

EDUCATING MEDICAID BENEFICIARIES ABOUT  
MANAGED CARE: APPROACHES IN 13 CITIES

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May 2000

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Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the Fund or its directors, officers, or staff.

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## EXECUTIVE SUMMARY

If they are to become knowledgeable and effective managed care consumers, Medicaid beneficiaries must understand how to choose a managed care plan, how to navigate the managed care system, and how to engage in healthy behaviors. Educating Medicaid beneficiaries about these key aspects of managed care presents enormous challenges that stem from the complexity of the system and the characteristics of the consumers. In many areas of the country, the Medicaid managed care program is extraordinarily complicated: numerous plans are in operation; carved-out services continue to be accessed through a fee-for-service system; and categories of beneficiaries are excluded or exempt from mandatory enrollment. In addition, the programs are subject to continual policy changes and pressures to enroll large numbers of people in short time frames. Beneficiaries themselves are hindered by low education and literacy levels. Many do not trust the system and many have developed “inappropriate” patterns of utilization in response to the failures and obstacles of the fee-for-service system.

This study is intended to help policymakers develop and sustain programs that will teach beneficiaries to understand, use, and benefit from Medicaid managed care. It documents the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country. The 13 cities were selected on the basis of the size of the Medicaid population, managed care penetration rates, and innovative managed care education and outreach practices. We also sought to have a range in maturity of the managed care programs and varied experiences using enrollment brokers. We collected information about educational approaches under way in January 1999 using three methods: (1) reviews of state Medicaid agency contracts with managed care plans and enrollment brokers; (2) interviews with state Medicaid and enrollment broker representatives; and (3) reviews of enrollment packet materials. Using these sources, we examined the development, design, and content of enrollment materials sent to beneficiaries. We also studied other mechanisms that are being used to convey information about managed care—public awareness campaigns, counseling sessions and presentations, and the use of community-based organizations—and the way in which government agencies monitor and oversee education and outreach efforts.

All 13 cities have tried to strike a balance between providing sufficient information on the one hand and not overwhelming the beneficiary on the other. Nevertheless, each site has taken a slightly different approach or placed different emphases on the substance of the message they convey. Some, for example, provide detailed grids that compare plans (one even includes details about when gifts are provided to members); others have taken a more bare-bones approach. Only one site furnishes data on customer satisfaction and none

of the cities compares plans on quality measures such as the Health Plan Employer Data and Information Set (HEDIS). Similarly, some enrollment materials focus primarily on advising beneficiaries about how to select a plan (for example, the District of Columbia provides eight pages in an interactive workbook format); others address the same subject in just a few sentences. Virtually all sites used public awareness campaigns, in-person and telephone counseling, and outreach through community-based organizations. Again, the extent and nature of these efforts vary, often depending on time and resource constraints.

These decisions—of what topics to cover and what approaches and techniques to use—involve trade-offs that are often made without a clear weighing of the options or an understanding of their implications. “We don’t know what works,” one broker representative explained with frustration. Although their efforts varied, all 13 sites suffered to some degree from the same set of weaknesses. These and other cities could benefit from the following recommendations:

- Medicaid programs should tailor their educational messages to meet the needs of beneficiaries. While these cities face an enormous educational challenge, few have sought any educational expertise or advice in the development of their enrollment materials or outreach strategies. Beneficiaries rarely have input into materials development, and the ways in which information is conveyed are often designed primarily to accommodate health plan concerns about bias and advocates’ concerns about comprehensiveness. The result in nearly all cases is that educational materials are poorly suited to the needs of Medicaid beneficiaries. An overall communications strategy is virtually nonexistent.
- Medicaid programs should develop up-to-date provider databases and provide appropriate plan-specific information. The number-one criterion that Medicaid beneficiaries use to select a health plan is their current provider’s plan affiliations. However, none of the sites has developed satisfactory methods to make up-to-date, accurate provider information available to beneficiaries when they are choosing a plan. The distribution of provider directories has proven expensive and inefficient, and the size of the reports has overwhelmed consumers. Electronic databases for use by telephone hotline staff or other counselors hold more promise, but substantial data-quality problems remain.

In addition to improving provider information, Medicaid agencies need to align plan comparison information with consumer needs. Conventional wisdom says that beneficiaries are incapable of understanding quality measures and comparative information about consumer satisfaction. Yet this is precisely the information that beneficiaries express interest in. Such information will be useless, however, unless

it is accompanied by translation of technical terms into everyday language.

- Medicaid programs need to develop tools to assess the effectiveness of their educational efforts. Ironically, localities often try to compensate at the back end for what they lack at the front end in their development of materials and outreach strategies. They do this by collecting huge amounts of data on numbers and kinds of presentations, counseling sessions, phone calls, etc. But despite these efforts, most state officials do not feel they are any closer to understanding the most effective way to reach beneficiaries and convey these complex messages, or how to judge the efforts now under way.
- Medicaid managed care education should be part of a comprehensive and continuing strategy, not merely a “one-shot” effort. In many places, the underlying system itself is so complicated—with numerous plans, carved-out services, excluded or exempt groups, and differing drug formularies—that the educational task is overwhelming. Certainly, many state officials and brokers with whom we spoke agree that the educational needs of beneficiaries cannot be met with a single set of materials as part of a one-time enrollment blitz. Most brokers and states acknowledge the need for continual education, but no one knows who will pay for it. Originally, many believed that this role would fall naturally to the health plans, which would have the incentive to teach patients how to use the system and how to access preventive care, keep themselves healthy, and manage their illnesses. But with half of patients enrolled in Medicaid for less than a year, and many others enrolled in plans for shorter periods (particularly in locations where there is no plan lock-in), the plans have little incentive to invest up front in the education of their members.

The enrollment process presents a critical moment for reaching beneficiaries to begin to explain the elements of managed care, but it is only one point on a continuum. Patients must understand how to choose a plan, how to access and navigate their way around the system, and how to keep themselves and their family members healthy. All of these messages cannot be delivered through the single vehicle of enrollment counseling or a brochure. In addition, from the beneficiary’s perspective, managed care is not an issue that stands apart from other social programs and benefits. Medicaid beneficiaries must also be familiar with a whole array of social service programs, benefits (e.g., Child Health Plus) and regulations (e.g., welfare reform). But right now, these competing and disconnected messages—usually delivered by different entities—threaten to drown each other out.

What is needed is a series of clear and focused messages tailored to the needs of Medicaid beneficiaries and delivered through multiple approaches and settings—all of

which are periodically and systematically evaluated. In other words, what these sites need, and what none has yet achieved, is a comprehensive education strategy.

# EDUCATING MEDICAID BENEFICIARIES ABOUT MANAGED CARE: APPROACHES IN 13 CITIES

## INTRODUCTION

States are becoming increasingly reliant on managed care programs to contain rising Medicaid costs and to improve the quality of care. In 1991, only 10 percent of the Medicaid population was enrolled in managed care. By the end of 1998, that figure had risen to 54 percent, or 16.8 million beneficiaries.<sup>1</sup>

In theory, managed care controls rising costs by replacing unnecessary specialty and acute hospital care with primary and preventive care. By providing enrollees with access to primary care providers who can coordinate their health care needs, it is intended to foster continuity of care. Quality of care is to be improved as managed care organizations compete against one another for enrollees while Medicaid beneficiaries “vote with their feet” by selecting better-performing plans. However, if cost savings are to be realized and enrollees are to benefit from the promise of managed care, Medicaid beneficiaries must understand how to choose a managed care plan, how to navigate the managed care system, and how to engage in healthy behaviors and manage their illnesses.

- **How to choose:** If they are to select the best health plan for themselves and their families, beneficiaries must understand that they have a choice, identify the criteria critical to making the choice, and synthesize information to compare plans. They must then act on their choice, either by completing the appropriate forms, or by calling a helpline. If they do not choose a plan, they are assigned to one, generally without regard to cultural, linguistic, or geographic considerations.<sup>2</sup> Often they are auto-assigned to the lowest-paid plans. This reduces the pressure on plans to compete for enrollment through quality.<sup>3</sup>
- **How to navigate:** To ensure access to health care services, beneficiaries need to understand and comply with managed care rules that are more complicated than those of the fee-for-service system and place more responsibility on the consumer. For example, enrollees are often required to notify their plan of a hospital

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<sup>1</sup> Health Care Financing Administration, “Medicaid Managed Care State Enrollment—December 31, 1998.” Accessed: [www.hcfa.gov/medicaid/omcpr98.htm](http://www.hcfa.gov/medicaid/omcpr98.htm).

<sup>2</sup> J. Ferber, “Auto-Assignment and Enrollment in Medicaid Managed Care Programs,” *Journal of Law, Medicine & Ethics* 24 (Summer 1996):99–107.

<sup>3</sup> K. Maloy et al., *Role of Auto-Enrollment in Mandatory Medicaid Managed Care: A Preliminary Report*, Princeton: Center for Health Care Strategies, July 1998.

emergency department visit within a specified time frame if the service is to be covered. They must know how to file for a fair hearing in order to continue receiving services that a plan intends to reduce or deny. Those who do not understand the rules are less likely to use their plans correctly and may seek care outside the plan's network.<sup>4</sup> They are also more likely to experience delayed or even denied care and, not surprisingly, are generally more frustrated and dissatisfied with the managed care system.<sup>5</sup>

- How to engage in healthy behaviors: Under the Medicaid fee-for-service system, limited access to outpatient care and lack of patient education have produced high rates of preventable hospitalizations and avoidable emergency room use and low rates of preventive care.<sup>6,7</sup> Studies have shown that health education can lower morbidity for Medicaid beneficiaries, and can be cost-effective even for chronic illnesses such as asthma.<sup>8,9,10</sup> Without extensive education, however, managed care plans will have to pay for inappropriate and unnecessary care.

Only a few studies assess how well Medicaid managed care beneficiaries understand the system, but the evidence that does exist indicates there is substantial confusion. In 1995, one-quarter of new Medicaid managed care enrollees in upstate New York reported that they did not know that there is a difference between fee-for-service and managed care.<sup>11</sup> Less than half of Tennessee Medicaid beneficiaries using the emergency department in 1995 knew that they might be personally liable for the bill if their visit was not for a true emergency.<sup>12</sup> Unpublished studies have confirmed

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<sup>4</sup> C. Molnar, D. Soffel, and W. Brandes, *Knowledge Gap: What Medicaid Beneficiaries Understand and What They Don't About Managed Care*, Community Service Society of New York, December 1996.

<sup>5</sup> Frederick Schneiders Research, *Medicaid and Managed Care: Focus Group Studies of Low-Income Medicaid Beneficiaries in Five States*, Henry J. Kaiser Family Foundation, May 1996.

<sup>6</sup> P. Cunningham et al., "The Use of Hospital Emergency Departments for Nonurgent Health Problems: A National Perspective," *Medical Care Research and Review* 52 (December 1995):453-74.

<sup>7</sup> The Medicaid Access Study Group, "Access of Medicaid Recipients to Outpatient Care," *The New England Journal of Medicine* 330 (December 1995):1426-30.

<sup>8</sup> Bolton et al., "The Cost and Effectiveness of an Education Program for Adults Who Have Asthma," *Journal of General Internal Medicine* 6 (September/October 1991):401-07.

