



## **Cybersavvy, old school, and everyone in between:**

How can DHS ensure that all Minnesotans on Medical Assistance can find the information they need to access health care?

March 2024



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## Executive Summary

Medical Assistance (MA) is Minnesota’s Medicaid program. It is a critical safety net program which provides access to health care for Minnesotans with low income or a disability. DHS hears anecdotally from members that they have a hard time accessing health care, even though they are enrolled in MA. They report difficulties finding information on which doctors, clinics, and other health care providers are in their network, figuring out which services are covered and how much they will have to pay for the service. Some also report difficulties getting transportation to their appointments or many other access barriers. To investigate the prevalence of these challenges, DHS conducted a representative survey in close collaboration with Wilder Research in the spring of 2022. The survey was completed by 2,985 MA members aged 18-64. This report provides an overview of these challenges as well as the solutions that DHS plans to implement.

### How do members want to find information on their benefits?

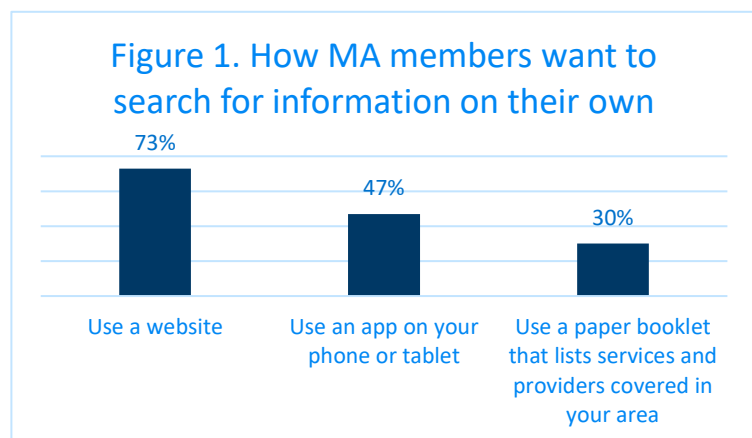
MA members are diverse, and to serve them all adequately, DHS must offer multiple communication modalities so each can choose the ones that they are comfortable with and have access to. One of the overarching findings in the survey was that MA members are divided in their access to the internet and technological devices, and somewhat along these lines, are divided in how they want to communicate about MA.

Three-quarters of MA members have home internet access through a laptop or similar device, or through their cell phone or smartphone. These members, for the most part, want to use these technologies to find information about their MA benefits.

One quarter of members do not have internet access at home. For these members, using paper mail and stopping by their county/tribal office were often just as popular as using the internet. Some groups (e.g. People with Disabilities) have especially large proportions of their members who prefer traditional (non-internet) communication modes. Being aware of this divide within the MA population is essential if we are to effectively communicate with all members.

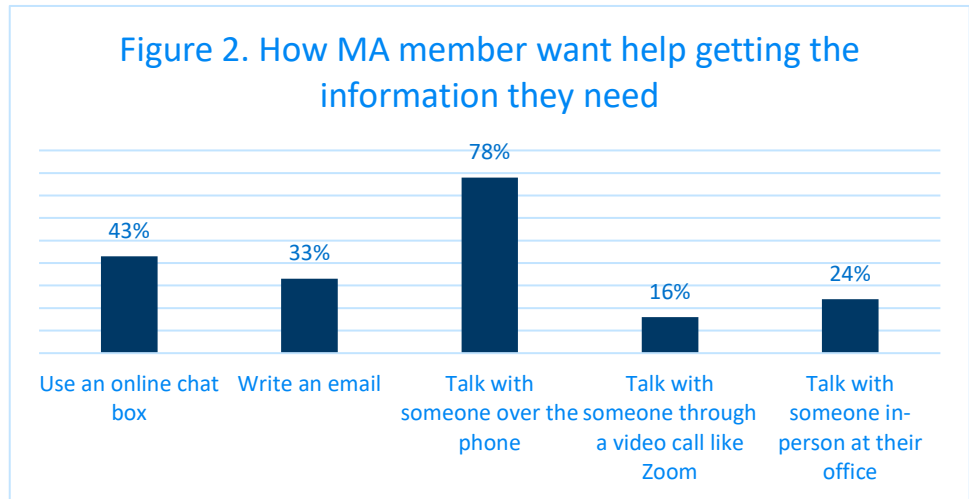
Given the challenges we sometimes hear from members on how difficult it can be to find information on their benefits, we included questions in the survey about how they want to search for this information. First, we asked how they want to search for information *on their own*. The results are shown in the next figure. The most popular option was to use a website; three quarters of members (73%) checked that option. Nearly half (47%) said they wanted to use an app on their phone or tablet. A smaller but still substantial percentage (30%) wanted to get information from a paper booklet.

As expected, the website was the most popular option among those with home



internet access (80% chose this option). For members without home internet access, a website was also the most popular option, but the paper booklet was a close second place (50% vs. 40%). Many people in this group must have internet access somewhere other than at home.

Sometimes members have questions that are too specific or too complex to figure out by doing research on their own. We therefore asked members how they would like to get help if they need it. The most popular option was to talk with someone over the phone, with nearly four out of five members selecting this option. This was true for those with and without home internet access. Apparently, having information easily accessible on one's electronic device is not a substitute for being able to talk with a live person, especially for complex questions.



## Are members able to access the information they need to get health care?

We asked MA members if they had a hard time figuring out which health care services are covered, which providers they can go to, and other information they may need to access health care. Here is what we found:

- 32% of members had a hard time finding a health care provider who accepts MA.
- 31% of members had difficulty figuring out which services are covered.
- 17% had difficulty figuring out how much their co-pay would be.
- 13% of members had a hard time getting to the clinic because they don't have access to a car or public transportation. 13% need a free ride to the clinic but don't know how to schedule it.

## FFS and MCO MA

Minnesota's MA program includes people who get their care paid for by a Managed Care Organization (MCO), as well as people in Fee-for-Service (FFS). When a Minnesotan applies for MA and their eligibility is approved, they must either choose an MCO, are excluded from managed care and will remain in FFS, or opt in to FFS. Only individuals eligible for MA under certain categories are permitted to opt in to FFS. Under the FFS model, health

care providers bill DHS directly for health care services, instead of going through a health plan. As of November 2023, 1,150,000 Minnesotans were enrolled in managed care and 200,000 were enrolled through FFS<sup>1</sup>.

Members who have a health plan and those with FFS report very similar experiences with accessing care and in describing how they want to get information. However, because their access to care and the way they get information on their benefits varies dramatically, we report these separately for the two groups.

## **MCO MA: How can we improve access to information and health care for these members?**

Overall, there is a relatively good fit between the MCOs' modes of sharing information with members, and members' communication preferences. Most MA members want to access information online, and all MCO's have their plan benefits on their website. About four in five members want to call someone on the telephone when they need help finding an answer to their question, and each MCO has a call center to meet this need. One-third of members want to get help with their questions by using email, and this is an option with all MCOs. It seems like the communication modes that most people want to use to find the answers to their questions are already in place. There may be a few remaining gaps which could be addressed.

- **Ensure that people without internet access can get the information they need.** Most MA members have internet access. Over half have both a smartphone/tablet and a laptop/desktop. Most of these members want to communicate using their electronic devices. However, ten percent of members said that they have none of these devices. Further, one-fourth do not have internet access at home. MCOs need to offer members information in whatever mode members can meaningfully access, including on paper.
- **Look into which communication modes each MCO uses.** MCOs publish the member handbook and many other benefits materials and make them available on their websites. If a member requests it, they will send the information through the mail. However, it is not clear whether members know that they can request these documents on paper. We should work with MCOs to ensure that everyone who needs information on paper is aware that those resources are available and can access them.
- **Begin the review of MCO communication modes with contracts that cover People with Disabilities.** Most People with Disabilities have internet access as well as devices to access it at home. However, their rates are lower than for other groups, and a large minority shows a strong preference for traditional modes of communication. For example, when asked how they want to find answers to their questions about MA coverage, 32% of People with Disabilities only wanted information via paper materials and didn't select online or app options. DHS might start with the contracts for People with Disabilities to find out if MCOs provide them with information through the mail, or if MCOs explicitly tell them that they can request information on paper.
- **Encourage MCOs to let members know what their co-pay is.** Co-pays were quite simple in 2022 when the survey took place and are even simpler starting in 2024 when they are \$0. Even so, in 2022 one in six members said they had a hard time figuring out how much their co-pay would be. MCOs need to find ways to share this information with members. MCOs used to include the co-pay amount on their

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<sup>1</sup> Internal analysis of MA renewals.

insurance cards, and now not all do this. A simple solution may be for DHS to ask MCOs to include the new co-pay amount (\$0) on their insurance cards.

- **Encourage MCOs to share information on the transportation benefit more widely.** Most MA members do not need assistance with transportation to their health care appointments, but for those that do, this can be a significant barrier. MCOs need to let members know who is eligible for which transportation assistance, and how to access that assistance.

DHS and MCOs regularly discuss MA members' barriers to care and how to reduce the barriers. For example, DHS is currently reviewing results of a transportation provider survey with MCOs to find new ways to alleviate transportation barriers. Also, in the last contracts with MCOs, DHS asked MCOs to describe how they will encourage after-hours access to health care. DHS and MCOs will continue to work to address these and other access barriers.

### **FFS MA: How can we improve access to information and health care for these members?**

There are significant gaps in FFS MA members' ability to find the information they need. DHS needs to get better at sharing benefits information with these members. Right now, the best resource for FFS MA members to learn about their benefits is the Health Care Consumer Support (HCCS) call center. They have about 20 staff dedicated to providing assistance to FFS MA members. The number to call is conveniently located on the back of member insurance cards. When we asked members how they would like help with finding information on their benefits, 78% said they would like to talk with someone over the phone. This confirms the value of the HCCS to members.

However, the HCCS should not be the only source of information for members. Many people want to and are capable of searching for information on their own. When we asked people how they want to search for benefits information on their own, most (73%) indicated that they want to do so on a website. DHS has a webpage for FFS MA, but it can be difficult to find.



Many people also want information in the form of paper booklets. This was true of 30% of all MA members, and for 40% of those without home internet access. At present, we do not send any benefits information to FFS members through the mail. In fact, we do not send them benefits information using any mode of communication.

### **DHS will create materials that describe FFS MA member benefits**

We can do a lot better, and we are committed to doing so. The tasks below outline our plan for communicating regularly with members. We think it combines the right resources with the most cost-efficient modes of member outreach, which we hope will make it easier for all members to access the health care they need.



- **Create a concise ‘Member Summary’.** This document would provide a broad overview of covered services, co-pays (notify people that these are sunsetting in 2024), the FFS website, where to look up health care providers, the website to look up county and tribal office phone numbers, and the HCCS call center number. It should also include some basic information on how to get started accessing health care.
- **Create easy-to-understand resources on covered services.** HCCS call center staff report that most members access DHS materials to answer a particular question they have, not to get a broad overview of services. We might develop resources, such as PDFs that can be posted online or sent to the member, on common health conditions and appropriate services. We might also develop resources to help members access especially complex services, such as transportation.
- **Consider publishing a detailed ‘Member Handbook’.** DHS could also create a member handbook with extensive information on benefits, ways to access these benefits, member rights and responsibilities, and other key information. Some members have indicated that they would value this as a reference. We could base it on the template that we ask MCOs to use.

