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Report to the Chairman, Special Committee on Aging, U.S. Senate

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# MEDICAID

# States' Efforts to Educate and Enroll Beneficiaries in Managed Care


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**United States**
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**Health, Education, and**
**Human Services Division**

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The Honorable William S. Cohen
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

In fiscal year 1995, federal and state Medicaid expenditures reached $159 billion and accounted for more than 19 percent of state budgets. To help control expenditures and expand access to health care, 48 states have implemented some type of managed care program. Initially, these programs were largely voluntary, but states are increasingly requiring Medicaid beneficiaries to enroll in managed care. As of June 1995, 11.6 million beneficiaries, or 32 percent of all Medicaid beneficiaries, were enrolled in managed care. In some states, however, Medicaid managed care programs have been plagued with allegations of marketing and enrollment abuses.

Given the expansion of managed care and reports of abuses, you asked us to (1) describe the role of marketing in expanding participation in managed care and the types of marketing and enrollment abuses that have occurred, (2) identify state efforts to curb or prevent these abuses and to ensure that beneficiaries are adequately informed about their health plan options and managed care as a service delivery approach, and (3) identify state efforts to measure the effectiveness of their education and enrollment approaches.

To develop this information, we reviewed documented cases of marketing and enrollment abuses in five states that have received media coverage: California, Florida, Maryland, New York, and Tennessee. We discussed with the Medicaid officials in these states the cases and any actions taken to prevent further abuses.

In addition, we asked experts to identify states whose education and enrollment programs were noteworthy for their innovative approaches. Based on their input, we visited four states—Minnesota, Missouri, Ohio, and Washington—to review their managed care programs.[1] We focused on mandatory enrollment programs for low-income families, women, and children, who constitute the majority of Medicaid beneficiaries in these

[1]The four states were judgmentally selected to represent diversity of program maturity, strategies for educating and enrolling beneficiaries, and geographical area.

states. We interviewed state and local officials in the four states and analyzed documentation on their education, marketing, and enrollment efforts. We also interviewed health care advocates and representatives of selected managed care organizations in each state to obtain their views on how well these functions are being conducted. For more detailed information on our scope and methodology, see appendix I.

## Results in Brief

To boost enrollment in their Medicaid managed care programs—especially where participation is voluntary—some states have allowed managed care organizations (MCO) to use various direct-marketing strategies, including door-to-door marketing, to encourage beneficiaries to sign up with their plan. Many of these states also have delegated to MCOs the responsibility of enrolling and disenrolling beneficiaries. However, some MCOs and their agents have engaged in unscrupulous practices to maximize beneficiary enrollment—and thereby maximize plan revenues and commissions. These practices include bribing public officials to obtain confidential information on beneficiaries, paying beneficiaries cash and other incentives to sign up, deliberately misinforming beneficiaries about access to care, and enrolling ineligible beneficiaries—as many as 4,800 in one state.

To address—or avoid—these marketing problems, many states have banned or restricted direct-marketing activities by MCOs and have retained responsibility for enrolling or disenrolling Medicaid beneficiaries. Four states that are viewed as having effective enrollment programs—Minnesota, Missouri, Ohio, and Washington—at a minimum, ban marketing door-to-door and at public assistance offices, and each has retained enrollment responsibilities rather than turning them over to MCOs. We found that, as part of their enrollment programs, these states devote considerable efforts to facilitating beneficiaries' difficult transition from fee-for-service to managed care. To do this, they have developed strategies to help beneficiaries understand the principles of managed care and make the often complex decisions involved with selecting an MCO.

Despite their common emphasis on using the enrollment process as an opportunity to promote beneficiary understanding of the program and selection of an MCO, the four states varied in their specific approaches—in part, due to their goals and circumstances. Minnesota relies on public employees to provide in-person education and counseling, thereby taking advantage of their knowledge of the Medicaid program and their experience with the population involved. Ohio also uses in-person education and counseling but, like a growing number of states, delegates

these responsibilities to an independent contractor—also referred to as an enrollment broker—believing a broker can ensure that beneficiaries receive information from a neutral source. Similarly, Missouri contracts with an enrollment broker, which combines in-person and telephone and mail strategies to meet Missouri's goal of rapid implementation statewide. Unlike the other three states, Washington mails informational and enrollment materials to beneficiaries and provides counseling by public employees via telephone. These four states' education and enrollment efforts are also often augmented by community groups, such as maternal and child health advocates, and by MCOs, who are contractually required to inform enrollees on a continuing basis of plan services and operations.

Although community groups in the four states we visited generally believe that their states' education and enrollment efforts have facilitated beneficiaries' transition or introduction to managed care, methods used to measure the effectiveness of these approaches have been limited. State officials and experts we contacted consider the best current measure to be the rate at which beneficiaries select their own health plan—rather than being assigned to one by the state. While these states attempt to reach voluntary selection rates of 80 percent or higher, their actual experience has ranged from 59 to 88 percent. As general measures of the overall operation of their Medicaid managed care programs, these states also track other indicators, such as the rates at which beneficiaries switch plans, complaints, and results of customer satisfaction surveys. However, none of these was designed or analyzed to specifically measure the effectiveness of the education and enrollment process.

## Background

In fiscal year 1995, Medicaid, a program jointly funded by the federal government and the states, provided health care coverage for about 40 million low-income individuals.[2] Over the past 10 years, Medicaid expenditures have more than tripled to $159 billion. Under current projections, they will double again within 8 years.

As budgetary pressures intensify, many states are increasing enrollment of Medicaid beneficiaries in managed care—as an alternative to the fee-for-service health care delivery system—in an attempt to control program costs. States also expect managed care to increase beneficiary access to health care services and to improve the quality and oversight of these services. Many states have attempted to maximize the benefits of

[2]Medicaid is administered at the state level; oversight and coordination are provided at the federal level through the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS).

managed care by requiring beneficiaries to enroll.[3] As of June 30, 1995, 36 states have mandated enrollment for some or all of their Medicaid beneficiaries in managed care plans.