<sup>9</sup> P. H. Mayo, J. Richman, and H. W. Harris, "Results of a Program to Reduce Admissions for Adult Asthma," *Annals of Internal Medicine* 112 (June 1990):864-71.

<sup>10</sup> L. S. Wissow et al., "Case Management and Quality Assurance to Improve Care of Inner-City Children," *American Journal of Diseases of Children* 142 (July 1988):748-52.

<sup>11</sup> L. Wright Morton, "Medicaid Enrollment Choice into Managed Care Health Plans," *Medical Care Research and Review* 55 (June 1998):211-38.

<sup>12</sup> C. Young et al., "Access to Emergency Care Under TennCare: Do Patients Understand the System?," *Annals of Emergency Medicine* 30 (September 1997):281-85.

that there is general confusion among Medicaid beneficiaries over the basic concepts of managed care.<sup>13,14,15</sup>

Educating Medicaid beneficiaries presents enormous challenges that stem from both the complexity of the system and the characteristics of the consumers. The Medicaid managed care program is extraordinarily complicated in many parts of the country. In some cities, there are as many as 18 plans in operation, with new plans emerging or (as is now more often the case) plans periodically withdrawing. Certain benefits, e.g., dental care, family planning, and pharmacy services, are often carved out and must be obtained through the fee-for-service system. In some state programs, services are carved out only for certain eligibility groups or selected plans.

Keeping information current is a constant challenge because policies change frequently. For example, during the first seven weeks of Maximus's enrollment broker contract in California, the broker reported that the state made more than 300 policy changes.<sup>16</sup> Such difficulties have been compounded in many places by programmatic pressure to enroll large numbers of people into mandatory programs within short time frames.<sup>17,18</sup> The need for education does not end after the initial wave of enrollment: less than half of all Medicaid beneficiaries stay on Medicaid for more than a year, creating a continual need to educate new enrollees.<sup>19</sup>

Beneficiaries themselves face significant obstacles in learning how to navigate the system. Many are hindered by low levels of education and literacy. The 1992 National Adult Literacy Survey found that 72 percent of the Aid to Families with Dependent Children (AFDC) population scored in the lowest two levels of document literacy.<sup>20</sup> At

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<sup>13</sup> United Planning Organization and the Academy for Educational Development, "Selected Findings: Audience Research with District of Columbia Medicaid Beneficiaries to Guide the Development of Educational Strategies for the Transition to Medicaid Managed Care," unpublished report, July 1997.

<sup>14</sup> Molnar et al., 1996.

<sup>15</sup> V. Lewis and K. Lawler, *The Transition to Managed Care: Experiences of Planned Parenthood Patients*, Planned Parenthood of New York City, April 1997.

<sup>16</sup> General Accounting Office, *Medicaid Managed Care: Delays and Difficulties in Implementing California's New Mandatory Program*, Letter Report (October 1, 1997), GAO/HEHS-98-2.

<sup>17</sup> K. Maloy et al., *Results of a Multi-Site Study of Mandatory Medicaid Managed Care: Enrollment Systems—Implication for Policy and Practice*, Princeton: Center for Health Services Research and Policy, March 1999.

<sup>18</sup> O. Carrasquillo et al., "Can Medicaid Managed Care Provide Continuity of Care to New Medicaid Enrollees? An Analysis of Tenure on Medicaid," *American Journal of Public Health* 88 (March 1998):464-66.

<sup>19</sup> P. Farley Short and V. Freedman, "Single Women and the Dynamics of Medicaid," *Health Services Research* 33 (December 1998):1309-36.

<sup>20</sup> P. Barton and L. Jenkins, *The Literacy Skills of Welfare Recipients in the U.S.*, Educational Testing

these reading levels, a person can generally locate an intersection on a street map, but cannot interpret a bus schedule. The majority of beneficiaries, therefore, faces substantial obstacles in interpreting the grid formats used to present comparative information about plans. Even the most basic terms used to describe managed care—e.g., “gatekeeper,” “grievance,” “network,” and “provider” are multisyllabic and consequently difficult to read.

Other Medicaid beneficiaries do not speak English. Translation of certain health care concepts poses significant challenges, particularly when there are no equivalent terms in the other language. Chinese and Vietnamese, for example, have no words for “routine checkup” and “mammogram.”<sup>21</sup> In addition, non-English-speaking immigrants are not always literate in their native languages.

Finally, many beneficiaries do not trust the system. Managed care marketing abuses have caused some to be skeptical. The failures and obstacles of the fee-for-service system have led many to develop inappropriate utilization patterns (e.g., reliance on emergency departments for routine care). These patients will need to be convinced that more appropriate use of the health care system will work to their benefit.

All Medicaid managed care programs face these and many other challenges as they try to design effective education programs. This study of managed care education efforts in 13 U.S. cities is intended to assist policymakers in developing and sustaining programs to help Medicaid beneficiaries understand, use, and benefit from managed care.

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Service, 1995.

<sup>21</sup> R. Pasick et al., “Problems and Progress in Translation of Health Survey Questions: The Pathways Experience,” *Health Education Quarterly* 23 (December 1996 Supplement):S28–S40.

## METHODOLOGY

This study describes educational approaches in use in 13 cities in January 1999. We used three methods to collect data: (1) review of state agency contracts with managed care plans and enrollment brokers; (2) interviews with state Medicaid and enrollment broker representatives; and (3) review of enrollment packet materials.

### SITE SELECTION

The cities in the study were selected on the basis of the size of their Medicaid populations, managed care penetration rates, and their use of innovative managed care education and outreach practices. The 13 were selected from a list of cities that met these criteria with the goal of securing a range in the maturity of the Medicaid managed care programs, broker experiences, and geographic distribution. The sites are Chicago, Detroit, the District of Columbia, Houston, Los Angeles, Memphis, Miami, Newark, New York City, Philadelphia, Phoenix, Portland, and Seattle.

Even though Medicaid is a state-run program, we chose cities as our unit of analysis because managed care programs do not always operate across an entire state. Even where programs are statewide, policies may differ by county or by city.

### DATA COLLECTION

For each study site, we reviewed the educational requirements set forth in requests for proposals (RFPs) or state contracts with managed care plans. We also reviewed broker contracts for the nine sites that contract with enrollment brokers. We reviewed each contract twice, using a list of education-related topics to extract relevant contract provisions.

Our second method of data collection consisted of interviews with state Medicaid agency and enrollment broker representatives about educational approaches used and lessons learned.<sup>22</sup> These interviews were particularly important in cities that did not contract with enrollment brokers, since there were no contracts to detail educational activities in those places. Most interviews were conducted by telephone. Interviews with officials from five states and all of the enrollment broker staff were held in person. One state official preferred to fill out the survey in writing.

Our third method of data collection consisted of reviews of enrollment packet

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<sup>22</sup> Appendix B lists the Medicaid agencies interviewed.

mailings to assess content, overall appearance, literacy level, and methods of communicating with non-English-speakers. Enrollment packets are the materials sent to beneficiaries when states are converting to mandatory managed care programs or, in converted markets, the materials sent to those who are newly eligible for Medicaid. Often these materials constitute the first notification beneficiaries receive that they must enroll in a managed care plan. The enrollment packets include a basic description of managed care and a form for beneficiaries to mail in with their choice of plan. Cover letters, plan comparison grids, and listings of community presentations are often included as well.<sup>23</sup> We selected three passages from each packet for use in assessing the literacy levels of the enrollment materials. In each case, the selections were taken from the introduction to the brochure, the definition of a primary care provider (PCP), and the description of how to choose a plan. We used the Flesch-Kincaid grade-level test included with Microsoft Word to assess the reading level of each site's combined selections.

## DESCRIPTION OF SELECTED SITES

The combined Medicaid population of the 13 sites is more than 6 million—about one-fifth of the nation's total Medicaid population. The selected cities represent a range in Medicaid managed care enrollment experience (Table 1). Enrollment in managed care was mandatory for the Temporary Assistance for Needy Families (TANF) population in all cities but Chicago and New York. The oldest mandatory program among the study sites is in Phoenix, where Medicaid managed care began in 1982. Three mandatory programs began in the early 1990s (Seattle, Portland, and Memphis), and the rest of the sites mandated that their Medicaid population enroll in managed care plans in the late 1990s. The Supplemental Security Income (SSI) population, which is made up of the aged, blind, and disabled, must enroll in managed care plans in six of the 13 sites.

Nine cities have contracted with enrollment brokers—the independent firms that states use increasingly to administer Medicaid managed care enrollment, education, and outreach services, in part as a way to curtail plan marketing abuses.<sup>24</sup> Five sites (Detroit, Houston, Los Angeles, Newark, and New York City) contract with Maximus, and two (Miami and Philadelphia) with Benova. Two others (Chicago and District of Columbia) have hired local organizations to act as the enrollment broker. Seattle does not have a

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<sup>23</sup> Three of the selected sites do not use enrollment packets to introduce the program to new beneficiaries. Two of these sites, Memphis and Phoenix, are older programs, and the third, Chicago, is a voluntary program that does not require beneficiaries to enroll in a plan and does not undertake mass mailings. The packet reviewed for New York City, which was not used until spring 1999, was included in Medicaid managed care mailings for voluntary enrollment.

<sup>24</sup> M. Kenneson, *Medicaid Managed Care Enrollment Study*, Center for Health Care Strategies, Inc., December 1997.

contract with a broker. Instead, the county health department administers a Medicaid outreach and enrollment project that contracts with community organizations to locate those who are eligible for Medicaid and explain how to enroll in and navigate the managed care program.

Table 1  
Characteristics of Medicaid Managed Care Programs

City	Mandatory Medicaid Managed Care	Enrollment Broker Contractor
Chicago	No	Health Smart
Detroit	TANF, SSI	Maximus
District of Columbia	TANF	United Planning Organization
Houston	TANF <sup>a</sup>	Maximus
Los Angeles	TANF	Maximus
Memphis	TANF, SSI	None
Miami	TANF, SSI	Benova
Newark	TANF	Maximus
New York City	No <sup>b</sup>	Maximus
Philadelphia	TANF, SSI	Benova
Phoenix	TANF, SSI	None
Portland	TANF, SSI	None
Seattle	TANF	None <sup>c</sup>

<sup>a</sup> Enrollment for SSI beneficiaries in Houston was mandatory in April 1999.

<sup>b</sup> Mandatory enrollment for TANF beneficiaries in New York City began in August 1999.

<sup>c</sup> Seattle has a Client Outreach Project in which the county contracts with local organizations to conduct outreach and education for Medicaid and managed care enrollment.

## FINDINGS

The first section discusses the design and development of the enrollment packets and the content of the information they provide. The second section describes other mechanisms that are being used to convey information about managed care to Medicaid beneficiaries, including public awareness campaigns, counseling sessions and presentations, and the use of community-based organizations. The third section describes how these education and outreach efforts are being monitored and overseen.