### **DHS will disseminate the materials**

Once we have developed the materials, we will use the following strategies to disseminate them to members.

- **Place the materials on the FFS MA webpage and make it easy to find.** Most MA members want to use a website when they search for information on their own, and DHS has a webpage dedicated to FFS. However, it is difficult to find, especially for the many members who don’t use the term ‘Fee for Service’ and instead call it something else, such as ‘straight MA’. Once we have a webpage with a robust array of materials, written in plain language, we will create a shortened URL so people can type it in if needed. This webpage will serve as the central location for all FFS member information, and we will include this URL on all materials sent to FFS members.
- **Investigate the best way to send every member an ‘Introduction to FFS’ letter.** All MA members are sent a welcome letter and a DHS insurance card once they are approved for MA. Next, they are asked to choose an MCO and some have the option to choose FFS. If they choose an MCO (or one is assigned to them), then that MCO sends them information on the plan, and they send a new insurance card specific to that plan. However, there is currently no process for sending similar information to those who have opted for FFS. We will send new FFS MA members the materials described in this section, along with an ‘Introduction to FFS’ letter, so they have the information they need to access health care right away.
- **Share resources with members, using the lowest cost mode of communication that a member has requested.** By the fall of 2024 (the end of the post-Public Health Emergency renewal process), DHS should have members’ updated communication preferences, including text and email. We should use the lowest-cost, easiest mode of communication that a member has requested to share the above resources with them. We might send emails to everyone who has provided an email address, and texts to those who don’t have email addresses. For those who have provided us with neither of these, we will need to print and send them information via US Mail.
- **Develop the ability to send just-in-time updates.** There are times when DHS needs to share urgent new information with members, such as when we offered free covid testing in the beginning of the covid-19 pandemic. For this type of time-sensitive communication, we should again use the lowest-cost

communication mode that a member has requested. As we experiment with emailing, texting, and mailing members the resources outlined here, we will learn the most efficient and effective ways of communicating, which will enable us to do this quickly when an emergent need arises.

### **DHS needs to make it easier to find a health care provider**

One in three MA members said that in the past year they had a hard time finding a healthcare provider who accepts MA. DHS has two resources for FFS MA members to help them find a provider: the HCCS call center and the online provider directory.<sup>2</sup> Call center staff note that many people find the provider directory's search logic to be non-intuitive and they have a hard time finding the type of provider they need in the directory.

In 2020, the federal Centers for Medicare and Medicaid Services (CMS) released several 'Interoperability rule requirements', including requirements for provider directories. DHS and other Medicaid payers are now required to offer a provider directory via an 'Application Programming Interface' (API). An API allows different applications to talk to each other. Right now, DHS' provider directory can only be accessed on DHS' website and is thus not in compliance with the API requirement. DHS expects to have a new provider directory, complete with API, in place by the end of 2025. As part of this process, we offer the following recommendations to ensure that it meets the needs of FFS MA members as well as the federal requirements:

- **Make sure that the provider directory is easy for members to navigate.** DHS staff who are developing specifications for the API need to work closely with staff in the HCCS call center to learn of the current directory's challenges to be avoided, and to learn which features members are interested in. Of central concern is the search logic. Whichever search logic is chosen, DHS should have MA members test it to ensure they can find what they're looking for.
- **Solicit feedback on the provider directory.** The API could be linked to a survey to solicit feedback from people who used the provider directory immediately after they exit it. This might solicit feedback on how easy the tool is to navigate, whether they had any problems with it, and if they were able to navigate to the service they were looking for. We should use this to make improvements.
- **Ensure that the least tech savvy MA members can access the directory information.** Not all MA members are internet savvy enough to find a trustworthy platform on which to access their health care data, using the API. With these members in mind, we will house our own (API-compliant) provider directory on the DHS website.
- **Enable providers to automatically update their information.** The Medical Provider Screening and Enrollment (MPSE) tool is where DHS keeps its provider enrollment information. In an upcoming MPSE improvement project, DHS is looking into whether there are some MPSE changes which could be made by providers, and be automatically accepted such that they update MMIS, with no human oversight. This would allow for a more efficient process, and free up staff time to focus on other aspects of provider enrollment.

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<sup>2</sup> <https://mhcpproviderdirectory.dhs.state.mn.us/>

A common challenge with provider directories, including ours, is that they reflect which providers are enrolled; not who is taking new patients. An MA member may have to call multiple providers listed in the directory before they find one who will take them as a new patient. This can be especially problematic when someone is looking for specialty care, and if they need an appointment right away. The API will not address this problem, and we do not have a plan for fixing it.

Nevertheless, DHS is planning dramatic improvements to our processes and systems that serve FFS MA members. We will be implementing a provider directory API, which should make it easier in some ways for members to find providers. We will be doing outreach to members through email, texts, and mailings, sharing basic information such as which services are covered, cost-sharing, who to call for various questions, and transportation and other benefits that can help people access care. The goal is to implement these improvements by 2025.

### How can we improve the process of choosing an MCO?

As noted earlier, most MA members need to choose an MCO. DHS sends them a paper packet in the mail with information on the MCOs they can choose from, as well as the MCO choice form that they need to fill out, and a return envelope for sending the completed form back to DHS. This process is done entirely on paper through the US Mail. We asked members<sup>3</sup> what it was like when they chose their current MCO under MA. We were hoping to learn which parts of the process were challenging.

- 47% told us that they had a hard time figuring out which MCO would let them see their doctor or a provider they had seen in the past.
- 35% had a hard time finding information on the MCOs.
- 14% had a hard time filling out the MCO choice form.
- 15% said it was hard to follow the process for mailing the form in.

These results indicate we can improve upon this process. To do so, we recommend making the following changes. Several of these include moving away from paper-only communications to give people the option of using online resources.

- **Create an online provider-MCO search tool.** Four out of five members said that being able to go to their provider is an important factor in choosing an MCO, and nearly half said they have difficulty figuring out which providers each MCO includes in their network. We should offer members a website where they can enter their doctor's name and search which MCOs have them in network.
- **Use text messages to let members know that the MCO choice form is ready to be filled out.** Communication experts advise that short text messages can be valuable as a 'heads-up' that a packet



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<sup>3</sup> We only included members who had chosen their MCO (not people for whom it had been assigned to them).

such as a MCO choice form will soon be arriving in the mail. The text can also give the deadline that it is due. Once the packet has arrived, we could again use text messages to remind people to fill it out. For people who do not opt-in to text messages, we could send emails instead.

- **Create an online MCO choice form.** We could make the whole process much simpler for many members if we had an online MCO choice form. Ideally, DHS would begin work on a statewide Electronic Document Management System (EDMS) and this would allow DHS as well as counties and tribes immediate access to each agency's forms, including the MCO choice forms. However, if a statewide EDMS is not possible, we should use a work-around to create an online MCO choice form that can be shared with counties and tribes.
- **Include business reply envelopes in MCO Choice packets.** Fifteen percent of members found *the process of mailing the MCO choice form* to be difficult. The MCO choice packet currently includes a return envelope, but the postage for returning the envelope is not paid, so members need to find stamps in the right denomination before they can send it back. Including a postage paid business reply envelope could make it easier for members to mail the form back in.

These are challenging recommendations, some with significant cost implications or the need for IT resources. However, many MA members found choosing an MCO to be a difficult process. These improvements are worth the effort as they would make it easier for members to make an informed choice on which MCO will best fit their needs, and to let DHS know of their choice in a timely manner.

## Conclusion

Many members have told us that it can be challenging to find the information they need on their MA benefits. Some are proficient at using the internet. For these members, we should offer fast, efficient ways to communicate with us online. Other members prefer traditional modes of communication, and so paper materials and telephone options are also needed. This report provides guidance on information and communication gaps as they are perceived by members, as well as recommendations for addressing these gaps.

# Introduction

Medical Assistance (often referred to as MA) is Minnesota’s Medicaid program. It is a critical safety net program which provides access to health care for Minnesotans with low income or a disability. DHS hears anecdotally from members that they have a hard time accessing care, even though they are enrolled in MA. They report difficulties finding a doctor, clinic, or other health care provider that is in their network, figuring out which services are covered and how much they will have to pay for the service, getting help with transportation to the appointment, and many other access barriers. This report provides an overview of some of these challenges and possible solutions.

The primary data source is a representative survey conducted in close collaboration with Wilder Research in the spring of 2022. The survey was completed by 2,985 MA members aged 18-64. It was conducted both online (for the first six weeks) and then a paper survey was sent to those who had not yet responded to the online survey. Wilder advised DHS on question development and survey design, the stratified random sample, processed all paper survey forms, and developed the sampling weights. A copy of the survey and the methods section are included in Appendices I and II respectively.

## Medical Assistance Delivery Systems

Minnesota’s MA program includes people on a health plan, or managed care organization, as well as people in Fee-for-Service (FFS). When a Minnesotan applies for the program and their eligibility is approved, they must either choose a health plan, are exempt from managed care and will stay in FFS, or opt in to FFS. Only individuals eligible for MA under certain categories are permitted to opt in to FFS. Under the FFS model, health care providers bill DHS directly for health care services, instead of going through a health plan.

Members who have a health plan and those with FFS report very similar experiences with accessing care and in describing how they want to get information. However, because their access to care and the way they get information on their benefits varies dramatically, we report these separately for the two groups. We start with the FFS members.

## Managed Care Organization (MCO) MA

After successfully enrolling in MA, most people must choose a managed care organization (MCO).

### What is an MCO?

DHS contracts with Managed Care Organizations to oversee the care of members who choose their plan. DHS pays the MCO a monthly rate, and in return the MCO pays the health care bills of those members. The MCO contracts with doctors, clinics and other health care providers and lets members know which providers they can get care from. They are responsible for providing members with all the information they will need for finding and getting care.

The MCO is required to cover almost all health care services in the MA benefit set. However, even for members with an MCO, some services are excluded. These services are overseen by DHS using the Fee-for-Service (FFS) model. This includes, among others, waiver services for People with Disabilities and long-term nursing facility stays.

## **Does everyone on MA have an MCO?**

Most people who successfully enroll in MA must get their care through an MCO. However, people under certain categories are not eligible to enroll in managed care such as children with disabilities who have MA under the TEFRA option, people with other private coverage, people newly eligible for MA with a spenddown, and people absent from the state for more than 30 days. People who have received a disability determination either from DHS or the Social Security Administration have the option of either choosing an MCO or opting for FFS. People who choose FFS follow DHS' own rules and guidelines on providers and how to access care.