To date, most states have largely targeted their mandatory enrollment managed care programs to low-income families who receive financial assistance under Aid to Families With Dependent Children (AFDC) and pregnant women and children who qualify for Medicaid. However, states are increasingly including managed care options for low-income elderly, blind, and disabled individuals receiving assistance under the Supplemental Security Income (SSI) program and who qualify for Medicaid.[4]

## Direct Marketing Increases Enrollment in Managed Care But Has Resulted in Some Abuses

In some managed care programs—primarily those that are voluntary—states rely on participating MCOs to inform beneficiaries about managed care and to encourage them to enroll.[5] To do this, MCOs use a variety of methods, including direct marketing.[6] Allowing MCOs to market to and enroll beneficiaries can benefit both the state and the MCOs. With the staff and experience to promote managed care, MCOs can relieve the state of the administrative burden of reaching beneficiaries and convincing them to enroll in managed care. In addition, if a state chooses to expand its managed care programs to some uninsured, MCOs can help solicit these newly eligible individuals, who can be hard to reach. MCOs also benefit as they can actively seek a larger share of enrollees.

[3]To mandate enrollment, states must obtain from HHS a waiver of certain requirements in the Medicaid statute. Two waiver authorities have been used widely by states. Under section 1915(b) of title XIX of the Social Security Act, states can obtain federal authorization to waive the "freedom of choice" provision and mandate enrollment with plan switches generally allowed on a monthly basis. Under section 1115, states can obtain federal authorization to require beneficiaries to remain enrolled in a specific health plan for 6 to 12 months and can expand eligibility to the uninsured, who would not otherwise qualify for Medicaid due to income limits. The 1915(b) waiver is the most prevalent.

[4]See Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 31, 1996).

[5]Federal regulations require states that contract with MCOs to ensure that marketing plans, procedures, and materials are accurate and do not mislead, confuse, or defraud beneficiaries or the state. HCFA has issued guidelines to assist the states in developing their marketing oversight standards. See HCFA, Medicaid Managed Care Marketing Guidelines for States (Washington, D.C.: Department of Health and Human Services, HCFA, Aug. 25, 1994).

[6]Direct marketing can occur at home, public assistance offices, health fairs, check-cashing locations, or through targeted mass mailings. In addition, MCOs may offer beneficiaries gifts costing less than $10 as incentives to enroll and memberships to children's programs, such as the Dr. Bear Club offered by a Missouri MCO.

However, MCO marketing activities are funded with part of their monthly capitation payments from the state—funds which might otherwise be used for medical services.[7] In addition, delegating marketing and enrollment activities to MCOs in the five states we reviewed—California, Florida, Maryland, New York, and Tennessee—has enabled some MCOs and their sales agents to commit a number of marketing abuses. These abuses include deliberately misinforming beneficiaries about benefits or available providers, subjecting beneficiaries to high-pressure sales tactics, and fraudulently enrolling beneficiaries. In some cases, these abuses have become more prominent when states announce that they intend to go to mandatory enrollment and plans anticipate that direct marketing will be restricted or prohibited.

Many of these abuses have resulted in access problems for beneficiaries—which are sometimes compounded by MCOs' delays in processing beneficiaries' requests to disenroll from their plan. For example, in August 1994, an MCO sales agent in California assured a newly enrolled beneficiary that she could continue to take her children to their current provider. However, in November 1994, this provider denied care for the beneficiary's infant because the provider was not affiliated with her MCO. Unable to find a provider for her infant, she took action to disenroll her family from the managed care plan. After several weeks of contacting the MCO to determine the status of her disenrollment, she received disenrollment forms—which she had already completed and submitted to the MCO. In March 1995, the beneficiary learned that she was still enrolled in the MCO when she attempted to take her infant to her fee-for-service provider for needed care. The beneficiary then sought assistance from the local Legal Aid office to help her switch back to fee-for-service. As a result of allegations of marketing and enrollment abuses, California has banned door-to-door marketing and enrollment by MCOs.

MCOs that use commissions to compensate their sales agents create an incentive for agents to increase enrollment. However, this incentive may also increase the likelihood for abuses to occur. A 1995 Tennessee audit of the marketing activities of a Medicaid MCO found that the MCO's sales agents had used fraudulent or abusive enrollment practices to enroll about 4,800 individuals. One MCO agent inappropriately enrolled over 200 prisoners, who are ineligible for Medicaid benefits. Another sales agent forged over 140 Medicaid enrollment applications for individuals who were not eligible because they were employed and had private health

[7]Under capitated managed care programs, MCOs receive payments that are based on a set monthly amount per enrollee—or capitation fee—to provide or arrange for a specified set of services.

insurance. The state audit also found that over 4,500 homeless individuals with the same address had been enrolled in the MCO. When the state could not verify their residence or eligibility, they were disenrolled from the plan.

Some MCO sales agents illegally obtained confidential information on beneficiaries, which enabled them to target potential enrollees, meet enrollment quotas, and increase commissions. For example, in Maryland, sales agents from four MCOs bribed state Medicaid officials to obtain the names, addresses, dependent information, and benefit status of Medicaid beneficiaries eligible for enrollment in managed care.

Each of the five states with reported marketing and enrollment abuses has taken a number of enforcement actions or levied fines against fraudulent and abusive MCOs. For example, Tennessee prosecuted and imprisoned two sales agents for fraudulent enrollments and recouped over $1.9 million in payments made to the MCO that had inappropriately enrolled homeless individuals. Maryland convicted 24 individuals—including sales agents and state workers—on charges related to bribery, unlawful disclosure of confidential information, and Medicaid fraud. According to a Maryland official, the state recouped over $25,000 in MCO overpayments. Florida imposed over $520,000 in fines on MCOs found to have fraudulently enrolled beneficiaries. (App. II contains more detail about recently reported abuses and corrective actions in California, Florida, Maryland, New York, and Tennessee.)

In addition to these actions, four states—California, Florida, New York, and Tennessee—have since banned or restricted door-to-door marketing by MCOs. Banning direct marketing, however, has resulted in significant declines in managed care enrollment in Florida and New York. As a result, New York has temporarily suspended its ban on direct marketing in order to increase enrollment again and is implementing certain steps to help avert marketing abuses by MCOs.

## In Moving to Mandatory Enrollment, States Generally Restrict Direct Marketing and Assume Responsibility for Outreach and Education

Mandatory managed care programs obviate the need for states to convince beneficiaries to switch to managed care from fee-for-service. Therefore, as states transition from voluntary to mandatory managed care programs—or move directly to mandatory managed care—they can reassess the value of delegating marketing and enrollment activities to MCOs.[8] Each of the four states we visited as examples of innovative enrollment programs has prohibited or significantly restricted MCOs from initiating contact with beneficiaries not enrolled in their plans. Each state also has elected to assume—either directly or through its counties or enrollment broker—the enrollment function and, as part of this process, to concentrate its resources on educating beneficiaries about managed care and helping them select a health plan rather than be assigned to one by default. Table 1 shows the marketing and enrollment strategies and other selected characteristics of the managed care programs in the four states we visited.