### THE ENROLLMENT PACKETS

#### Development and Design of Enrollment Materials

Because enrollment packets are the centerpieces of the educational efforts in each of the cities studied, we examined in some detail the way in which these materials were developed: Was formative research conducted with Medicaid beneficiaries? Were the materials tested prior to being finalized? What is their reading level? Are they available in languages other than English?<sup>25</sup>

#### *Formative Research*

None of the contracts with brokers requires or suggests that they obtain input from beneficiaries or conduct formative research as a starting point for the development of educational materials. However, United Planning Organization, the broker in the District of Columbia, and its subcontractor, the Agency for Educational Development, conducted formative research with Medicaid beneficiaries to guide its educational strategy. Using in-depth interviews with 38 Medicaid beneficiaries, including managed care enrollees and those in fee-for-service, they found that the most important criteria for choosing a plan were continuing provider relationships, access to the fullest range of services, and convenience. They also showed beneficiaries sample handbooks and talked through the process of choosing a plan, and found that most respondents needed assistance in comparison-shopping.

The broker used these findings to develop an enrollment package that focused on the primary need it had identified—assisting people in how to choose a plan. Through the interviews, they learned that Medicaid beneficiaries use the terms “straight Medicaid” for fee-for-service, and “health plans” for managed care plans, and they incorporated those

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<sup>25</sup> Enrollment brokers developed seven of the 10 enrollment packets with state input, review, and approval. Medicaid agencies developed their own packets in Seattle and Portland, where no enrollment brokers are used. California’s Medicaid agency required the broker for Los Angeles to subcontract with a consulting firm to revise the enrollment packet.

terms into the booklet.

*“In our RFP, what we wanted was, of course, everything: make sure they understand everything about managed care and make sure they know why they are in that health plan. And what we heard after all the focus groups, loud and clear, was, ‘We’ve got to have one message.’ You can’t muck up that one message or you’re going to completely lose them. We had to change . . . our expectations, too.”*

*—District of Columbia Medicaid official*

### *Pretesting Materials*

While no broker contracts require or mention the pretesting of materials, a number of sites did test their written materials before distributing them. In developing the materials for Seattle, for example, Washington’s Medicaid agency did extensive testing on different ways to display the results of the Consumer Assessment of Health Plans Survey (CAHPS) on satisfaction. Initial plans had called for the use of a single enrollment brochure for the entire state. Beneficiaries would have used a state map to locate their respective communities, identify the plans available there, and then look for those plans on a comparison grid that displayed all the plans in Washington. The state decided to take a different tack after testing the brochure with consumers. “Inadvertently, we really irritated some people,” a Washington state official explained. “They would not look at what was available to them; they would start off by saying ‘Where are the three-star plans?’ And then they’d go, ‘Ooh, it’s only available in Clark County’.” As a result of the testing, the state decided to produce county-specific brochures that included only the plans available in that location. Because of budgetary constraints, however, the state was unable to test its final version of the brochure; it has also been unable to test the enrollment packet when it is revised annually. Many government officials cited both time and budget limitations as the reason cities were unable to pretest materials. As a Texas Medicaid staff person explained, “The state would have preferred more extensive testing but there was a time crunch.”

### *Assuring Readability*

Most of the broker contracts specify the need to develop easy-to-read materials for the Medicaid population and require that written materials meet certain literacy levels. The requirements vary from the specific—Detroit requires the enrollment packet to be written at a fourth-grade reading level—to the more ambiguous—Philadelphia requires materials

to be at a fourth-grade level “whenever possible.” We used the Flesch-Kincaid grade-level test to test three sections of each enrollment brochure for literacy levels and found that the materials ranged from a low of third-grade, second month, in the District of Columbia to a high of eighth-grade, third month in Newark (Table 2).

Although broker contracts specify literacy levels, they do not address other low literacy writing guidelines recommended by literacy experts. In addition to reading grade level, factors considered essential to readability include limiting the number of concepts to a maximum of four per page and keeping pages uncluttered by using headers to break up text, illustrations to amplify it, and type no smaller than 12 points in size. Making the text interactive is also considered helpful.<sup>26,27</sup>

Although these sorts of literacy guidelines were not contractually required of any of the enrollment brokers, all the enrollment packets adhere to at least some of the principles. All packets, for instance, use headers to break up the text. Generally, the typeface is a 12-point serif. Several of the packets also take an interactive approach. The District of Columbia, for example, explains the managed care program using a dialog between two community residents. Other packets give beneficiaries action messages—e.g., call the helpline or your doctor.

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<sup>26</sup> C. C. Doak, L. Doak, and J. Root, *Teaching Patients with Low Literacy Skills*, 2nd ed. Philadelphia: J.B. Lippincott Company, 1996.

<sup>27</sup> National Cancer Institute/National Institutes of Health, *Clear and Simple: Developing Effective Print Materials for Low-Literate Readers*, NIH Publication 95-3594 (1995). Available at: [http://rex.nci.nih.gov/NCI\\_Pub\\_Interface/Clear\\_and\\_Simple/HOME.HTM](http://rex.nci.nih.gov/NCI_Pub_Interface/Clear_and_Simple/HOME.HTM).

Table 2  
Enrollment Packet Characteristics

City	Format of enrollment packet	Broker contract literacy-level requirements <sup>a</sup>	Flesch-Kincaid grade-level <sup>c</sup>	Type size of text in enrollment packet	Number of foreign languages available
Detroit	Folded brochure	4th grade	6.7	12	None
District of Columbia	Booklet	Not specified	3.2	14	1
Houston	Folded brochure	4th–6th grade	3.6	11	1
Los Angeles	Booklet	n/a	4.7	12	7
Miami	Booklet	“At or near 4th grade”	6.2	12	2
Newark	Booklet	Not specified	7.9	14	1
New York City	Booklet	4th grade <sup>b</sup>	5.4	12	4
Philadelphia	Folded brochure	4th grade “whenever possible”	6.7	12	4
Portland	Booklet	n/a	5.4	14	8
Seattle	Booklet	n/a	4.8	12	13

Note: Enrollment packets are not sent to new enrollees in Chicago, Memphis, and Phoenix.

<sup>a</sup> Portland and Seattle have no broker, and the broker contract for Los Angeles does not include the development of enrollment materials.

<sup>b</sup> The reading level requirement was not in the contract, but it was in the March 26, 1996, document “Answers to Prospective Bidders’ Questions Regarding the Medicaid managed care RFP for Benefits Counseling Services.”

<sup>c</sup> From each enrollment packet, we selected sections of text from the introduction, the definition of a primary care provider, and the description of how to choose a plan for literacy level testing. The Flesch-Kincaid grade-level test was used to assess each packet’s reading level—conveyed as month and grade of school required to read the passage.

Not all guidelines are followed, however. The most common problems are that the brochures’ pages are crowded, leaving little white space per page and the text is overloaded with multiple concepts. Miami’s enrollment packet was recently redesigned for this reason. “We all looked at it and thought, ‘Gee, this is wordy,’” explained a Medicaid official. Finally, few of the illustrations and photographs used in the materials relate to health care or help to clarify the specific topic under discussion.

#### *Materials for Non-English Speakers*

With the exception of Detroit, all sites have translated their enrollment packets into at least one other language. Seattle’s packet was available in 21 languages at one time; it is now available in 13. Surprisingly, none of the contracts specifies literacy-level requirements for non-English materials, though literacy tests are available in other languages.<sup>28</sup> Similarly none of the broker contracts requires the translation of foreign

<sup>28</sup> Doak et al., 1996.

language materials back into English, a practice that educators recommend to ensure that these texts are consistent with the intent of the original English document.<sup>29</sup>

Health educators believe the best way to develop non-English-language materials is to use formative research to determine the most culturally appropriate approach. One enrollment broker representative stated that he wished his firm had been able to develop culturally appropriate materials from scratch, rather than simply translating directly from the English language materials, but that the cost would have been prohibitive. Houston's contract was the most prescriptive: "Individuals translating in non-English languages must not only be fluent in the other language, but also culturally knowledgeable. This includes being able to convey public health issues and medical terminology in a culturally sensitive manner, using vocabulary that is familiar and nonoffensive to the recipient and his or her family. Word-for-word translations from English are not considered appropriate."

The cities in this study target native language packets to non-English-speakers in one of three ways. Houston and Miami distribute one set of bilingual materials, so all beneficiaries automatically receive the information in both Spanish and English. In other cities (including Miami for the Haitian/Creole population), a language preference field in the Medicaid data system determines the language of the mailing. However, caseworkers in many cities are not required to fill in the language field in the computer system, so non-English-speakers often receive packets written in English. In order to alert non-English-speakers who may have been missed by the computer system, almost every city studied includes a multilingual notice in the packet advising non-English-speakers to call the helpline for a packet in their language.<sup>30</sup> Los Angeles and New York City put the foreign language notifications on the outside of the enrollment packet envelope (nine languages in Los Angeles and 16 in New York City), while other sites use either inserts or messages within the brochure.

## Content

The process of choosing a health plan involves multiple steps. First, beneficiaries must understand that they need to make a choice of both plan and provider. Then they need to be informed about how to do so—not only the mechanics of the process, but also the substance of how to obtain information and weigh the options against their needs. They must understand the basic definitions and rules of managed care, as well as their rights and

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<sup>29</sup> A. Sperber, R. Devellis, and B. Boehlecke, "Cross-Cultural Translation," *Journal of Cross-Cultural Psychology* 25 (December 1994):501–24.

<sup>30</sup> Rather than offering materials in other languages, the foreign language notice in Newark tells beneficiaries that they should have the materials translated.

responsibilities. Finally, they must understand the concepts of preventive care, health promotion, and self-management. This section discusses the information conveyed to beneficiaries on these topics through the enrollment materials.

### *How to Choose a Plan*

All ten enrollment packets tell the reader how to go about choosing a plan, provide information about each available plan, and enclose an enrollment and plan selection form. The packets differ substantially, however, in the importance given to the message, the amount of guidance they offer, and the extent to which they supply plan-specific information. At one end of the spectrum, the District of Columbia dedicates eight pages in its enrollment brochure to selecting a plan. By contrast, the enrollment packet in Detroit addresses the subject in just three sentences: "Before you choose a health plan, make a list of the doctors, hospitals, and other providers that are important to you. Look over health plan information you have received, or call Michigan Enrolls for information. The call is free."

Most packets list a series of questions for the beneficiary to consider. With the exception of Houston's, all ask beneficiaries to consider what plans their doctors are in. Seven packets suggest that readers consider their hospital preferences, and five mention pharmacy location as a potential consideration. A few brochures, e.g., Newark's, recommend that beneficiaries consider additional plan features such as transportation arrangements, experience with special health conditions, and dental benefits. All packets invite beneficiaries to call a helpline for personal assistance. The packets for Los Angeles, the District of Columbia, and New York City recommend attending presentations to receive more help making a selection.

The District of Columbia's packet and, to a lesser extent, the packet in Los Angeles expand on the approach of posing questions for the reader's consideration by providing an interactive workbook. The District of Columbia's enrollment booklet is designed to walk the beneficiary through four steps. Step one is titled "Think about your family's health needs," and asks beneficiaries to read eight statements on plan features and check off those most important to them. The statements include having access to a specific health center or provider, adult dental care benefits, transportation assistance, and health education programs. Step two asks beneficiaries to use the accompanying plan information booklet to identify and then circle the plans that have the attributes they checked off in the previous step. Readers are then asked to determine which plan gives them "the most of what [they] want" by looking at what they have circled. The packet is unique both because it walks readers through the process of making a choice and because

it provides plan information for all of the features that beneficiaries are asked to consider in making their choice (with the exception of a specialist directory).