## **How do members choose an MCO?**

After they are approved for MA, people are asked to choose an MCO. They are given one of three MCO choice forms, depending on the MA program they are enrolled in. One is for Families with Children and MA Adults (PMAP), one is for People with Disabilities enrolled in Special Needs Basic Care (SNBC), and one is for seniors (age 65+)<sup>4</sup>. Everyone starts on FFS MA, and can remain on that for up to 60 days. If they do not choose an MCO within that time, they will be assigned one. In this chapter, we only describe people who are currently on an MCO (they had an MCO as of March 2022 when the survey started)<sup>5</sup>.

If they do not choose an MCO, then DHS assigns one to them. These members have the opportunity to change their MCO in the fall of each year. If DHS doesn't hear from them then, DHS will have them continue with their current MCO.

## **How do members get care when they have an MCO?**

MA members go to their MCO instead of to DHS when they have questions. They search for information on the MCO's website (not DHS'), they get help from the MCO's customer services line (not DHS'), they use the MCO's network of providers (not DHS'), and they follow the MCO's guidelines for accessing care. Some MA members would benefit from having someone help them to manage their care, such as care coordination. MCOs are responsible for providing this service to select groups (People with Disabilities and seniors).

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<sup>4</sup> PMAP: [Health plan enrollment form \(DHS-4106A\) \(state.mn.us\)](#)

SNBC: [DHS-6451-ENG \(Special Needs BasicCare \(SNBC\) Choice Form\) \(state.mn.us\)](#)

Seniors: [Health plan enrollment form for people 65 years old or older \(DHS-4106C\) \(state.mn.us\)](#)

<sup>5</sup> All administrative data for this report was pulled in January 2022 for the time period of December 2021. However, we pulled data on whether or not someone had an MCO in March of 2022, when the survey first began being filled out by members.

## Which MCOs can members choose?

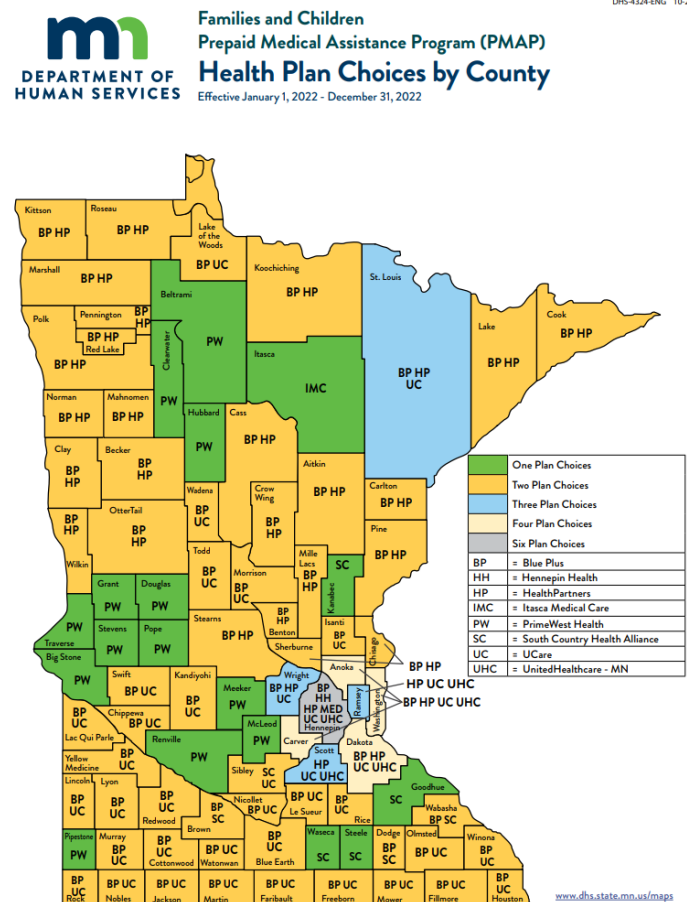
DHS uses a competitive bidding process to contract with MCOs as well as county-based purchasing plans. The latter are MCOs that are run by a county or group of counties and are developed specifically to serve certain Minnesota counties. In 2023, three county-based purchasing plans serve 33 of Minnesota’s 87 counties.

Each MCO contract is specific to the eligibility category of the members they’re serving (e.g. People with Disabilities). Within each of these categories, the MCO options also differ based on the county that members live in. The MCO options for each county are displayed in maps<sup>6</sup>. This report addresses the preferences and experiences of MA members age 18-64, so the two maps on the next pages are the ones relevant to this population.

### Parents, Children and Adults without Children

MA members whose income is low enough to qualify for MA, but who do not have a disability determination are required to receive MA through an MCO. The map shown here applies to MA members eligible for MA on the basis of income and are parents, children or adults without children under the age of 65 who do not have a disability determination. It shows which MCOs people in each county can choose from. Those in green have only one option as there is only one MCO serving their county. In plan year 2022 (when the MA survey was conducted), 18 counties had only one MCO. However, these tended to be less densely populated counties, so of all MA members in this group who responded to the survey, only 8% lived in a county with only one MCO.

In 2023, only one county has a single MCO (Itasca).



<sup>6</sup> [Maps for Managed Health Care Programs \(state.mn.us\)](https://www.dhs.state.mn.us/maps)

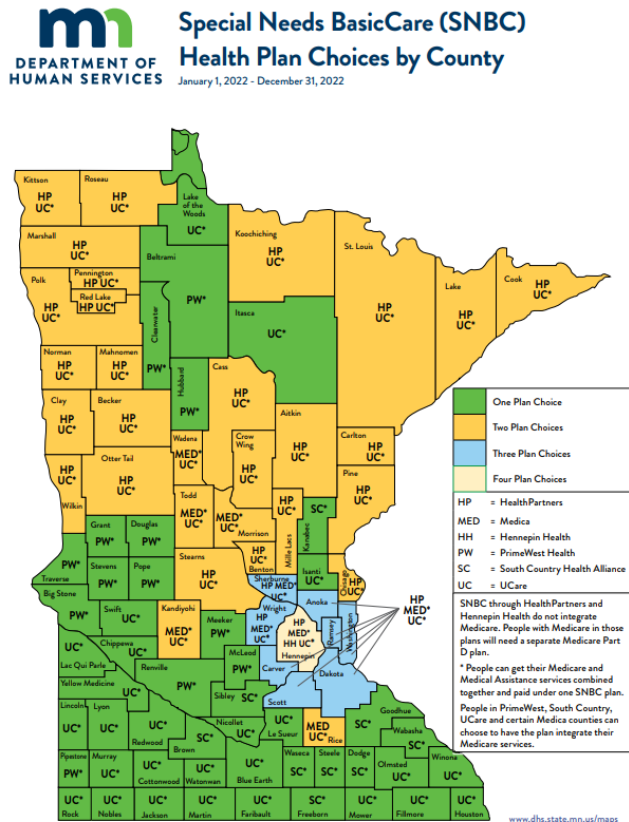


## People with Disabilities

People who have a disability determination can opt out of having an MCO. However, many people with a disability determination do not opt out of this process and have an MCO. Adults with disabilities that remain in managed care are enrolled into a Special Needs BasicCare (SNBC) plan. Children who remain in managed care have an MCO under the people with disabilities contract. The choices of People with Disabilities can be more limited than for other populations. As shown in the next figure, in 2022, 48 of 87 Minnesota counties have only one MCO. These counties also tend to be less densely populated, so in the MA survey, people who live in a county with only one MCO make up 20% of all disabled members who have an MCO.

If we combine everyone with an MCO, including those with and without a disability, then in 2022, 9% of members lived in a county which had just one MCO. This is important context for the upcoming questions about the process of choosing an MCO, as people in these counties did not have had the opportunity to choose.

It should be noted that this only represents the people surveyed, all of whom were age 18-64. Managed care also covers people age 65 and older.



## Fee-for-Service (FFS) MA

As noted above, under the FFS model, health care providers bill DHS directly for health care services, instead of going through a health plan. People on FFS also go to DHS directly for information on covered services, cost-sharing, and to determine which providers are covered under MA, instead of going through a health plan. In this report we use the term Fee-for-Service. However, it should be noted that people who are themselves enrolled in this program often refer to this as ‘straight MA’, reflecting the fact that they are working directly with DHS.

### Which MA members can be on FFS?

Most people on MA must have a health plan, and if they do not choose one, one is assigned to them. Approximately 200,000 people have FFS MA. People are only allowed to opt in to FFS if they meet certain criteria. Below are some of the situations that would allow a person to opt in to FFS:

- They are age 18-64 and have a disability. The disability has been verified either by the Social Security Administration or by DHS.



- They have more than one health care payer. This is usually Medicare but could also be an employer. About two-thirds of people in FFS MA are eligible for this reason.
- They are an enrolled member of an American Indian tribe, or they are American Indian and live on a Reservation
- They are a child receiving adoption assistance
- They have a Severe Emotional Disturbance or Serious & Persistent Mental Illness
- They have a terminal communicable disease and their primary care provider is only enrolled in FFS

### **How do members opt in to FFS?**

After successfully enrolling in Medical Assistance, people in the above categories can opt for FFS MA. If so, they must fill out the Special Needs BasicCare (SNBC) Choice Form<sup>7</sup>. The form asks them to choose an MCO or to opt out. DHS sends them the form through the US Mail, along with some materials on the MCOs they can choose from. There are instructions on how to fill out the form. Members are not notified if DHS received their paperwork and whether they successfully selected FFS; to learn this they need to call their county/tribe or DHS' Health Care Consumer Support call center.

### **How do members get care when they have FFS?**

People on FFS MA rely on DHS for everything they need to know to get health care. DHS is the owner of all information on which services we will pay for, how much members need to contribute for each visit, the list of all health care providers that they can go to, and all other information on accessing care for people on FFS MA. Some of them have access to care coordination services, but most people find providers and make appointments on their own.

In the next few chapters, we describe what people on FFS MA had to say about the program. The questions focused on what it is like to navigate these systems and to find information they need.

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<sup>7</sup> [DHS-6451-ENG \(Special Needs BasicCare \(SNBC\) Choice Form\) \(state.mn.us\)](https://state.mn.us/dhs/6451-ENG)

## How do members want to access information on their benefit set?

This and the next two chapters describe feedback we received from MA members on how they want to access information about MA. We start by describing their access to the internet, as this impacts their preferences.

### Home internet access and communication preferences among MA members

MA members are diverse, and to serve them all adequately, DHS must offer multiple communication modalities so each can choose the ones that they are comfortable with and have access to. One of the overarching findings in this report is that MA members are divided in their access to the internet and technological devices, and somewhat along these lines, are divided in how they want to communicate with DHS and their MCO.

Three-quarters of MA members have home internet access through a laptop or similar device, or through their cell phone or smartphone. These members, for the most part, want to use these technologies to communicate with DHS.

One quarter of members do not have internet access at home. For these members, using paper mail and stopping by their county/tribal office were often just as popular as using the internet. Some demographic groups (e.g. People with Disabilities) have especially large numbers of people who prefer traditional (non-internet) communication modes. Being aware of this divide within the MA population is essential if we are to effectively communicate with all members.