[8]Tennessee chose to use direct marketing when it implemented mandatory managed care enrollment statewide to facilitate enrollment, especially for the newly eligible uninsured.

**Table 1: Selected Characteristics of Medicaid Managed Care Programs in Four States, as of June 30, 1996**

| Program characteristic | Minnesota | Missouri | Ohio | Washington |
|---|---|---|---|---|
| MCO marketing | Prohibited | Restricted | Restricted | Prohibited |
| Responsibility for education before enrollment | State/local | State and enrollment broker | State and enrollment broker | State |
| Responsibility for enrollment processing | State/local | Enrollment broker | State/local and enrollment broker | State |
| Assignment rate[a] | 12 percent | 14-20 percent | 32-41 percent | 20-30 percent |
| Area of coverage | 16 counties | 15 counties and city of St. Louis | 2 counties[b] | Statewide |
| Eligible populations | AFDC, AFDC-related, and elderly | AFDC and AFDC-related | AFDC and AFDC-related | AFDC, AFDC-related, and SSI in selected counties |
| Percent of state Medicaid population enrolled in mandatory managed care | 35 | 35 | 38 | 69 |
| Frequency with which beneficiaries can change plans | Once during first year and during annual open enrollment period | Monthly[c] | Once during first year and during semiannual open enrollment period[d] | Monthly[c] |

[a]The assignment rate is the percentage of beneficiaries who have failed to select an MCO and for whom the state has designated a plan.

[b]Effective July 1, 1996, Ohio expanded its mandatory enrollment program to five additional counties.

[c]Beneficiaries enrolled in federally qualified health maintenance organizations must remain enrolled for 6 months.

[d]Semiannual open enrollment practice will be effective Jan. 1, 1997.

## States Are Restricting Direct Marketing

Because of their concern about potential marketing and enrollment abuses, Minnesota, Missouri, Ohio, and Washington prohibit MCOs from marketing door-to-door and at public assistance offices to beneficiaries in their mandatory programs.[9] Beyond this prohibition, these states have

[9]Ohio still allows MCOs to conduct door-to-door marketing in 8 of the 15 counties where enrollment is voluntary. Like other states, Ohio has taken over enrollment and most education activities and has imposed restrictions on marketing when counties move to mandatory enrollment.

adopted somewhat different approaches as to what type of direct contact the MCOs are allowed to initiate with beneficiaries.

Missouri and Ohio allow limited contact with beneficiaries because each state believes that some types of marketing have a role in outreach and education. For example, Missouri allows MCOs to make presentations to groups if all participating MCOs are present and to distribute nominal gifts if they are given to all Medicaid beneficiaries, not just to those who enroll with the MCO. Ohio allows MCOs to display marketing materials at enrollment centers and to mail promotional materials to beneficiaries via the state. Missouri and Ohio also review and approve marketing materials to ensure that they are accurate and understandable. Missouri further requires that MCO materials meet certain content and presentation standards. For example, Missouri requires that MCO marketing materials be written at a sixth-grade reading level.

Minnesota and Washington prohibit MCOs from initiating contact with Medicaid beneficiaries before enrollment. Both states review any materials that MCOs provide beneficiaries upon request and require that these materials meet certain criteria, such as reading-level and translation standards.

## States Emphasize Beneficiary Education and Choice Counseling

When implementing mandatory programs or enrolling new beneficiaries, the four states we visited assume the task of informing beneficiaries about how to access care in a managed care system and of counseling them on important choices they must make in selecting a specific plan and a primary care provider. Most beneficiaries are accustomed to fee-for-service care, where they may select services from any qualified provider. In contrast, managed care requires enrollees to select a primary care provider, or gatekeeper, who authorizes all care, including access to specialists. These states believe that the more beneficiaries understand managed care principles, the better the managed care system works for them. For example, the four states believe that when beneficiaries understand the role of the primary care provider and the availability of services, their use of more costly emergency room services for nonemergency care will decrease.

In the states we visited, one approach used to inform beneficiaries about the requirement to enroll in managed care is to provide this information when they come to their local public assistance office to apply for or seek redetermination of eligibility for financial assistance. Each state then

provides an overview of managed care, which generally emphasizes the benefits of developing a relationship with a primary care provider, the importance of primary and preventive care, and the appropriate use of emergency room services. Beneficiaries also are informed of the MCOs they can choose from, how and where to enroll, and their rights and responsibilities as a participant in managed care. After beneficiaries have selected a plan, states sometimes also try to identify those beneficiaries who have certain high-risk medical conditions, such as asthma and diabetes, and encourage them to seek routine care. For example, enrollment counselors in Minnesota and Missouri guide beneficiaries through a self-assessment of their health care needs,[10] which is passed on to the plan in which they enroll.

These states also provide to varying extents choice counseling to assist beneficiaries in selecting an MCO and in completing the enrollment paperwork. These states prefer that, when multiple plans are available, beneficiaries choose their own plan—as opposed to being assigned to one by the state.[11] Officials in these states believe that by choosing a plan, beneficiaries are more committed to managed care and are more likely to use the system appropriately. However, choosing a plan is not a simple exercise. The materials that describe managed care are generally complex and range in length from a few pages to over 100 pages. In reviewing these materials, beneficiaries must consider a number of factors, including whether their provider of choice is associated with a plan and whether other associated providers, such as hospitals, are conveniently located. In addition, numerous plans are offered in some areas. In the Seattle area, there are 11 plans to choose from; in St. Louis, Missouri, there are 7. To help beneficiaries choose a plan, the four states offer literature that lists providers in each MCO's network and, to varying degrees, work with individual beneficiaries to try to match them with plans that include their regular physicians, if the beneficiaries have established such relationships.

Although the states we visited use choice counseling, the intensity of this counseling varies. Where one state may offer extensive assistance to

[10]The health care assessment is a checklist of questions to identify common health conditions and special needs of beneficiaries. This assessment is done after the beneficiary has selected an MCO and is not a condition for enrollment.