Although the Los Angeles enrollment packet is not designed as a workbook, it does include a one-page worksheet. This sheet lists ten “family needs” for beneficiaries to consider, including languages spoken at the health facility, plan policy on vision and dental care, and whether there is a pharmacy on site. Beneficiaries may use the worksheet to compare two health plans. However, the information in the packet is not sufficient to fill out the grid. It includes plan information for the two “umbrella” plans in Los Angeles, but omits information about the nine subcontracting plans, which have differing policies.<sup>31</sup>

*Provider Lists.* Focus groups and surveys reveal that Medicaid beneficiaries place greatest importance on maintaining provider relationships when selecting their managed care plan.<sup>32,33,34</sup> All the enrollment packets acknowledge the central importance of this criterion, but the way beneficiaries are expected to determine which plans their provider(s) contract with differs substantially.

Three sites—Houston, Los Angeles, and the District of Columbia—include primary care provider directories in the enrollment packet mailing. Houston and Los Angeles furnish bilingual (Spanish and English) directories for each participating plan.<sup>35</sup> These directories list PCPs’ addresses, phone numbers, and practice type. Some, but not all, include the languages the primary care provider can speak, office hours, and hospital affiliations. In Los Angeles, the large packages cost as much as \$7 to mail and often do not fit in mailboxes. There are widespread stories—perhaps apocryphal—of kids playing soccer with undelivered enrollment packets in Los Angeles housing projects. It is also not clear how often the provider directories are actually used, even when they are received. Some Los Angeles beneficiaries are overwhelmed by the sheer size of the directories—more than 400 pages combined.

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<sup>31</sup> The mandatory Medicaid managed care program in Los Angeles is based on a two-plan model. However, the two plans subcontract with other managed care organizations, so in fact there are 10 plans.

<sup>32</sup> Maloy et al., 1999.

<sup>33</sup> United Planning Organization, 1997.

<sup>34</sup> J. Shineman and R. Simmons, *Medicaid Eligibility Quality Control Project #8: Chosen vs. Assigned* (final report). Medical Assistance Administration, Washington State, October 1998.

<sup>35</sup> The Los Angeles mailing includes directories from the two “umbrella” plans, each of which includes the networks of their subcontracting plan partners.

*One consumer explained, "I don't need a whole big dictionary sent to my house. 'Cause I didn't even open the dictionary—I got so scared I just threw it down. It scared me."*

By contrast, the District of Columbia has combined provider information into one slim booklet that lists each primary care provider's plan affiliation, but does not list address or telephone information. The rationale is to keep the listing small and manageable, while providing a tool for those with provider relationships.

Most states have opted not to use the directory approach because of the expense and the difficulty of keeping the directories current. Some sites rely entirely on the Medicaid beneficiary to research what plan their provider(s) are in. The Portland packet simply advises beneficiaries to "Find out what plan your PCP and your children's PCP is in." When Portland beneficiaries ask phone line staff for provider/plan information, they are instructed to call the plans or providers on their own. This is also the case in Memphis and Phoenix, though the latter has recently begun a pilot project to place telephones in the income-support centers so beneficiaries can conveniently make calls.

More commonly, sites use a telephone hotline staff to help beneficiaries find out their providers' plan affiliations. Eight of the 13 sites have electronic directories that counselors can access on their computers; Seattle's is publicly available on the state's web site.<sup>36</sup> The electronic directories can be searched by address or city (rather than only by provider name) and they can be updated more frequently. The Houston electronic directory listings are updated weekly; in Newark, Miami, and Seattle, they are updated monthly. By contrast, the Los Angeles paper directories are updated quarterly and the District of Columbia's three times in 15 months.

Despite these advantages, brokers and states are still experiencing substantial problems with the electronic directories. The information in the directories is only as good as what the plans submit. For example, mistakes in a primary care provider listing in Seattle can be immediately corrected in the web-based directory. However, if the plan resubmits the same mistake the following month, the correction is overridden. For this reason, the web directory contains the disclaimer: "Don't make your decision based only on the information in this directory. Call the health plan and the provider you select

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<sup>36</sup> <http://maa.dshs.wa.gov/ipnd/ImportantHOInfo.htm>.

before making a final decision.” Similarly, counselors in New York City have access to the electronic directory, but the enrollment brochure also suggests that beneficiaries call their doctors to learn what plans they work with.

*Primary Care Provider Choice.* While most sites offer ways for beneficiaries to determine what plan their provider is in, there is far less guidance about how to choose a PCP for beneficiaries who do not have one. Miami’s brochure suggests choosing a PCP “you can trust and can talk to easily.” None of the other enrollment brochures mentions other criteria—e.g., a provider’s location, language capacity, or hospital affiliation. Only the Philadelphia and Portland brochures warn beneficiaries that a PCP will be assigned to them if they do not choose one.<sup>37</sup>

*Plan Comparisons.* All of the sites provide some plan-comparison information. The least informative method, used only in Detroit and Seattle, gives plans advertising space in the enrollment packet. In most sites, the mailing includes a grid that compares plan benefits and networks (Table 3).

Table 3  
Plan and Provider Information

City	Provider Directories	Plan Comparison Information
Detroit	No	Plan advertising
District of Columbia	One directory for all plans	Comparison grid
Houston	Separate directories for each plan	Comparison grid
Los Angeles	Directories for two “umbrella” plans	Comparison grid for two “umbrella” plans
Miami	No	Comparison grid
Newark	No	Comparison grid
New York City	No	Comparison grid
Philadelphia	No	Comparison grid
Portland	No	Comparison grid
Seattle	No	Plan advertising and Comparison grid <sup>a</sup>

<sup>37</sup> The District of Columbia booklet states, “If you do not choose a personal doctor now, your health plan will help you choose one later.” This language is consistent with the broker contract, which states: “The chief responsibility for assignment of clients to PCPs lies with each [managed care organization], after enrollment.”

<sup>a</sup> The plan comparison grid of consumer satisfaction measures is not part of the enrollment packet in Seattle and is sent to beneficiaries under separate cover. The idea, according to one Medicaid official is, “The more times you remind a client that they need to choose a plan, they will [be more likely to] choose a plan.”

The most common category in plan comparison grids is hospital affiliation, an item included in all but two (Seattle and Newark are the exceptions). While most list the names of the hospitals each plan contracts with, Houston’s grid lists only the number of hospitals, and the grid for Los Angeles refers beneficiaries to the two provider directories. Only in Miami and Philadelphia do the grids mention that members can go to a participating hospital (in a nonemergency situation) only if their PCP or specialist has admitting privileges there. The grids for those cities warn that the PCP they select may not “work with all hospitals”; they do not spell out the consequences of having a provider who does not have admitting privileges at one’s hospital of choice.

Other common plan comparison categories are network pharmacies (District of Columbia, Los Angeles, Newark, and Portland); dental benefits for adults (District of Columbia, Houston, and Philadelphia); whether access to dental benefits is through the plan or through fee-for-service Medicaid (Newark, New York City, and Portland); and vision benefits (Houston, Newark, and Philadelphia). Half of the grids use an “additional benefits” category to accommodate plan features that do not fit in other categories (e.g., wellness classes or gifts). A number of sites have struggled to make sure that the “additional” services listed actually go beyond those that are contractually required. In New York City, the Department of Health has decided to drop this category from its grid because few of the plans offered any benefits that were truly “additional.”

Houston’s grid compares plans across 23 different categories—by far the most extensive of the group. Plans are compared on the services they provide—e.g., case management for people with special needs, obstetricians and gynecologists as PCPs, and a variety of mental health offerings. The grid also compares welcome gifts, prenatal programs that have gifts, and other health education programs that include gifts. Curiously, the grid omits the significant fact that one of the plans listed is actually a primary care case management program (PCCM), rather than a managed care plan. (In Miami, where there is also a PCCM program, the enrollment packet has an entire grid dedicated to the differences between the two programs.) The state of Texas is concerned that beneficiaries find the grid difficult to understand, and it is currently considering revamping or removing it from the mailing.

Seattle is the only site to include consumer satisfaction information in its grid, even

though all of the sites require that consumer satisfaction surveys be undertaken.<sup>38</sup> Washington State piloted the Medicaid version of the CAHPS satisfaction survey as a tool for monitoring health plan quality. When the state reviewed its first set of results in 1997, it realized how valuable the information would be to consumers who are choosing plans. A year later, the state began sending out a separate brochure that rated each plan on five summary satisfaction measures: getting needed care; getting care without long waits; doctors' communication skills; courtesy, respect, and helpfulness of office staff; and health plan customer service and paperwork. New Jersey also piloted the Medicaid CAHPS survey and at one point sent results to newly eligible beneficiaries. It has stopped this practice while it awaits results from a RAND evaluation of the effort.

None of the grids compares the plans on quality measures such as the Health Plan Employer Data and Information Set (HEDIS), nor does any include information about National Committee for Quality Assurance (NCQA) accreditation.<sup>39</sup> "I think that kind of information is really too sophisticated for most beneficiaries, most consumers period," one state Medicaid official explained. "Nobody knows what HEDIS is, nobody knows what any of that means." Although this is the conventional wisdom in many places, focus group studies have found that Medicaid beneficiaries are frustrated by the limited information available to them and are very interested in measures of quality.<sup>40,41</sup> Many of the participants in these focus groups were skeptical or confused about several of the measures and required additional explanations to translate technical terms into everyday language. But the participants expressed a desire for more comparative quality information and were particularly interested in measures of consumer satisfaction. Both Florida and the District of Columbia plan to provide this type of information to Medicaid beneficiaries in the future.

*Additional Plan Information.* A number of sites require managed care plans to furnish additional detailed information to Medicaid beneficiaries upon request. Plans in Phoenix, Portland, and Newark must disclose all physician incentive agreements. Miami and New York City plans must make drug formulary information and physician credentialing requirements available, and those in Chicago must give provider qualification information. New York City plans must also make consumer complaint information available, and

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<sup>38</sup> The State of New York has developed a report card that it planned to distribute in fall 1999. The card compares plans on consumer satisfaction and quality measures.

<sup>39</sup> New York's report card uses HEDIS-like measures to compare plans, but it was not available until late 1999.

<sup>40</sup> D. Gibbs, *Information Needs for Consumer Choice. Final Focus Group Report*, Health Care Financing Administration, Contract Number 500-94-0048, October, 1995.

<sup>41</sup> J. McGee, S. Sofaer, and B. Kreling, *Medicare and Medicaid Consumer Information Projects*, National

those in Newark must provide summaries of satisfaction surveys. Significantly, none of the state or broker enrollment materials distributed in these cities mentions that beneficiaries have the right to this information.