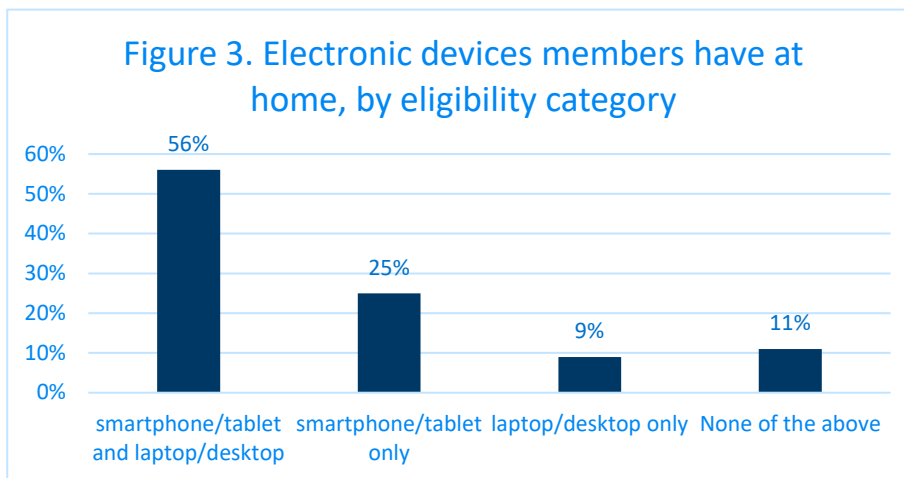
### Who lacks internet access at home?

There are disparities in access to the internet and to technology, and so adapting our communication modes to the needs of both groups will also help us to serve MA members equitably. Several groups were more likely than others to lack this resource:

- **Members age 50 and older.** 60% of members age 50-64 have home internet access, compared with about 81% of the younger age groups.
- **People with a Disability.** 66% of People with Disabilities have home internet access, compared with 72% of MA Adults and 82% of Families with Children.
- **Blacks, Hispanics, and American Indians.** The following groups had the lowest internet access: US-born Blacks (66%), Black immigrants (67%), Hispanics (70%) and American Indians (71%). Whites (79%) and Asians (83%) had the highest rates.

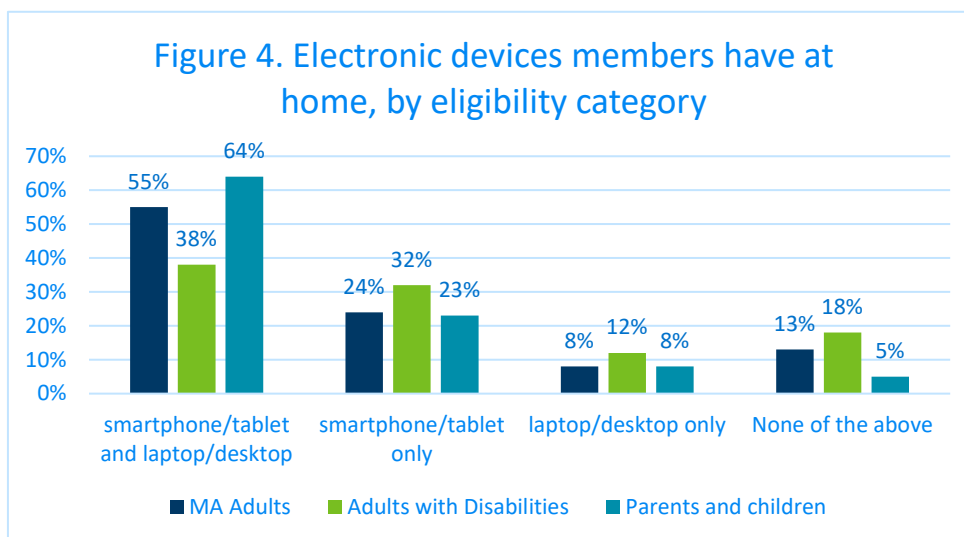
The next figure shows which devices people have access to at home. Over half have access to both a smartphone/tablet *and* a laptop/desktop. One quarter have access to a smartphone/tablet only. Nine percent have a laptop or desktop only, and 11 percent have none of these.

Other research validates our survey findings. In a survey of American households, the Pew Research Center found that adults in households with incomes below \$30,000 overwhelmingly own a cellphone or smartphone but are less likely to own a tablet<sup>8</sup>. Among this population, more than one quarter are smartphone-only internet users. A reliance on smartphones means that low-income adults are more likely to use smartphones for tasks traditionally reserved for larger screens. For example,



smartphone owners with lower incomes were especially likely to use their mobile device when seeking and applying for jobs. This can make completing those tasks on the smaller screen much more challenging.

MA members in the Families with Children eligibility category have the best access to devices at home, followed by people in the MA Adults program. However, as in the national study, many of these have a smartphone or tablet but no laptop or desktop computer, which can limit their ability to navigate complex websites to find information. People with Disabilities have a clear disadvantage in accessing the internet. Nearly one in five tell us that they don't have any of the devices we asked about. This will be important to keep in mind throughout the rest of the report as we discuss how to share information with these members and how to get information from them.



### Literature on communicating with Medicaid members

There is extensive literature on how Medicaid and public agencies should communicate with members. A summary of the major findings is described here.

<sup>8</sup> [Lower-Income Americans Still Less Likely To Have Home Broadband, Smartphone and Mobile Fact Sheet](#)  
 June 22, 2021, [Pew Research Center](#)

- Multiple modes of communication are needed to reach beneficiaries because of communications preferences, postal delays, technology access and comfort levels with technology.<sup>9</sup>
- Clear, specific messaging is critical; and defining who needs to act now versus later helps tailor messaging.<sup>10</sup>
- Even with extensive information on the internet, the ability to talk with a person or caseworker is still critical, especially for complicated questions.<sup>8</sup>
- Medicaid agencies should target people whose mail is returned through alternate modes of communication.<sup>11</sup>
- In order to keep contact information up to date, call centers should ask callers for updates.<sup>10</sup>

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<sup>9</sup> [Beneficiary Preferences for Communications Regarding Eligibility, Enrollment, and Renewal](#)

January 2022, [Medicaid and CHIP Payment and Access Commission](#) (MACPAC)

<sup>10</sup> [State Strategies for Sequencing Enrollee Communications When Medicaid Continuous Coverage Ends](#)

Aug. 3, 2022, State Health & Value Strategies, Princeton University; Julie Bataille and Kevin Caudill, GMMB

<sup>11</sup> [State Policy and IT Strategies to Prepare for PHE Unwinding-Updating Addresses and Returned Mail](#) Oct. 25, 2021, [State Health & Value Strategies](#), Kinda Serafi and Patricia Boozang (Manatt Health) and Jess Kahn (McKinsey and Company)

## Searching for information on one's own

The next section describes how members want to find information on their benefits. The questions we asked are below.

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**There may be times when you have questions about your MA coverage. You might be wondering where you can go to receive health care (such as clinics or hospitals), what services are covered in your plan (such as counseling, medicine), and how much your co-pay will be.**

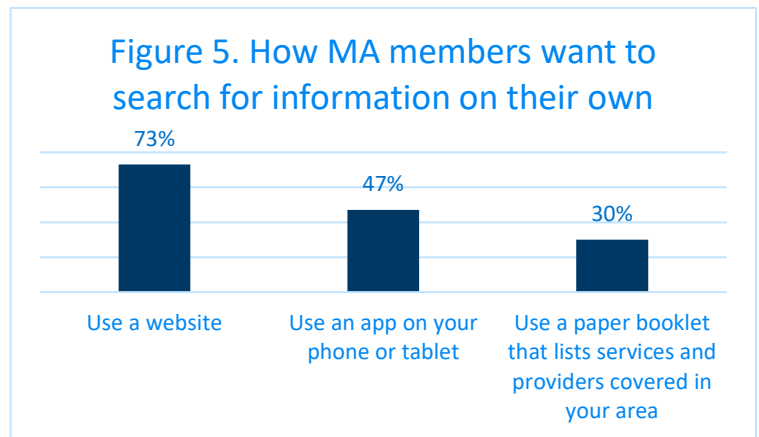
16. If you need to search for this kind of information on your own, how would you like to find it? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Use a website
- <sup>2</sup> Use an app on your phone or tablet
- <sup>3</sup> Use a paper booklet that lists services and providers covered in your area

17. If you can't find the information on your own and you need help, how would you like to receive help? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Use an online chat box
- <sup>2</sup> Write an email
- <sup>3</sup> Talk with someone over the phone
- <sup>4</sup> Talk with someone through a video call like Zoom
- <sup>5</sup> Talk with someone in-person at their office

We asked members how they want to search for information about their MA coverage. First, we asked how they want to search *on their own*. Members were allowed to check more than one of these options. The most popular option was to use a website; three quarters of members (73%) checked that option. Nearly half (47%) said they wanted to use an app on their phone or tablet. A smaller but still substantial percentage (30%) wanted to get information from a paper booklet.



### Which modes should be prioritized?

Many members indicated that they are interested in using multiple communication modes to access information (their results add up to more than 100%). On average, members checked 1.5 of the options. We did some further analysis to see if any two of the three modes of information sharing would meet the needs of almost all members. The results are below.

- Website and paper booklet: 88% of members want to use one or both of these
- Website and app: 85%
- App and paper booklet: 64%
- Only paper booklet: 16%

- All three modes: 99% of members checked at least one of these

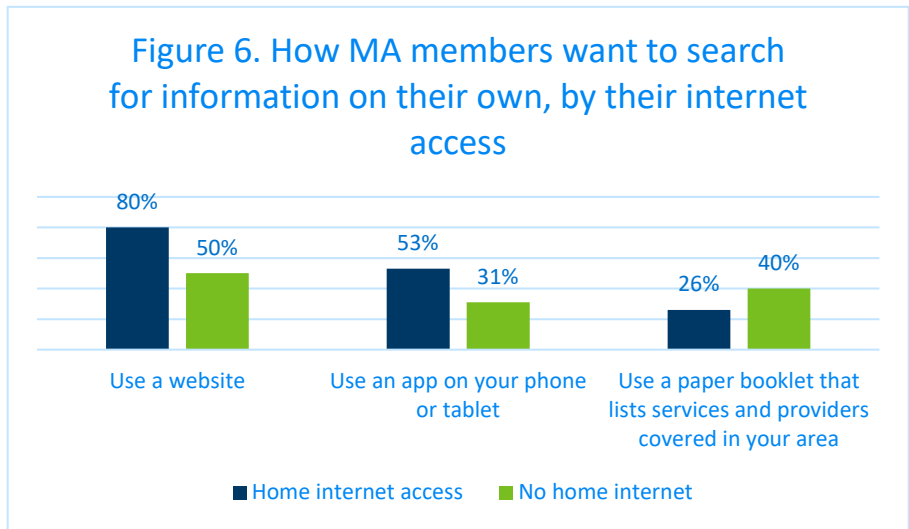
Offering information via a website and in a paper booklet may make the most sense. These two together brings the total to 88% of members.

One concerning finding of this analysis is that while 16% of MA members only checked the paper booklet option, 32% of People with Disabilities checked only this option. The paper booklet option may be an important supplement for everyone in this population, or members might be explicitly informed of which materials they can request.