[11]Beneficiaries who do not choose an MCO are automatically assigned to one by the state. In the states we visited, Ohio allows beneficiaries 15 days to make a selection before automatically assigning them to an MCO, Minnesota and Missouri allow 30 days, and Washington allows 60 days. Assignment in these states is conducted in different ways. Ohio, Minnesota, and Missouri make assignments to participating plans on a rotating or percentage basis. Washington has devised a methodology for assigning beneficiaries that gives preference to MCOs on the basis of quality measures and to a lesser extent on costs.

ensure that beneficiaries make informed choices, another state may be wary of biasing beneficiary decisions and, thus, simply inform beneficiaries of their options. Minnesota, for example, encourages enrollment counselors to work closely with beneficiaries to identify their individual needs and to help beneficiaries select the MCO and primary care provider that best meet these needs.[12] Minnesota believes that the chance of a beneficiary selecting an MCO increases when the beneficiary receives such individualized counseling. In contrast, Ohio officials believe that beneficiary selection of an MCO should not be influenced by enrollment broker staff. Therefore, Ohio's enrollment brokers focus on providing beneficiaries with information needed to make an informed selection; dialogue is reserved to answering questions beneficiaries may have about this information.

## Beneficiary Education and Enrollment Strategies Depend on State Circumstances and Goals

In the states we visited, their circumstances and goals—such as staff resources, expertise required, the importance states attach to assisting individuals in choosing a plan, whether the program is being first implemented or is ongoing, and state implementation schedules—influence their education and enrollment strategies in two key ways. The first is in how the states communicate with beneficiaries, such as through in-person meetings, mail and telephone contacts, or some combination of both. The second is in who carries out these activities—state and local employees or an enrollment broker.

The four states' education and enrollment efforts also are augmented by other players. Community organizations, such as maternal and child health advocacy groups, play significant roles in informing beneficiaries about managed care programs—sometimes at the urging of the state and sometimes at their own initiative. Once beneficiaries are enrolled in a plan, MCOs continue to educate them—as explicitly required by state contracts—on issues such as prenatal and well-child care, nutrition, and family planning. In addition, the states continue, at some level, to provide beneficiaries support in navigating the managed care system.

## States' Choice of In-Person or Mail and Telephone Contacts Is Often Resource- or Time-Dependent

A major contrast among states that we visited is whether the state chooses to educate and enroll beneficiaries in managed care through (1) in-person meetings with beneficiaries when they come to local public assistance offices to apply or request redetermination of eligibility for financial assistance or (2) mail and telephone contacts. While each approach has its

[12]Minnesota requires information on plan benefits and providers to be in a standardized format. This standardization facilitates comparison of MCO services and providers.

advantages and disadvantages, these states seem to use in-person interactions when the resources are available and mail and telephone contacts to facilitate a rapid enrollment schedule or maintain enrollment in an ongoing program.

In-person meetings can include small group or individual presentations—sometimes supplemented by charts and videos—or individualized counseling, or both. Meeting in the local public assistance office provides enrollment counselors an opportunity to sit with beneficiaries to review MCO and other potentially complex materials and explain the differences among plans. These face-to-face meetings can help beneficiaries sort out these differences and make difficult decisions about health plans and providers. However, this type of interaction requires additional staff resources for counseling. In addition, for states transitioning beneficiaries from the fee-for-service program to managed care, in-person interaction can take 6 to 12 months if these states link enrollment of current Medicaid beneficiaries in managed care to their semiannual or annual process for redetermining eligibility for financial assistance. Minnesota uses face-to-face meetings because state officials believe that this type of contact helps beneficiaries make informed selections that they can commit to. Ohio uses similar methods in its in-person meetings, although with less individualized guidance in choosing a plan.

As an alternative to in-person meetings and enrollment, some states with managed care programs may opt to mail managed care information packages to beneficiaries and to enroll them by mail or telephone. Through mail, more beneficiaries can be reached at less cost to the state. However, some MCOs and advocates are concerned that this form of contact may not provide some beneficiaries the assistance they need in learning about managed care. Washington, whose statewide program has been in place for several years, relies primarily on mail to inform beneficiaries about the requirement to enroll in managed care; however, beneficiaries can contact the state by telephone to obtain additional information or receive counseling in choosing their plan and provider. Beneficiaries can enroll by mail or telephone.

Missouri uses both in-person and mail and telephone contacts. The state always has available enrollment staff to meet with beneficiaries who come in to the local public assistance office. When expanding its program into new counties, Missouri uses mail and telephone contacts to expedite

enrollment. In 1995, for example, the state enrolled 150,000 people in the St. Louis metropolitan area in a 3-month period.

## States Are Moving to Contracting Out Education and Enrollment Responsibilities

Education and enrollment responsibilities can be done by state and local staff or contracted out to an enrollment broker. The four states that we visited considered a number of factors in determining who takes on this role. Although only two of these states—Missouri and Ohio—use enrollment brokers, experts that we spoke with indicate that states are increasingly contracting out their education and enrollment functions. We were informed that more than half of the states with Medicaid mandatory managed care programs now contract or are considering contracting with enrollment brokers.

Using state and local workers can be advantageous to a state because they are already on the public payroll; as the state transitions from a fee-for-service to a managed care program, staff can transition as well. Public staff already know and understand the Medicaid program and the population being served. However, transitions can be difficult. When managed care and fee-for-service programs are running simultaneously—especially if the new program has a rapid start-up—there can be a high volume of work and staff may require additional training on managed care. In addition, if a state cannot increase its staff or resources for local enrollment efforts, adding Medicaid managed care responsibilities to existing staff workloads can overburden staff and may result in beneficiaries not receiving sufficient education and enrollment counseling.

Contracting out education and enrollment functions has a number of advantages. In general, enrollment brokers can respond more readily to the demand of high-volume enrollment periods because they are frequently not constrained by state personnel rules and they can more easily build—or reduce—workforce capacity. In addition, enrollment brokers can provide information systems and expertise that assist states with verification of eligibility for MCO enrollment, enrollment processing, and data transmission at a potentially lower cost to the state than developing such a system in-house. Other services that states contract with enrollment brokers to provide include developing innovative education and outreach techniques; meeting the special needs of beneficiaries who do not speak English or who have vision, speech, or hearing impairments; and providing toll-free telephone lines to respond to beneficiary inquiries. Despite these advantages, enrollment broker

employees initially may have less knowledge of the Medicaid program than state and local workers. Moreover, state staff may need to acquire new skills and additional state resources may be needed to monitor broker education and enrollment activities, ensure compliance with contract requirements, and carry out other contract management activities.

Regardless of who performs the education and enrollment function, the state, local government workers, and enrollment brokers need to coordinate their efforts. Experience has shown that when local government workers are not included or kept informed, they may not communicate to beneficiaries the importance of the managed care program or sufficiently encourage them to meet with the enrollment broker.