*Information for People with Special Health Needs.* Two studies have shown that people with special health needs are particularly interested in specialty care provider directories, referral policies, and other health coverage information—much more so than healthy people.<sup>42,43</sup> Of the materials mailed in the six cities where enrollment is mandatory for the SSI population, only Houston's are specifically tailored to those with special needs. Houston's provider directories include specialty care provider listings, and its comparison chart emphasizes plan differences on health-related topics (e.g., whether plans offer syringes for diabetics, medication dispensers, or care coordination).<sup>44</sup> In addition, the informational brochure for the disabled population is printed in a larger type size and its content is almost entirely dedicated to the differences in the program for those who are dually eligible (i.e., qualify for Medicare in addition to Medicaid) and those who are not. Much of the basic program information from the TANF brochure is omitted.

#### *How to Navigate*

If enrollees are to navigate the managed care system successfully, they must understand basic managed care concepts—e.g., how to use a primary care provider, how to choose and change providers, when to seek emergency room care, and how to file grievances and complaints. One of the key challenges in educating beneficiaries is that these concepts are often new and the terms unfamiliar.

*One state official noted, "To us, 'fee-for-service' means you're not in managed care. . . . For them, it means you have to pay a fee for the service, so it's having the opposite effect of what we intended."*

Acquiring a new vocabulary, then, is part of being able to function within the system. All the enrollment packets include information on key managed care terms and concepts.

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Committee for Quality Assurance, July 1996.

<sup>42</sup> S. Edgman-Levitan and P. Cleary, "What Information Do Consumers Want and Need," *Health Affairs* 15 (Winter 1996):42–56.

<sup>43</sup> M. Kenesson, *Medicaid Managed Care Outreach and Enrollment for Special Populations*, Center for Health Care Strategies, Inc., February 1998.

<sup>44</sup> Provider directories in other cities (and Houston's TANF directory) include primary care providers only.

However, the materials vary in their level of specificity (Table 4).

*PCP's Role and Referrals.* All of the enrollment booklets explain the role of the primary care physician. While many do not use the word “referral,” all highlight the need to “go to your Primary Care Doctor first” (Los Angeles) before seeking specialty care. But only three cities warn that the plan may not pay the bill absent a referral from a PCP (District of Columbia, Seattle) or, more directly, “You may have to pay the bill” (Portland). Only Miami describes the possibility of getting a “standing referral” from a PCP “if you have a specialist that you see often.”

*Changing Health Plans and PCPs.* All the enrollment brochures inform beneficiaries that they may switch plans, and all but one (Newark) tell enrollees whom to call. The Los Angeles brochure, although quite explicit about how to disenroll, explains only how to change between the two umbrella plans, not how to change among the nine subplans.

Table 4  
Information About How to Navigate a Managed Care System

City	Role of PCP and referral concept	Need to choose PCP or be auto-assigned	How to change PCPs	How to change plans	Appointment standards/ waiting times	How to complain
Detroit	Yes	No	Yes	Yes	No/No	Yes
District of Columbia	Yes	No	Yes	Yes	Yes/No	Yes
Houston	Yes	No	Yes	Yes	No/No	Yes
Los Angeles	Yes	No	Yes	Yes, only between two “umbrella” plans	No/No	Yes, including detailed instructions, timeframes and fact that services will be continued during fair hearing adjudication
Miami	Yes, including standing referral concept	No	Yes	Yes	No/No	Yes
Newark	Yes	No	No	Yes, but does not say whom to call	No/No	No, but mentions possibility of changing plans
New York City	Yes	No	No	Yes	Yes/No	Yes
Philadelphia	Yes	Yes	Yes	Yes	No/No	Yes, notes that services will be continued during fair hearing adjudication
Portland	Yes	Yes	No, explains right to change plans, but not	Yes	No/No	Yes, notes that services will be continued during fair

Seattle	Yes	No	how Yes	Yes	No/No	hearing adjudication Yes
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Generally, the cities with plan lock-in are quite vague about when beneficiaries may change plans. For example, Detroit’s enrollment materials inform beneficiaries only that they “may change plans at certain times of the year.” The Portland brochure is more specific, listing three instances in which a beneficiary may change plans. The District of Columbia and Los Angeles, where there is no lock-in, refer to the option of changing plans as a way to deal with unresolved difficulties or general dissatisfaction.

With the exception of the New York City and Newark booklets, all enrollment packets state that enrollees have the right to change PCPs, and all but Portland’s explain how to do so. Nevertheless, Miami extols the benefits of maintaining continuity of care: “Keep that PCP so that he or she gets to know you and your health history. When you have been seeing a PCP for a long time, it’s easier for that PCP to take care of you and notice if your health is changing.”

*Emergency Department Use.* Medicaid managed care promises to control costs and increase continuity of care in part by decreasing inappropriate emergency department use. Not surprisingly, therefore, all of the enrollment booklets address the issue of when to seek emergency care. Some provide a specific definition: “An emergency is when someone might die or might be disabled if you don’t get medical care right away” (District of Columbia). Others supplement the definition with examples: “You have been hurt very badly; you are bleeding heavily; you have severe shortness of breath. . . .” (Philadelphia). Others simply provide directions in case of emergency (Newark) or explain that emergency care is only for a “true” emergency (Houston) without defining that term.

Some booklets have a cautionary tone. “Do not use the emergency room unless you think a delay might result in lasting injury or death” (Detroit). “Emergency room care is very expensive. If you use an ambulance or the emergency room for something that is not an emergency, you may have to pay the bill” (Portland). Others seem to encourage the beneficiary to seek emergency department help when in doubt. “If you become very ill or have a serious accident, you should always go to the nearest emergency department or call 911. You do not need a referral for emergency care” (Miami). The Seattle booklet suggests that beneficiaries discuss these issues with their PCPs and make advance plans about how to seek care if the office is closed or in the event of an emergency. None of the enrollment materials explains that enrollees must call their PCP or their health plan within a certain number of hours after going to the emergency department in order for the visit to be covered.

*Appointment Standards.* One of the potential advantages of managed care for beneficiaries is that providers can be held to a set of standards for appointment availability. Often, these requirements are set out in the plan contracts. Yet only the New York City and District of Columbia enrollment booklets inform beneficiaries about their right to receive appointments in a timely manner. None of the enrollment booklets provides any information about maximum allowable waiting times in physician offices.

*Complaints.* One of the areas of greatest concern among advocates has been that of how to define and explain enrollees' rights in situations in which they are dissatisfied with or have refused services. Studies have shown that Medicaid beneficiaries do not understand their rights under managed care and that they are almost twice as likely to be frustrated with their plans as other members.<sup>45,46,47</sup> However, none of the enrollment materials provides any guidance to beneficiaries about how to tell when their rights have been abrogated and they have cause to complain (e.g., if they are unable to get an appointment or obtain medications, or if they receive a bill).

Generally, enrollees have a number of options when they are dissatisfied, including complaining to the plan or filing an appeal, complaining to the state, or filing with the state for a fair hearing. The enrollment materials differ widely in how they address these issues. At one end of the spectrum, Newark provides no information whatsoever about what beneficiaries can or should do if they are dissatisfied, other than to switch plans. At the other end, Los Angeles provides detailed directions on how to file a grievance with a health plan, instructing the beneficiary to keep a copy of the letter and send one to the state, and providing information about required time frames for reply and resolution. Five of the cities (Detroit, Los Angeles, Philadelphia, Portland, Seattle) explain how to file for a fair hearing with varying degrees of detail; three of the five (Los Angeles, Philadelphia, Portland) explain that services will be continued while the matter is adjudicated.<sup>48</sup>

#### *How to Access Preventive Care and Engage in Healthy Behavior*

The third key component of education for Medicaid managed care concerns preventive care, healthy behavior, and self-management. Although central to the concept and promise of managed care, these educational issues are peripheral to the enrollment

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<sup>45</sup> Molnar et al., 1996.

<sup>46</sup> Lewis and Lawler, 1997.

<sup>47</sup> Lewin Group, "Preliminary Findings: Survey of Consumer Experiences in Managed Care," Kaiser Family Foundation, Sierra Health Foundation, and California Wellness Foundation, November 1997.

<sup>48</sup> The contracts between the states and health plans generally require that member handbooks, which are sent to beneficiaries upon enrollment, address navigational issues in general and complaints in particular. Although many of the plan contracts list the topics to be covered, sometimes at great length, there is little description of how the topics are to be addressed. The Phoenix plan contract is unique in

process. Not surprisingly, therefore, the broker contracts barely touch on this topic and the enrollment materials provide little information or advice. The Detroit and Miami enrollment materials, for example, provide no information on preventive care. Brochures from several of the cities briefly mention the role of the PCP in providing regular check-ups (Houston, Philadelphia, Newark, New York City) and some encourage beneficiaries to seek preventive care (District of Columbia, New York City, Portland). Portland's materials include information on the importance of prenatal care (including the risks of alcohol, drugs, and tobacco use) and advise beneficiaries to talk to their provider about treatment for drug and alcohol problems and smoking cessation. Seattle's enrollment brochure refers to the Healthy Kids program (or EPSDT—Early Periodic Screening and Diagnosis and Treatment), but does not give any information about screenings or time frames.<sup>49</sup>

## OTHER EDUCATION TECHNIQUES

The Medicaid system is complicated, time frames for enrollment are often compressed, other programs or initiatives compete for attention, and required changes in utilization patterns are enormous. An effective educational campaign, therefore, requires a set of strong, coherent messages that are transmitted through various media in multiple settings. Enrollment materials provide one mechanism to reach beneficiaries. This section discusses other techniques in use, including public awareness campaigns, counseling (through group presentations, one-on-one sessions, and telephone hotlines), the use of community-based organizations (CBOs), videos, and other mechanisms.

### Public Awareness Campaigns

Most of the study sites initiated public awareness campaigns to inform beneficiaries about Medicaid managed care enrollment. Some locations delegated responsibility for the

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requiring that plans include a specific text segment in their handbooks to describe complaint procedures.

<sup>49</sup> Many of the state contracts with plans set forth very general requirements concerning the preventive care content of the member handbooks. In seven of the selected cities, the plan contracts require the creation of wellness and prevention education programs, some with specific topics listed and reporting requirements to the state (Chicago, District of Columbia, Houston, Los Angeles, Newark, Philadelphia, Portland). In three of the cities (Houston, Los Angeles, Newark), plans must undertake periodic assessments to determine health education needs and, in Los Angeles and Houston, literacy levels. Several of the sites require that plans dedicate an employee to managing the health education program (Chicago, Houston, Los Angeles), in some cases specifying that person's qualifications (Houston, Los Angeles).

All sites require that plans provide information about EPSDT. In response to a court order, the District of Columbia places a particularly strong emphasis on this topic, requiring that within ten business days after enrollment, plans send out a pre-approved brochure explaining EPSDT, together with a pocket-size card with a schedule for screens, tests and immunizations. Several sites require family planning education (Houston, Los Angeles, Miami) and education about HIV and sexually transmitted disease (in the District of Columbia, Houston, Los Angeles, New York, in general; in Miami for women of child-bearing age and in Newark for pregnant women only).

campaign to the enrollment broker (Houston, Miami, Newark, New York City); in other cases, the state undertook the campaigns (Los Angeles, Memphis, Portland, Seattle). A number of sites used billboards and advertisements on public transportation; others targeted social service agencies or local gathering places (e.g., laundromats, nail salons). Los Angeles worked with a strong network of local advocates to disseminate information. Memphis distributed materials through emergency departments and churches, and sent materials home with children from school. The District of Columbia relied entirely on local health plans, which bought bus and radio advertising and listed the broker hotline number in their own materials.

