Are you aware of other interesting state models of investing in community partnerships to improve access to care?
- Are there other questions that you wish I had asked about the MNCAA program?
- Do you have any other feedback on the MNCAA program to offer at this time?

**Health Insurance Exchange/Navigator Workgroup/Policy Perspective**

- Briefly, what is your role within your organization and what are your main responsibilities?
- How much do you know about the MNCAA program?
- What are your impressions of the program?
- Is the size of this program adequate? Are program outcomes significant to MHCP?

- What relevance do you think this program has as Minnesota develops its own health insurance exchange?
- What changes would you suggest—to the design, financing, or administration of the program—to reach more clients or to increase the efficiency of the application process?
- Are you aware of other interesting state models of investing in community partnerships to improve access to care?
- Are there other questions that you wish I had asked about the MNCAA program?
- Do you have any other feedback on the MNCAA program to offer at this time?

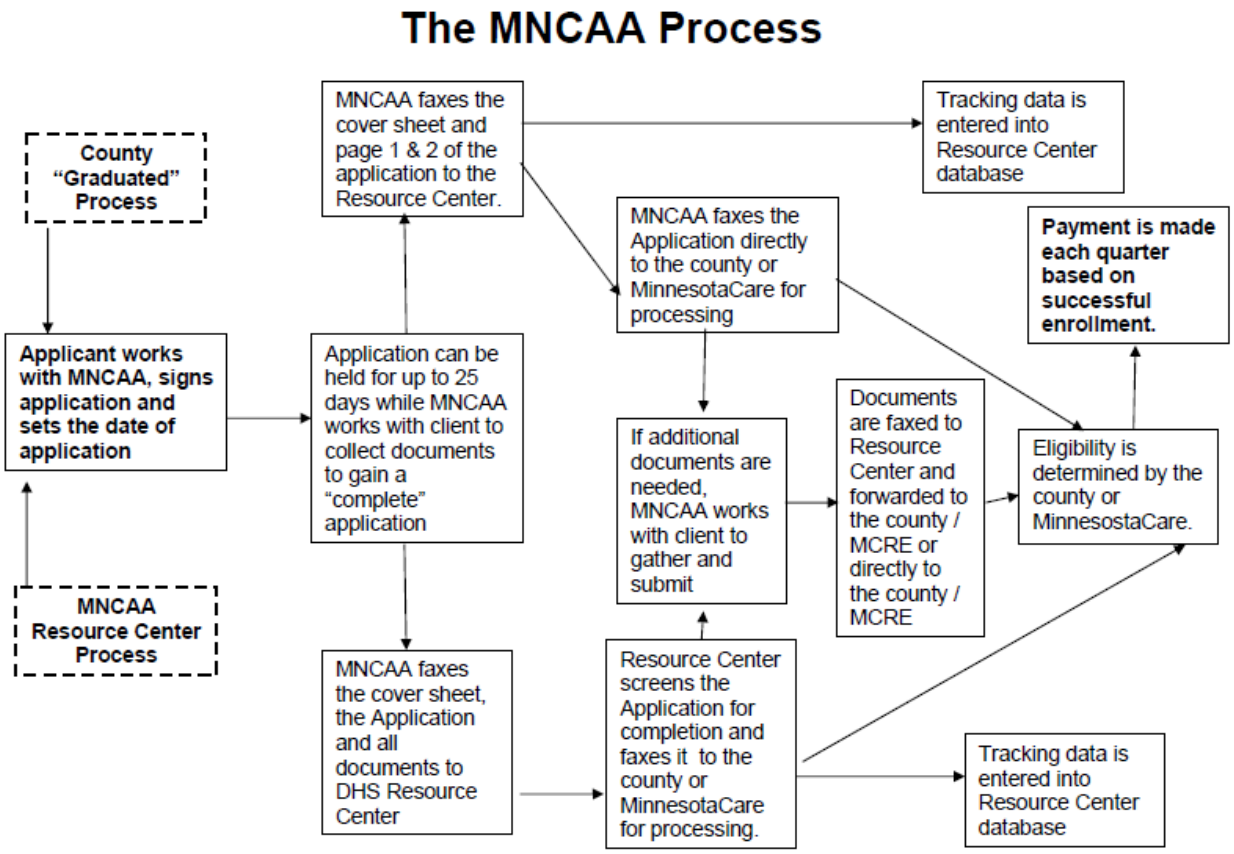
# Appendix C: Location and Type of Level I MNCAA Organizations