The states we visited did not conduct extensive analyses of the relative effectiveness or costs of using public employees or an enrollment broker. Rather, deciding which of these two approaches to use was primarily made on the basis of other factors, such as implementation schedules, the availability of adequate staff resources, and prior experience. For example, Missouri contracts with an enrollment broker primarily because of limits in hiring additional full-time state employees. In addition, contracting out allows Missouri to bring in the expertise needed to facilitate a rapid enrollment schedule. Ohio opted to use enrollment brokers when it expanded its mandatory program, because of its positive experience with a broker in the Dayton area, which Ohio felt provided a neutral source of information. (App. III describes in more detail the terms and services in Missouri's and Ohio's contracts and the states' performance expectations for enrollment brokers.)

When Minnesota began its managed care program in the mid-1980s, it contracted with an enrollment broker but found that the broker lacked the necessary understanding of Medicaid. Consequently, the state now provides counties funding for the staff that carries out education and enrollment responsibilities. However, due to budgetary concerns, Minnesota is considering alternative approaches for its statewide program expansion to rural counties and non-Medicaid individuals. Because there are few beneficiaries in rural counties and non-Medicaid individuals are expected to enroll in settings other than the local public assistance office, state officials believe that using county staff dedicated to education and enrollment activities in these areas may not be cost-effective. Washington also opted to use state workers to educate and enroll beneficiaries in managed care. When the state moved to implement its mandatory program

statewide, many state workers who had been working on claims processing for the former fee-for-service program became available to carry out managed care functions.

## Community Group and MCO Education Activities Complement State Efforts

In the four states we visited, community-based groups and MCOs also play important roles in educating Medicaid beneficiaries about managed care and enrollment choices and in promoting preventive and primary health care.

Generally, various community groups and programs—such as churches, Head Start, maternal and child health programs, programs for homeless people, and legal aid services—promote beneficiary understanding of a state's managed care program and provide assistance to beneficiaries in choosing an MCO. Because of their frequent direct contact with the Medicaid population, community groups have some understanding of the health care needs of beneficiaries and know the providers and MCOs in the community. Washington, for example, informed us that it relies heavily on community-based organizations to augment its mail and telephone outreach and enrollment efforts. Among other initiatives, this state has used a train-the-trainer approach that prepares these community organizations to provide face-to-face counseling to beneficiaries and help them enroll. In turn, community and advocacy groups that we contacted readily acknowledge that the state encouraged their involvement in its managed care program.

As part of their contractual agreement, the states we visited require MCOs to initiate contact with new enrollees in their plans and, in some cases, conduct an initial health assessment screening to identify individuals with certain high-risk health conditions.[13] MCOs provide enrollees information, through mailings and other contacts, on the importance of primary and preventive care and enrollee responsibilities—such as contacting their primary care provider first when they need care and reserving emergency room use for emergencies only.[14] MCOs may also be required to provide toll-free telephone lines to answer members' questions on services and other matters and to handle members' complaints. Some of the MCOs in the states we visited also assist enrollees by providing services that are not

[13]Health assessments may occur even if the state conducted an assessment at the time of enrollment.

[14]Some states have translation requirements for membership materials. For example, Washington requires MCOs operating in the Seattle area to translate materials into 13 languages, including Hmong and Tigrigna.

required by the state. For example, in general, the MCOs we spoke with had at least one social worker on staff to handle problems beyond health care.

In addition to their direct contact with beneficiaries, community groups in Washington and Ohio are part of county advisory committees, whose membership also includes providers; government officials; and, in Ohio, MCOs. These committees meet regularly to discuss issues regarding the managed care programs, particularly as they affect beneficiaries, and are generally viewed as constructive in addressing program challenges and concerns. In Ohio, for example, members of a county advisory committee worked with the local telephone company to help provide beneficiaries basic telephone services to facilitate their communications with their primary care provider and MCO.

## States Continue to Provide Beneficiaries Support After Enrollment

The four states we visited provide additional support to beneficiaries once they are enrolled in a plan. Each state has a complaint and grievance process, as required by federal regulations, and three have toll-free telephone lines to assist beneficiaries with questions and complaints on issues, such as access and health care services provided by their plans. In addition, Washington and Minnesota have state officials dedicated to assisting beneficiaries who encounter difficulties in the managed care system.

Of the states we visited, Minnesota has the most extensive system for supporting enrollees. The state provides funding for counties to hire advocates, who assist beneficiaries in resolving problems that may arise with their MCO. Minnesota also has a state ombudsman for the Medicaid managed care program to mediate grievances between beneficiaries and MCOs. The state and MCOs credit the advocates and ombudsman with generally being able to resolve problems to the satisfaction of beneficiaries and all other stakeholders.

# Measures of the Effectiveness of Education and Enrollment Efforts Are Limited

Collectively, the states we visited point to a number of data sources that can indicate beneficiary understanding of and satisfaction with the Medicaid managed care program. These include assignment rates, rates at which beneficiaries voluntarily switch MCOs, complaints, and results of customer satisfaction surveys. However, these sources—as currently designed and analyzed—do not directly measure the effectiveness of their enrollment and education programs.

Despite some limitations, assignment rates appear to be the best available indicator for measuring the effectiveness of a state's education and enrollment activities. A low assignment rate may indicate that beneficiaries have knowingly exercised their choice to select an MCO and a primary care provider. It is not, however, a perfect indicator of a beneficiary's knowledge and understanding of a state's managed care program. For example, a state or contractor could count a beneficiary as having made a choice when the beneficiary did not understand how the program or the selected MCO worked.

Comparing assignment rates across states also is problematic. The states we visited define assignment rates somewhat differently. For example, when enrolling newborns in their mothers' plans, Washington considers them assigned enrollees, whereas Ohio considers them voluntary. The states' process of assignments also vary somewhat. For example, the time allowed to beneficiaries to select a plan—which can affect the number of beneficiaries who choose a plan for themselves—ranged from 15 to 60 days.

The states we visited generally attempt to keep assignment rates at 20 percent or less. The most recent data available indicate that Minnesota's assignment rate has been stable at 12 percent, Missouri's assignment rate is between 14 and 20 percent, and Ohio's assignment rate is 32 percent in one county and 41 percent in another. In Washington, assignment rates reveal an interesting pattern. After an extensive education and enrollment effort during the statewide implementation of managed care, the assignment rate was relatively low—between 20 and 25 percent. In recent months, however, the assignment rate crept above 30 percent, and both state and MCO officials we contacted believe that to ensure beneficiary knowledge about managed care, sufficient resources need to be devoted to education and enrollment on an ongoing basis.