### Differences by internet access

As expected, people with home internet access were most interested in searching for information on the website, though about one quarter of them also want to search using paper documents.

Searching on a website was also the most popular option among those without home internet access, with 50% choosing this option. The next most popular option (40%) was using paper documents.



### What options do MCO MA members have for accessing information on their own?

MA members with an MCO and those with FFS have different access to information, so we discuss these separately. We start with information for MCO members. We compare the findings above with the information available to MCO members.

**Using a website.** MA members’ strong preference for finding information online is well paired with MCOs’ well-developed use of websites. This is the primary way that MCOs share information. All MCOs have webpages specifically for their MA members, and they use this to share information about services and providers. Their websites include ‘Member Handbooks’, which provide a broad overview of covered services, limitations to services, procedures for requesting a Prior Authorization (PA), co-pays, how this MCO administers their benefits, contact information for the help desk, and other information. These can be downloaded on a device such as a laptop or tablet, and printed if the person has a way to print documents (they’re well over 50

pages so it would be a lot to print). MCOs offer online provider directories so members can find covered providers.

**Using an online app.** The larger MCOs also offer information in apps, which can make it easier for members who access the internet on smartphones.

**Paper materials.** The survey results remind us that many members still value having paper documents for their reference. Those without internet access were much more interested in paper materials than those with internet access, but one-quarter of members with internet still value paper materials. As we'd expect, this was also more common among demographic groups that have less access to the internet. For example, people age 50-64, People with Disabilities, and American Indians were more likely to indicate that they want the paper booklet (49%, 45%, and 39% checked the box respectively).

The Center for Medicare and Medicaid Services (CMS) requires that MCOs make information on the plan available to members. Vital information such as the member handbook, and the provider directory need to be available online. They also need to be available on paper if requested. The availability on paper for those without internet access is described next.

**Welcome packets.** These are sent via US Mail. The contents vary by MCO, as the contracts aren't prescriptive, but they generally include the insurance card, information on covered benefits, the phone number for the member help desk, a short description of covered services, and a link to the provider directory and member handbook.

**The member handbook.** As mentioned earlier, these contain a wealth of information for members. In the contract with DHS, MCOs are directed to provide the handbook in different formats, depending on the needs of the member. They can provide it on paper by US Mail, or they can email a pdf file if the member consents to that. They can send a link to the online handbook via US Mail or email. DHS does not dictate how it is to be distributed, nor does DHS track how this is done. However, anecdotally we hear that MCOs often send a notice by US Mail letting people know where to find it online.

MCOs often include hyperlinks to their webpages in their notices to members. This works well for people who can click on the link (when viewed by email). But for people who are reading the notice on paper, they can't click on it and get to the website. For the 2024 plan year, DHS is requiring that MCOs spell out the entire URL so it can be typed into a computer or smartphone by hand. DHS is also requiring that all materials meet a Flesch Reading Ease standard and 508 accessibility compliance standards<sup>12</sup>.

**The Managed Care Ombudsman.** This DHS team is an important resource available only to members with an MCO. Members can call this DHS phone line and staff there can help them find resources, and if necessary, advocate on their behalf with the MCO. The Ombudsman's number is included in the first chapter of the member handbook, under 'Telephone numbers and contact information' as well as near the end of the handbook in the chapter on 'Grievance, appeal, and state appeal'. MCO members can also contact their county

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<sup>12</sup> [Home | Section508.gov](#)

for help. MCO MA members need to advocate for themselves and connect with people who can provide assistance if they're not getting what they need.

**The provider directory.** When it comes to finding a provider, it might be easier for people without internet access to call the MCO and ask for help than it would be for them to request, sift through, and then find storage for the hundreds of pages of a provider directory.

“If the member asks, they have the right to receive a paper directory. We have had members say they requested their provider directory and they were sent a series of boxes. That was true for large health plans that have an extensive provider network.”  
Soo Yeon Han, Contract Manager, Managed Care Contracting and Rates

Next we discuss the options for FFS MA members.

## What options do FFS MA members have for accessing information on their own?

People on FFS MA currently do not have easy access to information about their health care coverage. Information on what services are covered, whether they need to pay for any services they receive and if so how much, and which providers will see them are challenging to find answers to. Below is an overview of what is available.

- DHS has a two-page document with an overview of coverage, but we do not send this document to members; they need to find it online.
- As we will describe below, members can call the Health Care Consumer Supports call center with their questions.
- DHS also has an online provider directory. This has challenges with becoming out of date as providers sometimes do not update DHS when they stop taking new patients. However, this is a problem with all such tools, commercial or public health insurance.
- DHS has a website with information on applying for MA and other programs, for appeals, and for how to contact the county or tribe. However, we don't have any resources specifically designed for people on FFS MA to learn which health care services we will pay for, or information on cost-sharing. DHS does maintain an online 'Provider Manual' which we use to communicate with health care providers. However, as we will describe later, it can be difficult for members to understand the clinical terminology that is needed by providers.

### Barriers to providing members with information

DHS staff agree that communicating with FFS MA members is an important task, but it is currently not explicitly assigned to any particular staff, or even to any division within DHS. This task falls between the areas within DHS, each of which specializes in overseeing one or more aspects of the benefits, cost-sharing, or provider network relating to people on FFS MA:



Relevant DHS divisions	Questions this division oversees
The <u>Medicaid Payments and Provider Services</u> division develops the list of clinicians, clinics, hospitals and all other providers who are enrolled in MA and that people on FFS MA can go to.	<ul style="list-style-type: none"> <li>• Which doctors, clinics, and other providers can I go to?</li> </ul>
The <u>Pharmacy Program and Medicaid Decision Support</u> division oversees the benefit set regarding pharmaceuticals.	<ul style="list-style-type: none"> <li>• What pharmaceuticals am I eligible for?</li> </ul>
The <u>Behavioral Health Division</u> oversees the benefit set for behavioral health services.	<ul style="list-style-type: none"> <li>• What mental health and substance use disorder treatments am I eligible for?</li> </ul>
The <u>Health Improvement and Benefit Design</u> division oversees the benefit set for all health care services and products except pharmaceuticals and behavioral health.	<ul style="list-style-type: none"> <li>• Which other health care services and products am I eligible for?</li> <li>• What is my co-pay (if any)?</li> </ul>
<u>Health Care Integrity and Accountability Division</u>	<ul style="list-style-type: none"> <li>• How do I appeal when MA denies my eligibility for a particular health care service?</li> </ul>

This complex division of labor is necessary for DHS to stay in compliance with the many federal and state laws that dictate what we can do, collaborate with health care providers so they can work with us, and to work effectively within our unique IT systems. To do this, each division requires specialized expertise and the ability to focus on their area. However, this complex division of labor makes it harder for us to communicate with people on FFS MA as it is not clear who exactly is supposed to be sharing the information with members, and no one division has deep expertise in *all* the relevant areas.

As mentioned earlier, each year the Health Improvement and Benefit Design Division updates a short, high-level summary of which services are covered by MA and other public health care programs. This is published as e-doc 3860<sup>13</sup> and is available on the DHS website. However, finding it requires that one knows the key words to search for. The document itself is not sent out to members, nor is it advertised anywhere, so we don't know how many people find their way to it.

### How should we share information with FFS MA members?

A wealth of communication modes are available for DHS to share information with members. In their survey responses on a variety of topics regarding communication, two major themes arose: First, most people wanted information to be available in multiple modes. Second, people differed in which modes they preferred, with some wanting to use apps and newer online modes, while others preferred traditional modes such as paper

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<sup>13</sup> [DHS-3860-ENG 1-4-16 \(state.mn.us\)](https://www.state.mn.us/dhs/3860-ENG-1-4-16)

mail. These results emphasize the need for DHS to share information in multiple modes in order to meet the needs of all members.

**Central website for FFS MA members.** As noted earlier, the most popular place that members want to look for information is a website; 73% of members said that this is one place they'd like to search for benefits, providers, and cost-sharing on their own. MA MCOs each have a website<sup>14</sup> that contains a variety of information that the member might need. Websites include basic information about the plan, how to access care, a link to the health care provider search tool, the member handbook, and a lot of other information.

While the DHS website has several pages that contain helpful information, the pages can be confusing and finding those sites can be difficult. The closest thing DHS offers might be the 'DHS Health Care Consumer Support' (HCCS) webpage<sup>15</sup>. This page includes information on finding a health care provider, applying for MA, how to contact your MCO (if you have one), making changes to your eligibility or otherwise contacting your county or tribe, and figuring out which services are covered. It has the relevant information for a central website for everyone on MA. It might be easier for members to follow if there were a page just for people on FFS MA, a page just for people who have an MCO, and a page for people on MinnesotaCare. They are currently mixed together, as HCCS serves them all. This page is currently buried in the 'Contact us' section of DHS' health care programs and can be difficult to find.

Another page on DHS' website is called 'Fee-for-service coverage'<sup>16</sup>. This section is just for FFS MA members, though it might be hard for some of them to find if they aren't familiar with the 'Fee for Service' term (many call it 'straight MA'). We can use this site as the central website, but make sure that the language is understandable to members. This webpage is found on the website under 'Programs and services'. It includes information on FFS, member ID cards, how to find a provider, the covered services document 3860, contact information for HCCS and counties/tribes, and information on interpreter and transportation services. DHS has many resources for FFS MA members on our website, but it is hard to navigate and because we don't advertise it, people may not know to look for it.

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<sup>14</sup> Here are websites for the Families with Children plans:

[Families and Children \(PMAP\) – South Country Health Alliance \(mnscha.org\)](https://www.mnscha.org)

[Medica Choice Care PMAP | Medica](#)

[Hennepin Health-PMAP | Hennepin Health](#)

[Families and Children - PrimeWest Health](#)

[Families and Children Medical Assistance \(Medicaid\) | UnitedHealthcare Community Plan: Medicare & Medicaid Health Plans \(uhc.com\)](#)

[Medicaid \(Medical Assistance\) in Minnesota | HealthPartners](#)

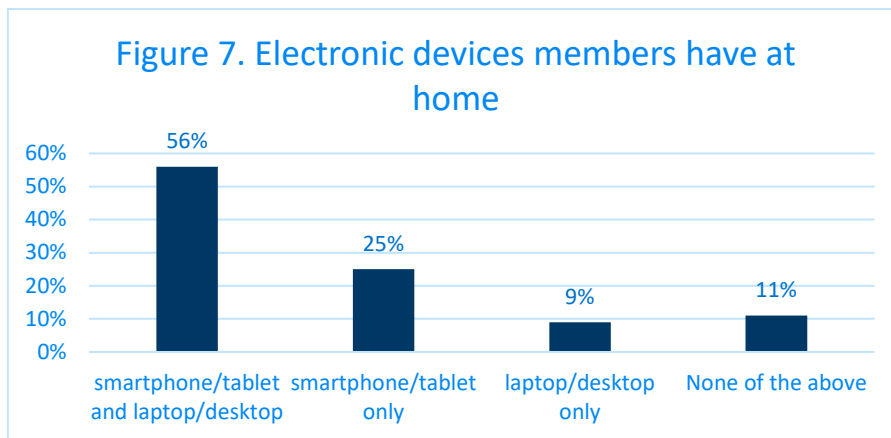
[Blue Advantage Families and Children | Blue Cross MN](#)

[IMCare Division | Itasca County, MN](#)

<sup>15</sup> [Department of Human Services \(DHS\) Health Care Consumer Support contact information / Minnesota Department of Human Services \(mn.gov\)](#)

<sup>16</sup> [Fee-for-service coverage / Minnesota Department of Human Services \(mn.gov\)](#)

Regardless of how the information is shared on our website, it should be designed primarily for smartphones, but also be compatible with larger screens. As shown in the next figure, one in four members has a smartphone or tablet but not a laptop or computer, and for these members, searching a website designed for a larger screen can be cumbersome.