| Level 1 MNCAAs as of June 2012 | Location | Organization Type |
|---|---|---|
| African Immigrant Services | Brooklyn Park | Human Service |
| Allina Health System - Unity Hospital | Fridley | Health Care |
| Altegra Health | Miami Lakes, Florida | For-profit Business |
| American Indian Family Center | St. Paul | Human Service |
| ARC Greater Twin Cities | St. Paul | Human Service |
| Aspire Insurance Agency | Apple Valley | For-profit Business |
| Bois Forte Reservation Health Services | Nett Lake | Human Service |
| CADT - Center for Alcohol & Drug Treatment | Duluth | Human Service |
| CADT- Residential Treatment/Detox | Duluth | Health Care |
| Cardon Outreach | Golden Valley | Health Care |
| Cardon Outreach - Albert Lea Medical Center | Albert Lea | Health Care |
| Cardon Outreach - Austin Medical Center | Austin | Health Care |
| Cardon Outreach - Duluth | Duluth | Health Care |
| Cardon Outreach - Hibbing | Hibbing | Health Care |
| Cardon Outreach - North Country Health Services -Bemidji | Bemidji | Health Care |
| Cardon Outreach - Rochester | Rochester | Health Care |
| Cardon Outreach - St. Cloud Hospital | St. Cloud | Health Care |
| Cass Lake Indian Hospital | Cass Lake | Health Care |
| Catholic Charities - Branch I Food Shelf | Minneapolis | Human Service |
| Catholic Charities - Branch II Food Shelf | Minneapolis | Human Service |
| Catholic Charities - Counseling | St. Paul | Human Service |
| Catholic Charities - Hope Street for Runaway and Homeless Youth | Minneapolis | Human Service |
| Catholic Charities - Seton Services | St. Paul | Human Service |
| Catholic Charities of the Archdiocese of St. Paul and Minneapolis | Minneapolis | Human Service |
| Center for Independent Living of Northeastern Minnesota | Hibbing | Human Service |
| Centro, Inc | Minneapolis | |
| Children's Dental Services | Minneapolis | Health Care |
| Children's Hospitals and Clinics of MN (Mpls) | Minneapolis | Health Care |
| Children's Hospitals and Clinics of MN (St. Paul) | St. Paul | Health Care |
| Children's Mental Health Services | Grand Rapids | Mental Health |
| Chinese Social Services Center | Richfield | Human Service |
| CILNM – Aitkin | Aitkin | Human Service |
| CILNM – Brainerd | Brainerd | Human Service |
| CILNM - Cass Lake | Cass Lake | Human Service |
| CILNM – Coleraine | Coleraine | Human Service |
| CILNM – Duluth | Duluth | Human Service |
| CILNM - International Falls | International Falls | Human Service |
| CLUES – Grantee | Minneapolis | Human Service |
| discapacitados abriendose caminos | South St. Paul | Human Service |
| East Side Family Clinic | St. Paul | Health Care |
| Face to Face Health and Counseling Service, Inc. | St. Paul | Health Care |
| Fergus Falls Public Schools | Fergus Falls | Local Government |
| Fond du Lac Human Services Division | Cloquet | Human Service |
| Genesis II for Families | Minneapolis | Human Service |
| HCMC - Hennepin County Medical Center | Minneapolis | Health Care |
| HCMC Brooklyn Center Clinic | Brooklyn Center | Health Care |
| HCMC Brooklyn Park Clinic | Brooklyn Park | Health Care |

| Level 1 MNCAAs as of June 2012 | Location | Organization Type |
|---|---|---|
| HCMC East Lake Clinic | Minneapolis | Health Care |
| HCMC Richfield Clinic | Richfield | Health Care |
| HCMC Whittier Clinic | Minneapolis | Health Care |
| Health Start School-Based Clinic | St. Paul | Health Care |
| Healthcare for the Homeless/House Calls | St. Paul | Health Care |
| HealthFinders Collaborative, Inc | Northfield | Health Care |
| Helping Hand Dental Clinic | St. Paul | Health Care |
| Hennepin County Medical Center (HCMC) - FY12 Grant | Minneapolis | Health Care |
| Hmong American Partnership | St. Paul | Human Service |
| Indian Health Board | Minneapolis | Health Care |
| Indian Health Board – Grantee | Minneapolis | Health Care |
| Inter-County Community Council Head Start | Oklee | CAP Agency |
| La Clinica (West Side Community Health Services) | St. Paul | Health Care |
| Lake Superior Community Health Clinic | Duluth | Health Care |
| Lakes and Prairies Community Action Partnership, Inc. | Moorhead | CAP Agency |
| LakeWood Health Center | Baudette | Health Care |
| Lao Assistance Center of Minnesota | Minneapolis | Health Care |
| Lao Family Community of Minnesota | St. Paul | Human Service |
| Leech Lake Tribal Health | Cass Lake | Health Care |
| Liberia Build Project | Brooklyn Park | Human Service |
| Mahube Community Council Inc. | Detroit Lakes | CAP Agency |
| McDonough Homes Clinic | St. Paul | Health Care |
| MedEligible | Minneapolis | For-profit Business |
| Migrant Health Services | Moorhead | Health Care |
| Migrant Health Services – Rochester | Rochester | Health Care |
| Minneapolis Public Schools | Minneapolis | Education |
| Minneapolis Urban League | Minneapolis | Human Service |
| Minnesota AIDS Project | Minneapolis | Human Service |
| Minnesota Veterans Home – Hastings | Hastings | Local Government |
| Native American Community Clinic | Minneapolis | Health Care |
| Northern Pines Little Falls | Little Falls | Health Care |
| Northern Pines Long Prairie | Long Prairie | Health Care |
| Northern Pines Mental Health Center | Brainerd | Health Care |
| Northern Pines Staples | Staples | Health Care |
| Northern Pines Wadena | Wadena | Mental Health |
| Northfield Community Action Center | Northfield | CAP Agency |
| Olmsted Community Action Program | Rochester | CAP Agency |
| Otter Tail County Public Health - OTCFSC | Fergus Falls | Human Service |
| Our Saviour's Outreach Ministries | Minneapolis | Housing Organization |
| Park Elder Center | Minneapolis | Human Service |
| Park Nicollet Health Services | St. Louis Park | Health Care |
| Park Nicollet Methodist Hospital | St. Louis Park | Health Care |
| Portico Healthnet | St. Paul | Human Service |
| Portico Healthnet – Grantee | St. Paul | Health Care |
| Prairie Five Head Start | Madison | CAP Agency |
| PrimeWest Health | Alexandria | Health Care |
| Project Life | Stillwater | Human Service |
| Rainy Lake Medical Center | International Falls | Health Care |
| Red Lake IHS Hospital | Red Lake | Health Care |
| Regina Medical Center | Hastings | Health Care |