Rates at which beneficiaries switch MCOs may be an important indicator of overall program quality and satisfaction, although not necessarily of the effectiveness of an education and enrollment program.[15] Rates of rapid disenrollment—the percentage of enrollees choosing to switch plans within the first 90 days of joining a plan in those states that allow monthly plan changes—might be a more direct indicator of the effectiveness of education and enrollment programs. Choosing to leave a plan within such a short time period can indicate that the plan does not meet the enrollee's expectations or needs. However, neither Missouri nor Washington—the

[15]Minnesota, Ohio, and Washington collect and analyze data on reasons for plan switches.

two states we visited that allow monthly plan switches—analyze their data for these purposes.

Other data sources, if modified, may have the potential to be used as indicators of the success of state education and enrollment efforts. For example, data are available on the number and nature of beneficiary complaints registered with MCOs and the state. However, more focused tracking and analysis of complaints and appeals might enable states to better identify and correct problems associated with their education and enrollment programs.

Customer satisfaction surveys also could be used to measure the effectiveness of state education and enrollment programs. However, these surveys generally have focused on beneficiary views on the overall quality of care received and have suffered from very low response rates. To better measure the effectiveness of their education and enrollment programs, states might include in their satisfaction surveys specific questions related to these programs. Washington has begun to do this. The state conducts monthly customer satisfaction surveys of random groups of beneficiaries and surveys of beneficiaries who switch MCOs to obtain reasons for plan changes. Both surveys include questions pertaining to beneficiary knowledge about their managed care plans.

## Conclusions

Allowing MCOs to directly market to Medicaid beneficiaries—whether to boost enrollment in voluntary managed care programs or to reach newly eligible uninsured in certain mandatory programs—has resulted in some abusive practices that states have found difficult to prevent. As states move to mandatory enrollment, they are increasingly retaining primary responsibility for the enrollment process or contracting with enrollment brokers. The four states we visited that are considered to have effective enrollment programs are focusing on educating beneficiaries about how to access services in a plan and counseling them to choose a primary care provider and MCO that best meets their health care needs.

For the majority of Medicaid beneficiaries, who are accustomed to a fee-for-service system in which they can choose their own provider, learning how to navigate the managed care system and choosing a plan can be a perplexing process. This process also can be difficult for new beneficiaries who are unfamiliar with fee-for-service or managed care. Consequently, some states believe that investing resources in educating beneficiaries—with an emphasis on choosing a primary care physician and

appropriately using health care services—is important for the beneficiary's smooth transition to this new health care delivery approach.

Differences in the relative effectiveness of how a state communicates with beneficiaries or who handles these communications have not been fully evaluated. Although in-person counseling can be more time-consuming and resource-intensive than mail and telephone contacts, this type of counseling may best meet the states' aim to match beneficiaries to an MCO and primary care provider. Learning about managed care and choosing an MCO can be a daunting responsibility, and some states believe that face-to-face interaction results in better understanding and use of the program. When faced with the decision to keep the education and enrollment activities in-house or to contract them out, states are increasingly electing to contract with an enrollment broker. Again, however, there is little evidence that this approach is more effective or less costly than performing functions in-house. Rather, states, such as the ones we visited, have made their decisions on the basis of factors such as available staff resources and the ability to meet peak workload demands associated with program expansions.

Also lacking are strong performance measures of effective education and enrollment efforts. While the rate at which beneficiaries select an MCO is one available indicator, it alone does not reflect the degree to which Medicaid beneficiaries understand and appropriately use the managed care system. Focused analyses of complaints and voluntary disenrollment patterns—especially within the first 90 days of enrollment—and well-designed customer surveys are additional tools that states might explore to further strengthen their education and enrollment processes.

## Agency Comments and Our Evaluation

A draft of this report was reviewed by officials in HCFA's Office of Managed Care and the Medicaid Bureau. HCFA officials provided technical comments that we incorporated as appropriate. We also provided the draft report to Medicaid staff from the nine states discussed in our report. All the states responded with technical or clarifying comments, generally agreeing with the accuracy of the information. In addition, three states—California, Florida, and New York—informed us of new initiatives they have recently undertaken or planned that are similar to the education and enrollment strategies used by states discussed in this report. Specifically, these states have restricted the types of direct-marketing activities MCOs can use. They also have acquired or plan to acquire the services of enrollment brokers to assume the functions of educating and enrolling beneficiaries in managed

care. Based on their comments, we updated the report where appropriate to reflect these initiatives.

In addition to requesting comments from HCFA and state agencies, we provided the draft report to independent researchers from the National Academy for State Health Policy, Virginia Commonwealth University, and Health Policy Crossroads. These experts generally agreed with the accuracy and comprehensiveness of our presentation of the issues and programs. We also incorporated their technical and clarifying comments as appropriate.

As arranged with your office, unless you announce its contents earlier, we plan no further distribution of this report until 30 days after the date of this letter. At that time, we will send copies to the Secretary of Health and Human Services. We also will make copies available to others on request.

Please contact me on (202) 512-7114 or Kathryn G. Allen on (202) 512-7059 if you or your staff have any questions. Lourdes R. Cho, Richard N. Jensen, and Karen M. Sloan were major contributors to this report.

Sincerely yours,

William J. Scanlon
Director, Health Financing and
Systems Issues

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**Abbreviations**

| | |
|---|---|
| AFDC | Aid to Families With Dependent Children |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |
| MCO | managed care organization |
| SSI | Supplemental Security Income |

# Scope and Methodology

To describe the role of marketing in expanding participation in managed care and the types of marketing and enrollment abuses that have occurred in Medicaid managed care to date, we obtained and reviewed documentation from state Medicaid agencies and state attorneys general offices. We selected cases in five states—California, Florida, Maryland, New York, and Tennessee—that have received media attention due to Medicaid managed care marketing problems. We reviewed these cases with state Medicaid officials and discussed their planned actions to correct the abuse problems identified with these cases.

To identify states' efforts to curb or prevent fraud and abuse in Medicaid managed care marketing and enrollment, we discussed existing or emerging state models for educating and enrolling beneficiaries in MCOs with experts in Medicaid managed care. We discussed these issues with officials from HCFA's Office of Managed Care and a representative from the American Public Welfare Association. We also consulted with the following researchers: Jane Horvath and Neva Kaye, National Academy for State Health Policy; Robert Hurley, Virginia Commonwealth University; Sara Rosenbaum, Center for Health Policy Research of The George Washington University; and Mary Kenesson, Health Policy Crossroads. We also reviewed the general literature on Medicaid managed care marketing and education.