DHS is currently transitioning to a smartphone-first design as many people access the website from smartphones.

**Member handbook.** DHS requires MCOs to offer a downloadable ‘Member handbook’ on their websites. This must be based on our member handbook template<sup>17</sup>. These handbooks are filled with information that a member might need. It includes information on cost sharing such as co-pays, lists of covered services, the appeal process, member rights, and a lot of other information. The pdf files are lengthy (over 50 pages). However, they are less than 2 mg of data, so even people with limited-data smartphone plans should be able to access them. DHS staff could modify the handbook template to describe the FFS MA benefits and processes. We could then put the handbook on our website for members to access.

**Paper packets.** The biggest limitation with sharing information on a website or an app is that it is not very accessible to the one-quarter of MA members who do not have internet access at home. This population needs alternatives to online information.

Thirty percent of FFS MA members told us that they wanted to look for information in a paper booklet. Among those without home internet access, this rises to 40% of members. Even for this population, this is still less popular than a website (50% - indicating they likely have internet access somewhere else). For many people, having a paper packet can be an easy way to access information, assuming they store it in a place that they can find.

However, there are also challenges with paper packets.

Sending a thick packet of information to all 200,000 FFS MA members would be costly and a poor use of funds if many

people just throw it away or misplace it. There are a multitude of services that members are eligible for, and

“The [online member manual] we would definitely use though. One thing to consider is paper – elderly people - a lot of people don’t have smart phones. We would absolutely [direct people to an online provider manual] but people like something in paper form that they can hold. Make notes on and refer back to.”  
HCCS call center staff

<sup>17</sup> [MCO Member handbook model guidelines / Minnesota Department of Human Services \(mn.gov\)](#)

many more that people may be eligible for if they meet diagnostic criteria. Including each service in a packet would require it to be very thick and few people would need the entire packet, again making the cost difficult to justify. Even more problematic, the list of providers who are enrolled with DHS can change at any time and not all of those providers have capacity to consistently take new patients, so MA members could never be sure that a provider listed in the packet is someone they can definitely get services from. As we consider how best to provide FFS MA members with information in paper packets, we will need to prioritize what to send and who to send it to.

**Provider manual.** The ‘provider manual’ is an online resource where providers can find information on which services are covered, which diagnoses make someone eligible for the service, and other information specifically relevant to providers.<sup>18</sup> If members can find their way to this site, they can search it to find covered services. However, the provider manual is written for providers, using clinical language, referencing diagnoses, clinical services, billing codes, and other clinical references that are not accessible to people without a background in the clinical world. If DHS set out to make the provider manual accessible to a lay audience, especially one in which many people have less than a high school diploma, it would likely require an entire re-write of the content related to covered services. If we did this, taking out the clinical language, this would make it more cumbersome and less precise for health care staff. We cannot sacrifice clarity in our communications with providers. As a result, the authors do not think it is feasible to repurpose the provider manual to be accessible to members.

**An app.** An online app was the second most popular option for how people wanted to look for information on their own. Forty-seven percent of members were interested in this option. DHS does not currently use smartphone applications (app’s) to share information.

**Patient portal.** Ideally, information on one’s benefits and available providers would be found on an MA member portal, where the member would log in, and access information specific to them. At present, DHS does not have such a portal for MA members. However, the Home and Community Based Services (HCBS) division at DHS is starting work on such a portal. This division oversees services such as case management, chore assistance, home delivered meals, and respite care for about 100,000 MA members who need this type of assistance. About two-thirds of members with HCBS services are FFS MA members. DHS staff in these two areas are discussing whether it would be possible to include both HCBS care and health care on the same portal.

## Communicate with members on where to find this information

Once all benefits information is available in places such as the DHS website, we need to find ways to let people know where to look. Again, there are many communication modes we could use to do this. Research on effective Medicaid communication indicates that multiple modes of communication are needed to reach beneficiaries because of communications preferences, postal delays, technology access, and differing comfort levels with technology.<sup>3</sup> In fact, experts say that audiences need to see a message 10 to 13 times across different channels (website, social media, text messaging, mail, etc.) to improve the chance they will remember and

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<sup>18</sup> [Provider Manual Table of Contents \(state.mn.us\)](https://state.mn.us)

respond.<sup>6</sup> Regardless of how we communicate with members, it is always important that the messaging is clear and specific.<sup>6</sup>

One of the questions on the MA survey asked members how they want to receive updates. This was in reference to their eligibility, but may be relevant here too.

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12. How would you like to receive information about your MA eligibility, such as when you need to renew your eligibility? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Email                      <sup>4</sup> Website  
<sup>2</sup> Text                        <sup>5</sup> Paper mail  
<sup>3</sup> An app for a smartphone or tablet
- 

MA members said they want to receive updates in the following modes (they could choose more than one):

- 63% would like emails
- 58% would like to get paper mail
- 42% would like text messages
- 19% would like to be notified via an app, and 12% via a website

As noted earlier, we do not currently send benefits information to people on FFS MA, so all of these communication modes would be new. We describe each of these modes next.

## Email

Email is a fast and inexpensive way to share information. DHS staff could send many emails at a time, with no special software. Further, nearly two-thirds (63%) of MA members said they would like to get updates in this communication mode. This seems like an excellent way to share information, especially since we can include live links to the relevant website in emails. New Jersey, New York, and Washington have been increasing the use of email to alert families to renewal and other notices. These states report that emails generate higher response rates than do other communication modes.<sup>7</sup>

At present, we lack email addresses for many people on FFS MA. For people who have disabilities, they enroll in the MAXIS eligibility determination system. This system began asking for email address in 2021 but people did not have to renew until the summer of 2023 because of the pandemic, so email addresses are not well populated. We can expect this field to be much better populated in the fall of 2024 as the post-PHE renewal process comes to an end.

FFS MA members who do not have a disability enroll through METS (MNSure). This system has always included a field for the member's email address, so these members often have email addresses on file. At the end of 2021, about two-thirds of adult MA members age 18-64 who had enrolled through METS had an email address on file. It is expected that because of the expanded use of the internet, this percentage will continue to grow.

In the current renewal process, which started with the July 2023 renewals, email address is prominently requested on all renewal forms, so we may have this information for most members. We should make plans to

use this information to communicate with members as it becomes available, and plan to use it regularly at the end of 2024 when we should have email addresses for many if not most members.

## US Mail

DHS traditionally only sends information to members via US Mail, though we do not send information on their benefits. Over half of MA members indicated that they would like to get updates via paper mail, so this may be a good mode for letting this group know where to find much more information on their benefits. Given the costs associated with US Mail, creating concise, easy-to-read communications with little to no legalese will be important. The letters should clearly communicate how to access the benefits website, using shortened website names and scannable QR codes.

## Text messages

Getting a text as an update was of interest to 42% of members, making it less popular than paper mail or emails, but still of interest to many. Phone numbers are well populated in the enrollment files (which is currently based on pre-pandemic information), but we cannot tell which phone numbers can receive a text. 2023 eligibility and renewals forms ask people for permission to send text messages and then ask for their phone number to do so.

Sending text messages to members is possibly the fastest, easy-to-access mode of communication, and the research literature tells us that it can be effectively used to send reminders, to send heads-ups, and in other ways to draw attention to something they will be receiving in a mode that allows much more detail (e.g. US mail). The following are some learnings that other researchers have found when using text messaging:

- Text messaging is best used in addition to, not as a replacement for, traditional communication modes.<sup>10,11</sup>
- Text messaging offers advantages over other forms of communication, such as it is nearly instantaneous, visual, an easy-to-reference record, and can be read at the recipient's convenience.<sup>10</sup>
- Clients want text message reminders at critical points in their cases, including appointment reminders and confirmation that agencies received documents.<sup>10</sup>
- Text messages can be used effectively to provide many different types of information to members. Other states have used texts to provide a reminder about renewal dates; a request to update one's address; a confirmation that information was received; a prompt to log into an account or call the agency, or a 'heads-up' notice sent before or after a traditional communication piece (such as print mail) was sent.<sup>3, 4, 7, 10</sup>
- Texts are most useful when they include links or numbers that can be used to take the required action.<sup>11</sup>

The cash/food areas at DHS have been using the Pinpoint platform to send text messages to their participants. The MA eligibility area recently began using the same platform to support the renewal process. We should be able to use this platform to let members know where to go to access their benefits information.

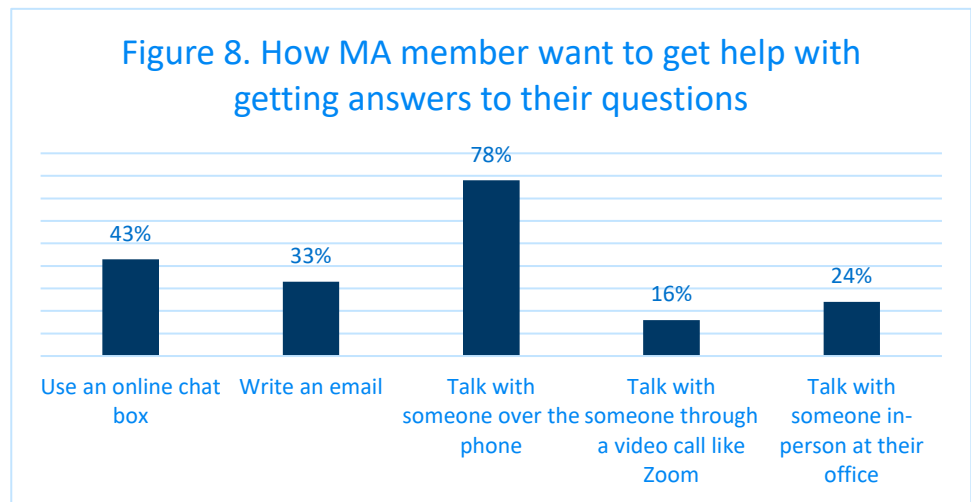
## On the MA card itself

The most important place to reference a website with benefits information is on the MA card itself. MA members probably keep their insurance card in their wallet or purse, and thus it is the most accessible place to find information. DHS includes the HCCS call center phone number on the back of all insurance cards for FFS MA. We should also include information on where to access their benefits information.