Enrollment broker representatives repeatedly emphasized the importance of these efforts. Indeed, in places where the enrollment process was delayed, local officials and enrollment staff saw the delay as an opportunity to extend and expand public awareness. Conversely, in places where the enrollment process occurred within tight time frames, local officials and broker staff expressed regret that the public awareness campaign was often given short shrift.

## Enrollment Counseling

### *In-Person Counseling*

All sites provide some degree of in-person counseling to educate Medicaid beneficiaries about managed care and to assist them in the enrollment process. In most cities, there are group presentations, usually led by the enrollment broker, although sometimes also by CBO staff (Los Angeles, New York City, Seattle) or by the state together with health plan staff (Phoenix). As discussed below, most of the cities use CBO offices as settings for these presentations, and many also use Women, Infants and Children (WIC) sites and welfare offices.

With the exception of Phoenix, all of the cities also offer one-on-one counseling, which many view as the gold standard.<sup>50</sup> One-on-one counseling, explained a state official in Chicago, “is the best way to enroll people. People who receive one-to-one counseling want to be enrolled. [Those sessions] allow health benefit representatives to assess beneficiary needs and wants and make a good match with an appropriate plan.”

All of the cities that have tried to use eligibility workers to perform this role have encountered difficulties. For example in Portland, which offers one-on-one counseling as part of the Medicaid eligibility interview, one state official explained, “the focus of the eligibility worker is generally not medical, it’s financial.” Phoenix faced some of the same

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<sup>50</sup> In Seattle, the client outreach project targets its one-on-one counseling at specific populations not yet enrolled in Medicaid.

challenges: “They are TANF and food stamp staff as well as Medicaid eligibility staff, and we are constantly trying to ensure that they understand the importance of Medicaid and enrollment and health maintenance, and all of the things that are important to our service.” Seattle tried and then abandoned this approach, finding it too difficult to reorient the eligibility workers to represent the program.

Initially, as reflected in the broker contracts, both Miami and the District of Columbia had a strong preference for face-to-face counseling. In fact, the District of Columbia contract provided that the “goal is for the contractor to meet with at least 90 percent of the households who must select an MCO.” But the broker and the District soon came to believe that many beneficiaries did not want that personal contact and preferred the convenience of telephone counseling. Similarly, Miami officials, after visiting other states where they saw that individual counselors were underutilized, decided to shift resources into telephone counseling. A Benova representative explained that although some beneficiaries wanted a “face-to-face interaction . . . the vast majority of people, if they have a choice, look for a fairly businesslike discussion over the phone.”

#### *Telephone Counseling*

All of the sites rely heavily on telephone counseling (second only to mailings) as a way to help beneficiaries enroll and disenroll. The broker or state staff operate the phone lines. (In Portland, prison inmates operate one of two state phone lines.) Generally, the lines are open during business hours, although they also operate during the evenings and on Saturday mornings in several locations. All sites except the District of Columbia provide toll-free numbers. All of the lines have Spanish language capacity. Most cities rely on the AT&T language line for languages other than English, although the New York City broker reported that its staff can cover 20 languages.

Several sites also use the phone lines to make outreach calls. The District of Columbia is the most ambitious. Staff call all newly eligible Medicaid beneficiaries every month and make home visits to those without telephones. Seattle outreach calls are made to women who qualify for Medicaid based on pregnancy, because it is important that pregnant women understand how to access care. Seattle also calls enrollees whose plans discontinue participation in the Medicaid managed care program, and Philadelphia calls those who have delayed making a plan selection. While some brokers say it is often a challenge to reach beneficiaries on the phone, beneficiaries often appreciate it.

*A Medicaid official in Washington State described a typical reaction as, “Wow, I got a call from the state—I can’t believe you’re calling to help me!”*

### *Quality Assurance*

To assure that the information provided at presentations and counseling sessions is accurate, unbiased, and comprehensive, most of the localities have developed a script for the broker or CBO enrollment counseling staff. Some cities, such as Miami and Los Angeles, insist on strict adherence to the script (although Los Angeles allows the use of a set of bullet points that give the presenters greater flexibility for the shorter presentations at WIC sites). Both the broker and the CBOs in Los Angeles feel constrained by the script, but the state sees no alternative other than improving the script and trying to make it more interactive. Miami’s goal is to have presenters follow the script, “word-for-word, but not in the sense that they’re reading from a book; we’d like them to have it memorized.” Most other localities have opted for a more interactive, responsive format, using the script as a guide for points to be covered. In Philadelphia, presenters use a flip chart that provides talking points; the District of Columbia uses its enrollment workbook as a guide through the process, thereby eliminating the need for a script altogether.

In another quality assurance effort, all of the cities that contract with enrollment brokers mandate training for counselors. Some broker contracts include a fairly extensive list of what the counselors must know (Los Angeles, Philadelphia). Some cities require that the counselors meet specific qualifications, e.g., they must have a college degree or the equivalent, a requirement that is waived for Medicaid beneficiary employees (Miami, Newark). In Miami, the state department of insurance must license counselors. This process entails a 40-hour course, an exam, and a background check.

### **Collaboration with Community-Based Organizations (CBOs)**

Most state officials and broker staff saw a value to involving community-based organizations (CBOs) in their educational efforts because of the CBOs’ familiarity with and access to those receiving Medicaid. “Local organizations know their communities better than we do,” explained the former assistant secretary for medical assistance administration in Washington State.

CBOs play a variety of roles in the 13 cities. The District of Columbia’s enrollment broker is itself a CBO; the Chicago broker is a former CBO. In Houston,

Detroit, Los Angeles, and New York City, the broker (Maximus) subcontracts with CBOs for community outreach and education. Maximus has subcontracts with almost 30 Los Angeles CBOs, most of which use their own staffs to conduct education; a minority lease space to Maximus for its employees' use. Philadelphia, Miami, and Phoenix use CBOs as sites for group presentations without remuneration. Seattle King County contracts with CBOs for its Client Outreach program, and TennCare in Memphis contracts with a patient advocacy group to maintain a Hispanic hotline.

### *Reaching Beneficiaries*

These CBO relationships are intended to secure access to Medicaid beneficiaries, and often to those who are the hardest to reach among them. In Texas, for example, the enrollment broker is required to contract with at least two CBOs in Houston.

*The Texas broker contract explains why the state wanted the broker to contract with CBOs: "Since many recipients cannot or will not read written materials or attend an informational session, creative means must be developed to achieve an effective outreach. One key to accomplishing these goals is involving those in the community who interact with*

Many state officials and brokers have opted to use CBO offices as sites for counseling sessions and presentations. In Illinois, a Medicaid representative explained that using the offices of CBOs worked particularly well because they are "safe, friendly places for beneficiaries." By contrast, in welfare offices beneficiaries are often distracted by and concerned with an array of other issues. As one New York City beneficiary explained, "The people . . . trying to relate the message [about] health plans in the public assistance area . . . are trying their best, but that's not reaching a lot of people. Because in the Welfare Department, most of the people that come there are concerned about their case."<sup>51</sup>

### *Strengthening Relationships with the Community*

Some states have found that CBOs not only provide access to hard-to-reach Medicaid beneficiaries, but can also help give the managed care program credibility within the community. Arizona's Medicaid agency has used CBOs in Phoenix to strengthen the tie between the community and the Medicaid system; at the same time, the agency has trained CBO staff about the program. In the District of Columbia, Medicaid officials believe that by having a CBO for a broker, the program gets "buy-in" from other advocacy groups.

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<sup>51</sup> S. Kaplan and J. Greene. Unpublished focus group findings, 1999.

*A California Medicaid representative explained one benefit of using community organizations to educate Medicaid beneficiaries: "The number of beneficiaries that they're seeing is very small. . . . I think from our perspective it's worth it because it brought so much goodwill with that community, because they were so against managed care."*

The relationship between the program and CBOs has been strained in some instances. Using CBOs to host presentations in Philadelphia was difficult at first because of the organizations' early opposition to the program. Michigan's Medical Services Administration found that the CBOs did not have enough staff to carry out the work. Several broker contracts reflect concerns about the role and capacity of CBOs. For instance, the Houston broker contract requires that CBOs be thoroughly trained and have a specific liaison on the broker staff who will answer questions as required. Broker contracts in Detroit and Houston have provisions to assure that CBOs have no conflicts of interest. The New York City broker contract is unique in giving the state the right to approve all subcontracts with CBOs to provide outreach and education.

#### Other Mechanisms

A number of cities have experimented with using videos as a way to introduce beneficiaries to Medicaid managed care (Chicago, Detroit, Houston, and Newark, currently; previously Portland and Phoenix; and a video is under development in Miami). The videos are no longer than 11 minutes, and are generally shown in waiting areas in Medicaid and welfare offices, although in Detroit they are incorporated into the community presentations. Some states have found videos to be helpful in providing consistent information at every presentation. Others have been frustrated because of how quickly the videos become obsolete. For example, Maximus considered using videos in Los Angeles, but decided not to, in part because of the number of program policy changes. In Houston, Maximus offers the audio portion of the video to beneficiaries with vision and reading problems. The state reports that there have been hardly any requests for the cassette tapes. This may be because there is no notification of their availability in the enrollment packet. Cassettes are also available in Philadelphia but there, too, they are not mentioned in the enrollment materials.

Several cities used other methods of educational outreach, including hanging reminders on people's doors (Philadelphia), and installing a computer with Medicaid managed care program information in each Medicaid office (Miami). In several cities,

enrollment brokers and plans disseminate information at health fairs. The Arizona Medicaid office sends CBOs serving the Latino community a newsletter for distribution.

## PERFORMANCE OVERSIGHT AND INCENTIVES

### Performance Goals

Several of the broker contracts set numerical goals for the percentage of beneficiaries who choose their own plan (those who do not choose on their own in mandatory programs are defaulted or “auto-assigned” to a plan). The Detroit broker is to assure that 85 percent of the population exercises a choice in year one; that number rises to 90 percent by year three. The District of Columbia’s goal is that 75 percent of the eligible population will make a choice; in Newark, the goal is 50 percent.

Several of the contracts have process or outreach goals as well. For example, the District of Columbia contract sets the goal that the broker will “meet with at least 90 percent of the households that must select an MCO.”<sup>52</sup> The Miami contract states that the broker shall “provide every Medicaid client who is included in the mandated population the opportunity to personally visit with an agent” of the broker.

### Performance Incentives

With the exception of the District of Columbia, all of the broker contracts provide performance-based financial incentives, which range from 3.3 percent of the contract amount in New York City to 40 percent in Newark.<sup>53</sup> Four cities (Detroit, Houston, Newark, New York City) use bonuses or withholds to create an incentive based on choice rates of varying percentages (90 percent in Detroit, 80 percent in Houston, 60 percent in New York City and Newark). Several of the cities base payment rates in part on the number of enrollees (Houston, Miami, Newark, Philadelphia, Seattle) or the number of enrollment and disenrollment transactions (Los Angeles). Miami pays more for enrollments that result from face-to-face counseling and that occur early in the 90-day choice period. Other contracts contain incentives that take into account client satisfaction (Detroit for 90 percent satisfaction on client surveys), number of client meetings, attendance at outreach sessions, percentage of calls answered live (New York City), and administrative efficiency (e.g., no backlogged choice forms in Los Angeles). The Houston contract provides that if the Medicaid program as a whole achieves cost savings, the

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<sup>52</sup> As noted previously, the District of Columbia ultimately decided that this goal was inappropriate—and probably not achievable.