We judgmentally selected four states for case studies—Minnesota, Missouri, Ohio, and Washington. Each state has mandatory capitated managed care programs in some or all of its counties that represent diversity of program maturity, strategies for education and enrollment, and grographic areas. In these four states, we focused on programs for low-income families, women, and children, who constitute the majority of Medicaid beneficiaries in these states. Among other selection criteria, these states had been recommended to us as having assignment rates that were low in relation to other states—one potential indicator of an effective education and enrollment process. In each of the four states, we interviewed state Medicaid officials and reviewed documentation to determine how the managed care programs were organized and operated and how education, marketing, and enrollment functions were conducted. In addition, we interviewed local public assistance officials and community-based groups to obtain their views on how well the educational, marketing, and enrollment efforts were proceeding. We also interviewed representatives of selected managed care plans in each state to obtain their views on education and marketing issues. Finally, we interviewed the enrollment brokers in Missouri and Ohio.

To identify states' efforts to measure the effectiveness of their education and enrollment approaches, we discussed the use of various performance indicators with program officials in the four states. We then assessed the extent to which these indicators accurately gauge the effectiveness of these states' education and enrollment programs.

We conducted our review from November 1995 to August 1996 in accordance with generally accepted government auditing standards.

# Marketing, Enrollment, and Disenrollment Abuses and State Corrective Actions

In the past 2 years, at least five states have received media attention due to deceptive or inappropriate marketing, enrollment, and disenrollment practices by some MCOs. Each of these states allowed plans to market directly to Medicaid beneficiaries. At the time of the reports of marketing abuses, four of the states—California, Florida, Maryland, and New York—had managed care programs with voluntary enrollment in MCOs. Since then, California and Florida have switched to mandatory enrollment, and Maryland plans to switch in January 1997.[16]

Beyond moving to mandatory programs, these states and New York have taken several actions intended to respond to marketing and enrollment abuses. In May 1996, California banned door-to-door marketing and MCO enrollment and significantly restricted the types of marketing activities MCOs can use. In July 1996, it contracted with an independent firm to enroll and disenroll beneficiaries in managed care statewide. Florida has banned direct marketing in managed care programs effective July 1995, and is in the process of acquiring the services of an enrollment broker. Effective October 1996, Maryland will ban direct marketing to prepare for its mandatory program. New York banned door-to-door marketing in New York City, where marketing abuses were found, and has begun the process of contracting with an enrollment broker to educate and enroll beneficiaries in managed care.

In addition to these actions and in direct response to problems associated with abusive or fraudulent practices, states have modified their MCO contracts and taken enforcement actions against the MCOs and sales agents. For example, Florida cancelled or did not renew the contracts of three MCOs as a result of its investigation into the plans' marketing and enrollment activities. In addition, Florida imposed over $520,000 in fines on MCOs found to have fraudulently enrolled beneficiaries. Maryland prosecuted and convicted MCO representatives found to have bribed state officials for information on Medicaid beneficiaries. Maryland also successfully recouped $25,000 from the MCOs involved in the cases. Tennessee successfully prosecuted three sales agents and recouped over $1.9 million in MCO overpayments.

Table II.1 summarizes abuses encountered by the five states and actions taken by state officials to address these abuses. We did not evaluate the effectiveness of these corrective actions because they were recently implemented and were outside the scope of our work.

[16]Tennessee has a mandatory enrollment managed care program that has an option for the working uninsured to voluntarily participate. To assist uninsured individuals with enrolling in managed care, the state has allowed MCOs to conduct direct-marketing activities.

**Table II.1: Examples of Marketing and Enrollment Abuses in Medicaid Managed Care and State Corrective Actions**

| Problem | Corrective/enforcement action |
|---|---|
| **California** | |
| Cash and other incentives to beneficiaries as an inducement to enroll | Banned plans' use of door-to-door marketing |
| Misinformation about managed care | Prohibited plans from directly enrolling beneficiaries |
| Misrepresentation of plan benefits and choices of providers | Decertified some enrollers and made the state certification process more difficult |
| False claims by marketing agents | Suspended enrollment in some plans |
| Delays in disenrollments | |
| **Florida** | |
| Fraudulent enrollments | Banned marketing activities conducted door-to-door, at food stamp lines, and at the public assistance offices |
| Misrepresentation of plan benefits | Required marketing agents to be salaried employees of health plan |
| Cash to beneficiaries as an inducement to enroll | Capped sales commissions to a specific percentage of total salary |
| Delays in disenrollments | Amended managed care contracts to allow the state to recoup capitation payments for beneficiaries who disenroll within the first 3 months of enrollment without using plan services |
| | Terminated contracts with three managed care plans |
| | Imposed fines on MCOs of over $520,000 |
| **Maryland** | |
| Misrepresentation of managed care | Prohibited marketing agents from obtaining medical information during enrollment process |
| Fraudulent enrollments | Prosecuted and convicted MCO representatives and state employees |
| Bribes to state officials to obtain confidential information about Medicaid beneficiaries eligible for managed care | Recouped $25,000 in payments to plans for fraudulent enrollments |
| | Established fines of up to $5,000 for each violation of marketing and enrollment contract requirements |
| | Established fines of up to $10,000 per Medicaid beneficiary enrolled as a result of marketing fraud |

(continued)

| Problem | Corrective/enforcement action |
|---|---|
| **New York** | |
| Misleading information about health plan benefits and choice of providers | Prohibited plans in New York City from directly enrolling beneficiaries<br><br>Banned the use of door-to-door marketing by plans in New York City<br><br>Froze enrollment in selected managed care plans |
| **Tennessee** | |
| Fraudulent enrollments | Prosecuted and convicted MCO agents for fraudulent enrollments<br><br>Recouped over $1.9 million in payments to plans for fraudulent enrollments<br><br>Required MCOs to submit their marketing materials to the state for review and restricted direct marketing<br><br>Limited commissions and bonuses paid to MCO agents to not more than 50 percent of their compensation<br><br>Prohibited MCOs from submitting beneficiary enrollment applications<br><br>Amended contract to require managed care plans to report suspected fraud and abuse to the state |

# Enrollment Broker Contracts in Missouri and Ohio

Of the four states we visited, Missouri and Ohio elected to use enrollment brokers to conduct their Medicaid managed care education and enrollment functions. Both states contract for similar types of services; however, there are several notable differences in their enrollment broker contracts with regard to contract terms, service requirements, and performance expectations. Tables III.1 and III.2 delineate these differences, as well as the similarities.