## Getting help to find information

Sometimes members have questions that are too specific or too complex to figure out by doing research on one's own. We therefore asked members how they would like to get help if they need it.

**Talk with someone over the phone.** The most popular option for getting help was to talk with someone over the phone, with nearly four in five people saying they want this option. This was also checked by at least three-quarters of people in each subgroup. DHS staff were surprised that talking with a live person in one of these ways was of interest both to those with and those without home internet access. Apparently, having information easily accessible on one's electronic device is not a substitute for being able to talk with a live person, especially for complex questions.



**Talk with someone in person at their office.** One in four members (24%) want to be able to talk with someone at their office. This was preferred more often by People with Disabilities (33%) and people who said they need an interpreter (39%).

**Talk with someone using a video call like Zoom.** 16% want to talk with someone using a video call. Researchers were surprised by this low percentage, given the popularity of telehealth.

**Use an online chat box.** Forty-three percent of MA members are interested in using an online chat box.

**Write an email.** One-third of members want to be able to ask questions by email. As expected, both the chat-box and email options were most popular among people with home internet access and among people age 18-49.

## What options do MCO MA members have for getting help to answer their questions?

Overall, there is a relatively good fit between the MCOs' modes of sharing information with members, and members' communication preferences.

- About four in five members want to call someone on the telephone when they need help finding an answer to their question, and each MCO has a call center to meet this need. This phone number is listed on the back of their insurance cards.
- Most MA members want to access information online, and all MCO's offer information on their plan benefits on their website.
- One-third of members want to get help with their questions by using email, and this is an option with all MCOs. This is offered as a way for members to ask them questions and for them to communicate information back to them
- Online chat boxes were of interest to 43% of members and are an option offered by some of the larger MCOs. Some MCOs also offer patient portals.

The challenge MCOs have for communicating with members may lie in also serving the smaller number of members who have other preferences. The following are some suggestions for ensuring that everyone can get the information they need.

### **Offer communication modes for people with and without internet access**

Most MA MCO members have internet access. Over half have both a smartphone/tablet and a laptop/desktop. Most of these members want to communicate using their electronic devices. However, ten percent of members said that they have none of these devices. Further, one-third do not have internet access at home. Whenever we communicate with members, we need to ensure that it can be done easily over the internet *or* in more traditional modes of communication such as the US Mail or meeting in person with someone from one's county or tribe.

The survey indicates that most People with Disabilities have internet access as well as devices to access it at home. However, their rates are lower than for other groups, and there are large minorities who show a strong preference for traditional modes of communication. For example:

- When asked how they want to find answers to their questions about MA coverage, 32% only wanted information via paper materials, and didn't select online or app options.
- When getting help with a coverage question, People with Disabilities had a strong preference for talking over the phone (82%), as did other members. However, they were also much more likely to want to meet with someone in person (33%) than were other groups.

As noted earlier, members need to be able to access information in traditional communication modes. DHS requires that MCOs have the member handbook formatted in a way that can be either viewed online or printed, and that other materials will be sent on paper if requested. However, it is not clear whether members know that they can request these documents on paper. Having mailings available upon request does not benefit members if they don't realize this is an option they can request.

DHS could send out a 'Request for Information' to MCOs to find out which materials each MCO sends out on paper each year, and how they let members know that they can request other materials through the mail. We might start with the MCO contracts with People with Disabilities, as this population had the largest percentage of members who preferred non-internet communication. The resulting data could provide DHS with a better



sense for how many members, if they lack internet access, may have a hard time getting access to all the information they need.

## What options do FFS MA members have for getting help to answer their questions?

**Talk with someone over the phone.** The most popular option for getting help was to talk with someone over the phone, with nearly four in five people saying they want this option. This was even more popular among people age 50-64 (86%). Researchers find that the ability to talk with a person or caseworker is critical, even during times when many alternative communication modes are available, especially when it comes to complex questions.<sup>3</sup>

The Health Care Consumer Support (HCCS) line provides assistance over the phone and as such, is a key method of DHS' communication with people on FFS MA. People in this call center can answer questions on which services are covered, and they can answer eligibility questions for people who are not disabled (whose enrollment was done through the METS system).

**Talk with someone in person at their office or using a video call like Zoom.** Twenty-four percent of MA members were interested in talking with someone at their office, and 16% wanted to use a video call. We do not offer either of these options.

**Use an online chat box.** Forty-three percent of MA members are interested in using an online chat box. This would be a great addition to a website filled with benefits information for people on FFS MA. If this was available, people could use it to ask questions of an expert while they are looking for information on their own. DHS does not offer this option in any of its programs, so it might be difficult to implement.

**Write an email.** One-third of members (33%) want to be able to ask questions by email. We also do not offer this. This might be a good option to consider adding for people who cannot call during the HCCS' hours of 8:00-5:00 Monday thru Friday (e.g. if they have a job that does not allow a long break). Also, sometimes it is easier to ask a question and attach the document that one is asking about. Email can make this possible.

The HCCS currently offers the mode of assistance that a large majority of members want: a place where people can call on the phone and get answers to their questions. If HCCS is open to expanding their modes of communication, email might be the option to expand into. Nearly one-third of members were interested in being able to communicate by email, and email is a mode of communication that DHS staff already have access to.

### Benefits information that has been personalized to meet individual needs

DHS staff have also been discussing the possibility of sharing information designed to meet a FFS MA member's particular needs. This might include sharing information they have asked for (e.g. on healthy eating), information that is relevant to people with a particular diagnosis (e.g. doula services that are available for people who are pregnant), or sharing information about other programs they may be eligible for (e.g. SNAP).

These options were discussed at a Participant Expert Panel (PEP) meeting, in which six MA and Minnesota Care members were present and gave their feedback. Here were some of the take-aways:

- We told members that we could identify people with particular conditions and send them information on services they're eligible for. For example, we could identify people who are pregnant, and let them know that doula and other services are covered.
  - Members were very positive about this idea. Some described times when they'd had a difficult time finding the care they need. Some noted that its especially difficult to find information about less common conditions, and they would appreciate any assistance we can provide.
  - Members would like DHS to ask them before sending them information like this (instead of DHS sending mailings on things they hadn't requested). An opt-in option should be used.
- We also asked them if they would like information about services for a particular diagnosis that they don't have.
  - Members said they would like this information too, as they can share it with people in their networks.
- Next, we asked whether they would be interested in general information about being healthy (e.g. healthy eating, mindfulness).
  - Members were positive about this too. A few members preferred the opt-in option for this too. Some people said they were interested in this information even if it wasn't relevant to them, as they could pass the information on to others. The importance of people's social network and their interest in helping each other was prominent in this meeting.
- Lastly, we asked if they would like to be told about other programs they appear to be eligible for, but are not enrolled in.
  - There was an enthusiastic yes to this question. One person gave an example of being told she was just barely over the income limit for MNCare so she did not qualify for health insurance. She tried to get her employer to pay her a little less, with no luck. She didn't know what to do. Then 'the county called me and told me I was eligible for Medical Assistance. Out of the blue. It was like an angel'.
  - Others said that most people don't know what assistance is available, and they need more information on this.

When it comes to connecting people with income-tested programs (other than MA), we should work with counties and tribes, as they are experts in these programs. We can partner with other organizations too when they have the relevant expertise.

## **Recommendations for improving communication with FFS MA members**

Major gaps exist in DHS' communication with FFS MA members, and we are committed to filling these gaps and getting members the information they need. The recommendations below describe how we plan to do this. It includes creating new documents specifically targeting the needs of this population, making it easier to navigate the websites where they are found, and making them available at other locations, and most importantly, to start communicating with members on an ongoing basis using their preferred modes of communication.

## **Assign the task of compiling and sharing information to a ‘Communication Coordinator’**

One DHS staff should be tasked with compiling and sharing information with FFS MA members. This person might be considered a FFS Communication Coordinator and they would work with policy experts in different service areas to guide development of the communication and verify that it is accurate. Whatever form the information takes (e.g. mailings, a website), the Coordinator should also get feedback from MA members on the communications to ensure that it makes sense to them, and that they can quickly find what they are looking for.

## **Create a concise ‘Member Summary’**

We should create a member summary document similar to edoc 3860 that specifically addresses FFS MA. The current 3860 includes information on multiple programs which can be confusing for members as they might not know which program they are in, especially since programs have multiple names. A more useful summary would be program-specific, with one specifically for FFS MA. This document would provide a broad overview of covered services, co-pays (notify people that these are sunsetting in 2024), the website to look up health care providers (with a shortened URL), the website to look up county and tribal office phone numbers, and the HCCS call center number. It should also include some basic information on how to get started. The member summary might be formatted as a two-pager, which could be printed on a single double-sided piece of paper and inserted into a mailing, or electronically attached to an email or text.

## **Create hand-outs, each of which describes a particular type of service**

HCCS staff report that most members access DHS materials to answer a particular question they have, not to get a broad overview of services. Many questions are asked over and over and would benefit from a short hand-out describing that service area. We might start with conditions which are relatively common (e.g. pregnancy, asthma, diabetes), and describe the services people with these conditions are eligible for, and how they can access them. DHS pays for many services that can help people with these conditions, including some that aren't well-known (e.g. doulas). Some types of services are especially complex, such as transportation, and a hand-out on these services could also be beneficial.

DHS policy experts should develop hand-outs such as these, and then the Communication Coordinator can refine and distribute them. The Communication Coordinator will develop a template for hand-outs, ensuring that they are easily recognizable as a FFS MA document. This staff person will also leverage feedback from members to ensure they are easy to read and understand from a member's perspective.

The policy staff in HIBD and the call center staff in HCCS will need to work together to ensure the hand-outs include the right information on who to contact if the member has further questions. Call center staff might also advise on the questions that members call about most often. Policy experts can then develop hand-outs that are tailored to respond to those questions.

The Member Summary and other handouts can be disseminated in a few different ways.

- They should be available on the FFS website.
- Call center staff can send them out to members when they ask a relevant question.

- We will make the Member Summary and hand-outs available to members via email or text, depending on their communication preferences. We will also send these via US Mail if a member does not want emails or texts. We will know more about the costs of mailing as the unwinding continues and more people fill out the email and text section on their renewal forms.
- We might also share the hand-outs with community organizations that frequently work with MA members. These would be targeted to the services they provide. For example, we might share a hand-out on services related to pregnancy with community organizations that provide doula and other services related to pregnancy.

### **Conduct a survey to learn which topics members want information about**

As noted in a previous section, DHS could share information and handouts that are requested by members. In community engagement with a group of MA members, several people said they would prefer to opt-in to receiving information in that way. This seems like a respectful way to interact with members. The ideal way to solicit and maintain information on their preferences would be through a patient portal. However, since DHS is not currently working on such a portal, we will instead want to put together a survey of all members to learn their preferences. We could ask members if they would like further information from DHS, and if so, which types of information.

Another thing we might do in a survey of FFS members, is to ask them whether they would be interested in providing feedback on their experiences with the MA program and services. DHS staff could keep this list and draw from it when we are doing community engagement or an in-depth research project.