<sup>53</sup> Because the District of Columbia broker role was shared between two entities, the District government did not feel that it could create a financial incentive that would hold them jointly accountable. The District’s new contract combines the administrative, education, and outreach functions into a single entity, and will now include performance incentives.

broker and other contractors will share in a \$2 million payment.

### Monitoring and Evaluation

Many of the contracts have quite extensive reporting requirements to permit monitoring of whether these goals are being met and whether the brokers are in compliance with contractual requirements. In Chicago, the broker must report monthly on the number and duration of individual counseling sessions, and the number, duration, and attendance at group presentations, as well as common questions or concerns that arise, and the number of subsequent individual contacts. Los Angeles and the District of Columbia also explicitly require monthly reporting. The District of Columbia report must include information on community outreach activities, as well as problems that may affect the program's success.

With the exception of Houston and Miami, all of the cities that contract with brokers require them to undertake surveys of consumers to measure satisfaction with broker services. In several locations, the surveys are intended to go beyond customer satisfaction to assess enrollee knowledge of managed care concepts (District of Columbia, Detroit, Newark), and even enrollee "changes in health behavior as a result of health education" (Newark).

Most localities have developed mechanisms to monitor broker phone lines. Some have the capacity to directly access and monitor calls in real time (Miami, Newark, Philadelphia). Others tape calls for monitoring purposes. The monitoring of calls in languages other than English presents greater challenges. Several states have staff that are able to monitor in Spanish. At one point, Philadelphia contracted with a CBO to help monitor calls in Cambodian.

Many broker contracts set requirements for phone line performance. Because data are so readily obtainable from the telephone company, and because measurement of phone line performance is relatively straightforward, the broker contracts tend to be very specific about these standards. For example, many broker contracts require that calls be answered within a certain number of rings and mandate the maximum amount of time in the queue (requirements range from 30 seconds to five minutes). Some set call-abandonment and busy-signal rates, or require that calls be of a specified duration.

## STUDY LIMITATIONS

This study has several limitations. First, although the plan and broker contracts reveal how states envisioned the task of educating Medicaid beneficiaries about managed care, we know from interviews with state officials that the contracts do not always reflect what actually occurred. For example, in one case, a beneficiary satisfaction survey described in the broker contract was never undertaken; in another, a plan handbook was never translated into the required languages. However, no such ambiguity exists with regard to the enrollment packets, since these are the actual products that were sent to beneficiaries.

Second, the development and implementation of educational policies and approaches occurs through continual interaction among state and local officials, brokers, CBOs, advocates, and the Health Care Financing Administration. A more fine-grained understanding of these dynamics is outside the scope of this study and could best be accomplished through case studies of individual sites.

Finally, although we learned a good deal about the various approaches that have been taken, we did not attempt to assess which techniques achieved better outcomes. Policymakers have struggled with the question of how to measure enrollment performance. To date, there are no measures that work across states. For example, auto-assignment data, which are frequently used, are not comparable across sites.<sup>54,55</sup> Thus, we were not able to link the various approaches to objective outcomes.

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<sup>54</sup> I. Fraser, E. Chait, and C. Brach, "Promoting Choice: Lessons from Managed Medicaid," *Health Affairs* 17 (September/October 1998):165–174.

<sup>55</sup> Maloy, 1998.

## DISCUSSION

Our review of approaches taken in 13 cities highlights the challenges of educating Medicaid beneficiaries about managed care. All of the cities have struggled with how to reach out and effectively convey information about a complex program to a population that often has low levels of literacy and a high degree of skepticism.

The list of topics covered is fairly uniform across all sites: how to choose a plan, how to navigate within the system (e.g., the role of the PCP, restrictions on emergency department use, how to switch plans, etc.), and, less frequently, how to keep healthy through self-management and preventive care. The sites rely on a common set of communication techniques: enrollment packets mailed to beneficiaries, presentations and counseling sessions (by phone and in person), and public service campaigns (usually quite limited).

All the sites attempt to strike a balance between providing sufficient information on one hand and not overwhelming beneficiaries on the other. They also seek to ensure that the information is accessible and understandable to beneficiaries. Nevertheless, the sites take slightly different approaches or place different emphases on the substance of the message. For example, some sites use a simple folded brochure that provides only the most minimal information and refers beneficiaries to a counseling hotline. In the District of Columbia, the enrollment materials focus quite narrowly, but very thoroughly, on plan choice, and counselors use the brochure as a guide for their discussions with clients. By contrast, the Los Angeles enrollment materials try to cover a broad range of topics, including, for example, detailed information about grievance and complaint procedures. In part because of the complexity of the information they seek to convey, counselors are required to use an approved script for most presentations.

These decisions—of what topics to cover and what approaches and techniques to use—involve trade-offs that are often made without a clear weighing of the options or an understanding of their implications. As one broker representative explained with frustration, “We don’t know what works.”

All 13 sites suffered to some degree from the same set of weaknesses that undermines their effectiveness: (1) a failure to tailor their outreach programs to the specific educational needs of the Medicaid population; (2) poor quality information about providers and plans; (3) an inability to monitor program performance on educational objectives; and (4) reliance on a single intervention to convey information about such a complex set of topics. These and other cities could benefit from the following

recommendations:

Medicaid programs should tailor their educational messages to meet the needs of beneficiaries. These 13 cities, like others across the country, are faced with an enormous and complex *educational* task. Yet from our surveys of state officials, our review of contractual requirements, and the content and appearance of the enrollment materials, it is clear that few have tapped into educational expertise in designing their outreach approach and materials. For example, only the District of Columbia, through its broker, subcontracted with a firm specializing in education.

To communicate effectively and to understand the areas of concern or confusion within the targeted population, it is essential to undertake formative research through focus groups, interviews or surveys. Yet not one of the enrollment broker contracts requires such a development process, and only in the District of Columbia was this kind of groundwork undertaken systematically. Similarly, pretesting of all materials, including the 'final version,' is considered essential for communicating with low-literacy-level populations. Again, only a handful of places (District of Columbia, Houston, Los Angeles, New York City, Seattle) did any systematic pretesting and only one tested the final version of the materials that were sent to beneficiaries.

Educational experts also agree that information is best conveyed to low-literacy groups in an interactive, rather than in a lecture, format. Indeed, one study found that Medicaid clients who actively engage in discussions about health plan choices were more likely to enroll in a managed care plan.<sup>56</sup> Yet, in an effort to assure uniformity and accuracy, a number of sites have insisted that presenters and counselors read or memorize an approved script.

Reaching non-English-speakers is also an enormous and universal challenge. Managed care terms are not uniform even in English. For example, in the English language enrollment packets we reviewed, a primary care provider is referred to variously as "primary provider," "primary care doctor," "personal doctor," and "primary care practitioner." Not surprisingly, it is often unclear how these terms should be translated into Spanish, Cambodian, or Chinese.

Many contracts specify in detail the language capacity required of the broker and the languages into which materials must be translated. But none sets forth requirements for how materials should be developed. As with the English language brochures,

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<sup>56</sup> Wright Morton, 1998.

pretesting of materials (including different subgroups, e.g., Spanish speakers of different ancestry) is critically important; but none of the contracts requires this and it does not seem to have been the practice in any of the sites. Although many contracts specify reading levels for English language materials, none does so for other languages, and none specifies preferred translation methods (e.g., back-translation from other languages into English to assure accuracy). Materials in languages other than English are simply translated directly from previously developed English materials and are not tailored to meet the needs and characteristics of the immigrant audience. One broker explained that although the costs would be prohibitive, to really improve the quality of these materials and make them culturally appropriate, they should be developed from scratch.

Materials development and outreach design for a low-literacy, low-income population is an expensive and time-consuming process. Under the pressure of launching an enrollment program, formative research with beneficiaries, consultation with educational experts, pretesting of materials, and back-translation or adaptation can appear to be a luxury. As a Medicaid official in the District of Columbia explained, “I was a prime skeptic because I saw the deadline. I thought, ‘forget that stuff.’ Just get something on paper and move on.”

In addition, enrollment materials and outreach strategies are designed not only to meet the needs of beneficiaries, but also to accommodate the requests of health plans and advocates who have concerns about bias (in the case of the plans) and comprehensiveness (in the case of many advocates). One broker representative compared the development of the handbook in one of the sites to a “swing designed by a committee.” The result in nearly all cases is that the materials are poorly suited to Medicaid beneficiaries’ needs and an overall communications strategy is virtually nonexistent.

Medicaid programs should develop up-to-date provider databases and provide appropriate plan-specific information. Studies, as well as anecdotal evidence, indicate that the number-one criterion Medicaid beneficiaries use in selecting a health plan is their current provider’s plan affiliations. However, none of the sites has developed satisfactory methods to make up-to-date, accurate provider information available to beneficiaries when they are choosing a plan. Sending out provider directories, as in Los Angeles, has proven expensive, and the voluminous reports have overwhelmed consumers. Even in Houston and the District of Columbia, where the directories are thin, the information is quickly out of date.

Telephone hotline staff need to have computer access to electronic provider

databases, and consumers need to know to call the hotline to find out the plans with which their provider contracts. Electronic databases enable phone line staff to search not only by a doctor's name, but also by a clinic or street name if that is what the beneficiary recalls. Although electronic provider listings are increasingly becoming the tool of choice, there are substantial data quality problems. In some cases, the problems are due to the structure of the database—e.g., it may not include information about whether a provider is accepting new Medicaid enrollees. In most instances, however, the most significant problem is that plans often submit inaccurate or out-of-date information which is then passed on to beneficiaries. More than one broker and state representative described the situation as, "Garbage in, garbage out." In theory, plans should be motivated to submit accurate information in order to increase the chances that beneficiaries will find that their provider is in the given plan's network. However, since no program has yet overcome the problem of poor data, states should consider including financial incentives related to data accuracy in plan contracts.

In addition to improving the accuracy of provider information, Medicaid agencies need to align the plan comparison information with the needs of the consumers. According to conventional wisdom, beneficiaries are incapable of understanding quality measures and comparative information about consumer satisfaction. Yet this is precisely the information that many beneficiaries express an interest in. Similarly, although Medicaid beneficiaries are known to care about transportation services,<sup>57</sup> only one comparison grid provides this information. As more report card comparisons on quality and satisfaction measures are developed, states and brokers cannot forget that beneficiaries need translations of technical terms into everyday language and explanations of how to use such information.<sup>58</sup> Other cities may want to follow the lead of the District of Columbia. There the comparison information is included in a booklet, with two pages to explain each plan's policy for every given category.

Medicaid programs need to develop tools to assess the effectiveness of their educational efforts. Ironically, cities often try to compensate at the back end for what they lack at the front end in their development of materials and outreach strategies. Our study confirms previous findings that states generally have not developed a strategic approach to data collection and reporting.<sup>59</sup> Nevertheless, they are collecting huge

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<sup>57</sup> J. Brown et al., "Special Issues in Assessing Care of Medicaid Recipients," *Medical Care* 37 (March 1999 Supplement):S79–MS88.