## Contract Terms

Missouri's and Ohio's enrollment broker contracts both delineate the geographic area to be covered, the duration of the contract, and the method of reimbursement; however, some key terms vary. Missouri awarded one contract to a national Medicaid claims processing firm to serve as a statewide enrollment broker. In contrast, Ohio awarded seven county-based contracts and encouraged local companies to bid for these contracts. Both states currently reimburse brokers on a per-enrollment basis. Ohio initially reimbursed the enrollment broker on a cost basis, but found that this type of reimbursement required too much direct oversight. Neither state reimburses their enrollment brokers for plan switches.

**Table III.1: Selected Terms of Enrollment Broker Contracts in Missouri and Ohio**

| Contract terms | Missouri | Ohio |
|---|---|---|
| Scope | All regions with mandatory enrollment programs | County-based |
| Duration | Annual with renewal option for two more 1-year periods | Annual with renewal option for two more 1-year periods |
| Type of reimbursement | Per-enrollment | Per-enrollment |
| Per-enrollment rates[a] | $9.78-$19.17 | $7-$25 |
| Annual cost | About $5 million | 7 contracts ranging from $130,000-$760,000 (with most about $230,000) |
| Type of company holding current contract(s) | For-profit, national claims processing firm | Local for-profit companies |

[a]The per-enrollment rates vary according to the geographical region of the state and the stage of the managed care program implementation. For example, enrollment brokers may receive a higher rate of per-enrollment reimbursement in the regions where Medicaid managed care is first implemented.

## Contract Services

In their enrollment broker contracts, Missouri and Ohio specified education, beneficiary, and administrative and clerical services that would complement state capabilities. Although there are many similarities in the states' requirements for carrying out these services, there are some

notable differences. For example, Missouri's enrollment broker carries out all enrollment functions using automated systems to input enrollment data and to transfer these data to the state and MCOs. In Ohio, the enrollment brokers send completed enrollment forms to the state; the state then inputs the enrollment data and provides the MCOs with enrollment information. Table III.2 displays the similarities and differences in these two states' contracts.

**Table III.2: Examples of Contract Requirements for Enrollment Brokers in Missouri and Ohio**

| Contract requirement | Missouri | Ohio |
|---|---|---|
| Develop innovative education and outreach techniques to target specific needs of the county and maintain and distribute all state- and MCO-provided materials to beneficiaries. | | • |
| Create, produce, and mail education and enrollment materials, including letters, brochures, and other outreach materials. | • | • |
| Conduct neutral and impartial presentations to beneficiaries about MCO options. | • | • |
| Provide choice counseling to beneficiaries to help them select an MCO and a primary care provider. | • | • |
| Assist beneficiaries in completing enrollment forms.[a] | • | • |
| Contact and provide over-the-telephone education and counseling to beneficiaries who do not meet with staff at public assistance offices. | • | |
| Meet the special needs of non-English-speaking beneficiaries and beneficiaries with vision, speech, or hearing impairments. | • | • |
| Provide toll-free telephone lines to respond to beneficiary inquiries, provide MCO enrollment information, and log beneficiary complaints. | • | • |
| Use toll-free telephone lines to enable beneficiaries to enroll and switch MCOs. | • | |
| Provide enrollment counselors access to the state information systems to enable them to respond rapidly to beneficiary questions about eligibility, to review MCO provider networks, and to conduct enrollment. | • | • |
| Conduct a health assessment, identify third-party health insurance coverage, and promote voter registration. | • | |

(continued)

| Contract requirement | Missouri | Ohio |
|---|---|---|
| Provide enrollment counselors training on managed care, how to disseminate information in an effective manner, and general customer service principles, including managing hostile callers. | • | |
| Provide enrollment counselors 40 hours of training on managed care and cultural sensitivity. | • | • |
| Develop and use automated systems to log in enrollment applications received through the mail, to verify eligibility status (through state eligibility files), generate eligible-specific enrollment forms, and accept client enrollments electronically from local public assistance offices. | • | |
| Verify enrollment eligibility using the state automated system. | | • |
| Assign beneficiaries to MCOs based on the state's algorithm. | | • |
| Resolve or refer to the MCO or state beneficiary complaints about the enrollment broker, participating MCOs, and providers. | | • |
| Make available to the state on a regular basis via electronic media a list of newly enrolled beneficiaries. | • | |
| Track and monitor beneficiary inquiries and complaints. | • | • |
| Provide periodic statistical reports on all broker activities, such as enrollments, assignments, and the number and types of inquiries received. | • | • |
| Maintain logs of completed enrollment forms mailed to the state for processing and of processed forms picked up by MCOs. | | • |
| Maintain active communication with the local public assistance offices and other key stakeholders in the enrollment process. | | • |

[a]Ohio gives beneficiaries 3 working days to change their choice; contractors must hold on to enrollment forms during this time.

## Performance Expectations for Enrollment Brokers

Missouri and Ohio have set a number of performance expectations for their enrollment brokers in facilitating beneficiary selection of an MCO. Missouri explicitly requires its enrollment broker to maintain an

assignment rate of 20 percent or less.[17] Other state requirements include performance expectations for education and beneficiary services.

In educating beneficiaries, both states require their enrollment brokers to meet certain special needs. For example, Missouri requires that education materials be written at a sixth-grade reading level and be printed in several languages to ensure that most beneficiaries will comprehend the materials. Ohio requires that the enrollment broker have available interpreters and other staff to assist non-English-speaking beneficiaries and those with vision, speech, and hearing impairments.

Both states expect their enrollment brokers to be responsive to beneficiaries. Ohio requires that enrollment packages be mailed within 2 days of receiving a request. Missouri requires that undeliverable packages returned to the broker be forwarded to the state within 3 days of return. Both states' toll-free telephone lines must be operational during typical business hours, Monday through Friday. Missouri also requires that lines be answered by the fifth ring 97 percent of the time and that no caller can be put on hold for longer than 2 minutes. Ohio requires that the enrollment brokers provide a system that allows beneficiaries to obtain basic program information and to leave requests for call-backs 24 hours a day, 7 days a week. Call-backs must be made no later than the end of the next business day.

[17]Missouri attaches a penalty to its broker reimbursements if an assignment rate of 20 percent or less is not met. For each 1 percent above 20 percent, the state reduces the next month's total payment to the enrollment broker by 1.5 percent. To date, the enrollment broker in Missouri has had an assignment rate below 20 percent, and no penalty has been imposed.

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