| Level 1 MNCAAs as of June 2012 | Location | Organization Type |
|---|---|---|
| Riverwood Healthcare Center | Aitkin | Health Care |
| Robbinsdale Area Schools Welcome Center | New Hope | Education |
| SafeZone - Face to Face | St. Paul | Youth |
| Salvation Army | Roseville | Human Service |
| SAO - CCO-Center City | Minneapolis | Human Service |
| SAO - Central Corps/Need | Minneapolis | Human Service |
| SAO - Dakota/Scott/Carver County | Rosemount | Human Service |
| SAO - Eastside Corps | St. Paul | Human Service |
| SAO - Harvest Corps/Anoka | Anoka | Human Service |
| SAO – Lakewood | Maplewood | Human Service |
| SAO - Parkview Corps/North | Minneapolis | Human Service |
| SAO - St. Paul Citadel Corps/West 7th | St. Paul | Human Service |
| SAO - Temple Corps/South | Minneapolis | Human Service |
| SAO - Washington County | Woodbury | Human Service |
| SAO - Wright/Sherburne County | Buffalo | Human Service |
| SAO -Noble Corps | Brooklyn Park | Human Service |
| South Lake Pediatrics | Minnetonka | Health Care |
| Southside Community Health Services | Minneapolis | Health Care |
| Southside Dental Clinic/Admin-SS | Minneapolis | Health Care |
| Southside Medical Clinic | Minneapolis | Health Care |
| Southside Outreach | Minneapolis | Health Care |
| Southwest Senior Center | Minneapolis | Human Service |
| St. Cloud Area Legal Services | St. Cloud | Legal Service |
| St. Croix Family Medical Clinic-SS | Stillwater | Health Care |
| St. Joseph's Area Health Services | Park Rapids | Health Care |
| St. Mary's Health Clinics | St. Paul | Health Care |
| Stevens Community Medical Center | Morris | Health Care |
| TCC Action | Little Falls | CAP Agency |
| The Minnesota Chippewa Tribe | Cass Lake | Senior Service |
| U of M Physicians – PFS | Minneapolis | Health Care |
| UMP - Bethesda Clinic | St. Paul | Health Care |
| UMP - Broadway Family Medicine | Minneapolis | Health Care |
| UMP - Phalen Village Clinic | St. Paul | Health Care |
| UMP - Smiley's Clinic | Minneapolis | Health Care |
| University LifeCare Center | Minneapolis | Human Service |
| University of Minnesota Physicians - Family Medicine Clinics | Minneapolis | Health Care |
| Vietnamese Social Services of MN | St. Paul | Human Service |
| Volunteers of America of Minnesota | Minneapolis | Human Service |
| West Side Dental Clinic | St. Paul | Health Care |
| West Suburban Teen Clinic | Excelsior | Youth |
| Winona Senior Advocacy Program | Winona | Human Service |
| Working Well Mental Health Clinic | St. Paul | Health Care |
| Zumbro Valley - Mental Health Center | Rochester | Mental Health |

## Appendix D: Diagram of the MNCAA Process




*Source: "MNCAA Program Annual Report (January 1 to December 2008)", prepared by Sarah Kelsea, Minnesota Department of Human Services*