<sup>58</sup> D. A. Gibbs, J. A. Sangl, and B. Burrus, "Consumer Perspectives on Information Needs for Health Plan Choice: Consumer Information in a Changing Health Care System," *Health Care Financing Review* 18 (September 1996).

<sup>59</sup> S. Rosenbaum et al., *A Nationwide Study of Medicaid Managed Care Contracts*, 2nd ed. Washington

amounts of data from the brokers on numbers and kinds of presentations, counseling sessions, phone calls, etc. A Florida official noted that her office monitors Benova “daily, monthly, quarterly, and annually” for 91 contract standards. The day we met with Maximus staff in their Los Angeles office, they were submitting a four-inch-thick stack of monthly reports to the state. The state of California found that it had to develop new capacity and ultimately a new administrative division within the government to monitor these “system-type operations” in Los Angeles. Despite these and other comparable efforts, most state officials do not feel that they are any closer to understanding the most effective way to reach beneficiaries and convey these complex messages, or how to judge the efforts now under way. In fact, one official, asked about the effectiveness of the state’s enrollment materials, could only say, “I think they’re great; but again, I’m not a beneficiary.”

Medicaid managed care education should be part of a comprehensive and continuing strategy, not merely a “one shot” effort. In many places, the underlying system itself is so complicated—in terms of numbers of plans, carved-out services, excluded or exempt groups, differing drug formularies—that the educational task is overwhelming. Certainly, many of the state officials and brokers with whom we spoke agree that the educational needs cannot be met by a single set of materials as part of a one-time enrollment blitz. As one official acknowledged, “it is a stretch to call the enrollment process ‘education’.” One broker listed all of the objectives that the enrollment packet was trying to achieve and concluded that it was staggering under that weight: “The problem is that the enrollment packet often acts in all of those roles and because it is trying to do so much, it can be way too complex.”

In response, the Washington state Medicaid agency has contemplated making the enrollment materials “bare bones,” and then identifying areas of confusion from the calls received by their hotline and creating follow-up mechanisms to help teach enrollees how to navigate the system. Sites like the District of Columbia that have created a more narrowly focused set of enrollment materials have planned to “complement our enrollment packets, at a later date, with materials which focus on other behaviors (i.e., clients use their plan correctly, clients protect their rights).” Yet often these follow-up activities do not occur, or are fragmented and ad hoc.

A number of state and broker representatives noted that as the conversion process winds down, the level of interest in and funding for education and outreach diminishes.

Indeed, in cities like Phoenix and Memphis where mandatory Medicaid managed care has been fully implemented, there is essentially no up-front education for new beneficiaries on how to use the system or on beneficiary rights and responsibilities.

Most brokers and states acknowledge the need for continuing education, but no one knows who will pay for it. Originally, many believed that this role would fall naturally to the health plans, which would have the incentive to teach patients how to use the system and how to access preventive care, keep themselves healthy, and manage their illnesses. However, because half of patients enroll in Medicaid for less than a year and many enroll in plans for shorter periods (particularly in locations where there is no lock-in), the plans have little incentive to invest up front in the education of their patients. In response, a number of cities (e.g., Chicago, the District of Columbia, Houston, Los Angeles, Newark, Philadelphia, Portland) have stopped relying on marketplace incentives to get plans to educate members and are requiring them to create comprehensive health education programs.

The enrollment process offers a critical moment to reach beneficiaries and to begin to explain the elements of managed care. But it is only one point in a longer continuum. If the promise of managed care is to be realized, we have to do more than scratch the surface. Patients must understand how to choose a plan, how to access and navigate their way around the system, and how to keep themselves and their family members healthy. All of these messages cannot be delivered through the single vehicle of enrollment counseling or a brochure.

In addition, from the beneficiary's perspective, managed care is not an issue that stands apart from other social programs and benefits. Medicaid beneficiaries must also be familiar with a whole array of social service programs, benefits (e.g., Child Health Plus) and regulations (e.g., welfare reform). Right now, these competing and disconnected messages—usually delivered by different entities—threaten to drown each other out.

Just as managed care, when implemented correctly, can shed light on the deficiencies in the health care delivery system, so, too, the enrollment process can shed light on the deficiencies in systems for educating Medicaid beneficiaries. What is needed is a series of clear and focused messages, tailored to the needs of the beneficiaries, using multiple approaches and settings—all of which are periodically and systematically evaluated. In other words, what these sites need—and what none has yet achieved—is a comprehensive educational strategy for Medicaid beneficiaries.

APPENDIX A  
LIST OF MANAGED CARE PLAN AND ENROLLMENT BROKER  
CONTRACTS AND REQUESTS FOR PROPOSALS REVIEWED

Chicago

State of Illinois, Department of Public Aid. Contract for Furnishing Health Services by a Health Maintenance Organization. April 1998.

State of Illinois, Department of Public Aid. Contract for Conducting Health Benefits Education in Cook County. June 1998.

Illinois Medical Assistance Program. Request for Proposals to Conduct Health Benefits Education in Cook County. February 1998.

Detroit

Contractual Services Terms and Conditions. October 1997.

Contract Agreement No. 071B7000569 Between the State of Michigan and Maximus, Inc. July 1997.

District of Columbia

Government of the District of Columbia Contract for Goods and/or Services: Medicaid Managed Care. 7010-AF-NS-2-CR. April 1998.

Government of the District of Columbia Solicitation, Offer and Award for Supplies or Services: Client Education/Enrollment Broker for Medicaid. RFP# 7009-AA-NS-4-DL. October 1996.

Houston

Texas Department of Health Contract for Enrollment Broker Services. June 1997.

Request for Proposal: Enrollment Broker Contractor. Texas Department of Health. December 1996.

Contract for Service Between The Texas Department of Health and HMO. 1997.  
Los Angeles

Contract 96-26397 Between LA Care Health Plan and the State of California. March  
1997.

Contract 95-23523 Between Foundation Health and the Department of Health Services.  
April 1996.

Contract 96-26293 Between Maximus, Inc., and the Department of Health Services.  
October 1996.

### Memphis

Contractor Risk Agreement Between the State of Tennessee, d.b.a. TennCare and [name  
of contractor]. September 1995 (with 6 amendments incorporated as of May 10, 1999).

### Miami

Agency for Health Care Administration 1998-2000 Medicaid HMO Model Contract.  
July 1998.

Medicaid Choice Counseling, Enrollment and Disenrollment Services Contract. ITN  
MHC 97-01. 1998-2001. Contract Number M9829. May 1998.

### Newark

Contract Between State of New Jersey, Department of Human Services, Division of  
Medical Assistance and Health Services and HMO Contractor.

Request for Proposal for Outreach, Education, Enrollment and Other Services for a  
Medicaid Managed Care Program for the State of New Jersey, Department of Human  
Services. May 1994.

### New York City

New York City Medicaid Model Contract for Fully Capitated Managed Care Providers  
Under the Partnership Plan. July 1996.

New York State Department of Health, Office of Managed Care Request for Proposal for Benefits Counseling Services. OMC-96-1. February 1996.

Contract # C014917 between the New York State Department of Health and Maximus, Inc. January 1998.

### Philadelphia

HealthChoices Physical Health Agreement Between Commonwealth of Pennsylvania and [name of contractor]. January 1997.

Department of Public Welfare Contract with Benova, Inc. #918161200. August 1996.

### Phoenix

Arizona Health Care Cost Containment System Solicitation, Offer and Award. Request for Proposal YH8-0001. May 1997.

### Portland

Oregon Health Plan. Fully Capitated Health Plan Agreement with FCHP. October 1998.

Oregon Administrative Rules. Chapter 410, Division on Oregon Health Plan. 1999 Compilation.

### Seattle

1999 Contract for Healthy Options. January 1999. (including quality improvement program 1999 standards).

MAA Client Outreach Project Application. 1998.

APPENDIX B  
LIST OF STATE MEDICAID AGENCIES AND BROKER  
AGENCIES INTERVIEWED

State Agencies

Arizona Health Care Cost Containment System

Commission on Health Care Finance, Washington, DC

Bureau of Managed Health Care, Agency for Health Care Administration, State of Florida

Bureau of Managed Care, Department of Medicaid Programs, State of Illinois

Medical Services Administration, State of Michigan

Division of Medical Assistance and Health Services, New Jersey State Department of Human Services

Division of Health Care Access, New York City Department of Health

Office of Medical Assistance Programs, Oregon Department of Human Resources

Department of Public Welfare, Commonwealth of Pennsylvania

TennCare, State of Tennessee

Tennessee Department of Health

Bureau of Managed Care, Texas Department of Health

Medical Assistance Administration, State of Washington

Broker Agencies

Benova, Inc.

Maximus

United Planning Organization, Washington, DC (and subcontractor Academy for Educational Development)

## RELATED PUBLICATIONS

#378 *Using Community Groups and Student Volunteers to Enroll Uninsured Children in Medicaid and Child Health Plus* (March 2000). Melinda Dutton, Sarah Katz, and Alison Pennington, Children's Defense Fund–New York. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#372 *The Role of WIC Centers and Small Businesses in Enrolling Uninsured Children in Medicaid and Child Health Plus* (March 2000). Inez Sieben, Terry J. Rosenberg, and Yoly Bazile, Medical and Health Research Association of New York City, Inc. In this field report, the authors evaluate two innovative models for enrolling uninsured New York children into Medicaid or Child Health Plus.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

*Growing an Industry: How Managed Is TennCare's Managed Care?* (January/February 2000). Marsha Gold and Anna Aizer. *Health Affairs*, vol. 19, no. 1. On January 1, 1994, Tennessee moved virtually all its Medicaid beneficiaries into TennCare, a managed care program. This article analyzes the state's strategy given its limited experience with managed care and examines to what extent health plans have been able to develop managed care infrastructure. The authors find that the progress that has been made is threatened by concerns over TennCare's financial viability and the state's commitment to program objectives. Copies are available from *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, E-mail: [healthaffairs@projhope.org](mailto:healthaffairs@projhope.org).

#311 *Medicaid Managed Care and Cultural Diversity in California* (March 1999). Molly Coye and Deborah Alvarez, the Lewin Group. The authors examine the effect of cultural competence contract provisions that were enacted in 1993 by Medi-Cal, California's Medicaid program. Analysis finds early promise in improving access to and understanding of health care services for low-income, non-English-speaking minority enrollees.

#305 *Insuring the Children of New York City's Low-Income Families: Focus Group Findings on Barriers to Enrollment in Medicaid and Child Health Plus* (December 1998). Peter Feld, Courtney Matlock, and David R. Sandman. This qualitative study sheds light on why a large majority of New York City children who are eligible for Medicaid and New York State's Child Health Plus (CHP) program remain uninsured, even as the state is set to expand coverage to many more low-income families. The report reveals that parents face serious obstacles to getting their children on Medicaid and keeping them on, and have minimal awareness of CHP.

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In the list above, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at 1-888-777-2744 and ordering by number. These items can also be found on the Fund's website at [www.cmwf.org](http://www.cmwf.org). Other items are available from the authors and/or publishers.