### **Consider creating a detailed ‘Member Handbook’**

DHS could also create a member handbook with extensive information on benefits, ways to access these benefits, member rights and responsibilities, and other key information. This is what MA and commercial health plans do. A template exists so we would just need to fill in the information. If DHS does move forward with a member handbook, it should be made into a pdf edoc, available on the DHS website. This is where most people will access it. DHS could also create paper copies of the member handbook, and send these to counties, tribes, and navigator organizations that help members find information. DHS could even send them to public places such as libraries. Covered services, co-pays, and similar considerations do not change very often so an annual member handbook with that content would stay up-to-date until the next year’s handbook comes out.

### **Share these resources with members, using the lowest cost mode of communication that a member has requested**

DHS needs to reach out to members and tell them that this information is available and where to find it. The renewal process that is underway as this report is being written asks members for permission to send them information via email and text, and if they give permission then we ask for their email address and/or phone number for texting. By the end of the renewal season, at the end of summer 2024, we will hopefully have members’ updated communication preferences as well as their contact information.

At that time, we should begin sending information to FFS MA members. We should use the lowest-cost, easiest mode of communication that a member has requested. For example, we might start by sending emails to everyone who has provided an email address. For those who have not, we can send them a text. For those who have provided us with neither of these, we can send them information via US Mail. This last option is costly, so we should look for opportunities to piggy-back on other mailings so we do not incur unnecessary postage costs.

Significant changes are happening to the dental benefit and to co-pays at the beginning of 2024. This could provide us with an early opportunity to begin building the communication infrastructure to email and text FFS MA members. If we have developed the two-page member summary by then, we could also share this. Building the infrastructure is very important, though implementing it before the end of summer 2024 (when these fields are better populated) would be an ambitious goal.

### **Investigate the best way to send an 'Introduction to FFS' letter to each member after they have opted for FFS**

All MA members are sent a welcome letter and a DHS insurance card once they are approved for MA. Next, they are asked to choose an MCO or to opt in to FFS. If they choose an MCO (or one is assigned to them), then that MCO sends them information on the plan, and they send a new insurance card specific to that plan.

DHS needs to find a way to provide an 'Introduction to FFS' letter to FFS members too. This should happen right after they have opted in to FFS. They do not need a new insurance card (they use the DHS card), but we should include basic information about the plan such as the Member Summary and other hand-outs. Once we have become familiar with the communication preferences of members, we can develop a plan for sending this out in a cost-effective way.

### **Create a webpage for people on FFS MA, and make it easy to find**

Right now, the information relevant to people on FFS MA is in a variety of places on the DHS website. The wide variety of resources needed by FFS MA members needs to be located on the 'Fee for Service coverage' page, and this webpage needs to be easy to find. Once we have done this, this website should be included in all materials to people on FFS MA, so they know that it exists, and where to find it. Whenever we send emails, texts, or mailings, we should include a shortened URL to this website, as well as a QR code whenever possible. We should also include this site's shortened URL on the back of the MA insurance card. This is possibly the least costly and easiest way to reach members as they should all have an insurance card.

### **Develop the ability to send just-in-time updates**

This chapter has focused on getting benefits information into the hands of members so they can access it whenever they need it. However, there are also times when we may need to share updates or urgent new information with members. This was needed during the pandemic to tell members about their covid benefits. We should have told members that we cover covid testing, covid vaccines, and that members will not have to pay any part of those costs. However, we did not have the communication infrastructure to do this, so no such communications were sent out.

For this type of unanticipated, time-sensitive communication, it might make sense to again use the lowest-cost communication mode that a member has requested to send out the information as soon as possible. These communications would provide basic information to members and refer them to more detailed information on the website or elsewhere. This is not something we have to do very often, but we must develop the infrastructure to make it easy to do when the need arises again.

This section outlines a very ambitious plan for how we can better communicate with members. We believe it combines the right documents with the most cost-efficient member outreach, so members are able to access the health care they need. The next chapters describe the *types of information* we should be sharing with members, and their experiences in trying to access care.

## Members' access to information on getting health care

This chapter describes what members told us about their access to health care. We asked members about their ability to figure out which health care providers they can go to, which services they have access to, how hard it is to make appointments, and to find transportation to those appointments. The questions we asked are below.

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**The next questions are about your experiences getting health care. In this survey, when we say health care, we mean visits to your doctor, dentist, mental health provider, substance use counselor, physical therapist, or another person who provides a health care service to you.**

19. People sometimes have problems getting health care. For each of the items listed below, please tell us if any of these have been a problem for you getting the health care you need in the past year. **(CHECK ALL THAT APPLY)**

- <sup>1</sup> I had a hard time finding a health care provider who will accept MA
  - <sup>2</sup> I had a hard time finding a health care provider who schedules appointments when I am available
  - <sup>3</sup> I had a hard time figuring out if MA will pay for the health care I need
  - <sup>4</sup> I had a hard time figuring out how much my co-pay will be
  - <sup>5</sup> I had a hard time getting to the doctor's office or clinic because I do not have access to a car or public transportation (e.g., bus, train)
  - <sup>6</sup> I needed a free ride to the doctor's office or clinic, but I did not know how to schedule it
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## Finding a provider who accepts MA

The first question we asked members in this section was whether they had a hard time finding a healthcare provider who accepts MA. One-third of members said they do (32%). In fact, this was the most commonly checked barrier on the list.

Finding a provider requires that a member knows where to look (e.g. the provider directories or a call center). But it also requires that the network of providers is large enough that there is a provider available in their area. We cannot tell from the results which of these is the bigger challenge.

MA MCOs and FFS do this in somewhat similar ways, but the opportunities for improvement are different, so we discuss them separately.

## How do MA MCO members find a provider?

This section describes the requirements and options that MCOs have for helping MA members find a provider.

**Ensuring that the provider network is adequate.** All managed care organizations must follow state guidelines regarding the adequacy of their provider networks. Minnesota state law specifies that MCOs must

ensure that members have access to primary care, mental health, and a hospital no more than 30 miles or 30 minutes away from their residence. Further, they must have access to a specialist within 60 miles or 60 minutes.<sup>19</sup> MCOs that serve MA members must meet these requirements. However, there are many challenges with monitoring and holding MCOs accountable for this.

- An MCO may have health care providers in their network who are no longer taking new patients. If the provider doesn't formally disenroll, then there is no way for DHS to know that the MCO shouldn't be counting this provider in their network.
- An MCO may have providers in their network who *are* taking new patients, but their next available appointment is months away. Anecdotally, we hear that this is more common in specialty care, such as mental health and dental care.

In each of these cases, an MCO has providers who are technically in network (they count towards network adequacy), but whom members cannot access on a timely basis.

One benefit of being a member of an MCO is that MCOs have an obligation to help members find a provider. If the MCO does not provide help, then members have the option of calling the ombudsman who can advocate for the member with the MCO. However, if there simply are no providers of the type a member needs within the distance requirements (whether in network or not), the MCO can work to make a provider available outside the required distance. However, having to travel long distances to see a provider can be a barrier to care in and of itself.

DHS is seldom involved in initiatives to expand the availability of providers statewide; this is the purview of the Minnesota Department of Health. Their Office of Rural Health and Primary Care has a variety of initiatives to help ensure that all places in Minnesota have access to health care providers. They administer loan forgiveness programs, which provide incentives to health care providers who locate in rural and underserved areas. They advocate for advanced health care training to take place outside of the metro area. This is important because providers tend to practice close to where they trained. The Department of Health is also working to get health care programs to include rural rotations to give students a view of practice in rural areas. Students sometimes see a broader scope of practice and greater independence which can be attractive features of rural practice. They also have scholarship programs that help move providers in rural areas up in their profession—while continuing to work where they live or to have a job to come back to when their education is complete.

The federal Centers for Medicare and Medicaid Services (CMS) has proposed new, more robust provider network requirements for MCOs that include appointment wait time standards for routine and specialty care services.

In future surveys we might ask follow-up questions such as which geographic areas and specialties people have a hard time finding a provider. This could allow us to find where we most need to focus our attention.

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<sup>19</sup> [Managed Care Frequently Asked Questions - Referrals and Physician Networks - MN Dept. of Health \(state.mn.us\)](https://www.health.state.mn.us/managedcare/frequentlyaskedquestions-referrals-and-physician-networks.html)



**Ensuring members know about providers who are in network.** The other part of the provider challenge is making sure that members **know about** the providers who are in network. There are many ways that MCOs strive to do this. They try to keep their provider directories up-to-date, their call center staff assist members with finding providers, and they offer care coordination to select member groups.

In past years, MCOs sent members a full list of providers through the mail. However, this was so large that members told us it was unmanageable. This was especially true for the MCOs that have contracts all across the state as their provider list is even larger than most. For this reason, all MCOs have moved their provider directories to an online format. This is also the only way to keep it as up to date as possible. Members can utilize their MCO's call center to get help with finding a provider. Some MCOs also have patient portals where a member can log in and find providers that apply just to them.

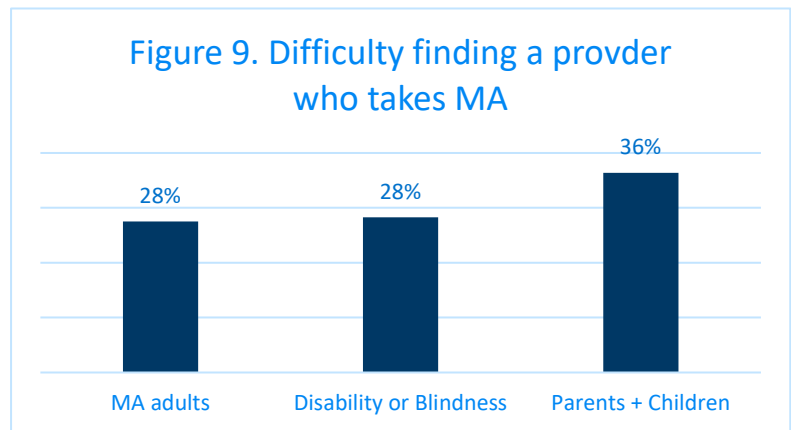
These resources have been created and must be made available upon request. DHS approves the welcome letter or other materials that describe the resources that are available. In future surveys such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS), it might be useful to ask members whether they know about these different resources. If we did this and members of an MCO said they didn't realize something was available, this could inform that MCO's plans for communicating with their members.

One of the findings that was initially surprising was that Families with Children were more likely than People with Disabilities or MA Adults to say they had a hard time finding a provider who takes MA (36% vs 28%). DHS staff expected that People with Disabilities would have a more difficult time as they often need more specialized care and more health care appointments than other members. However, this may be an encouraging sign that the care coordination required of MCOs in their contracts for People with Disabilities is working. (People with Disabilities in FFS do not have this benefit.)

This care coordination is described next.

**Care coordination.** DHS contracts with MCOs to offer 'Special Needs Basic Care' (SNBC), an integrated program for People with Disabilities who have both MA and Medicare. Members on this program are eligible for care coordination.<sup>20</sup> At a minimum, this care coordination must include assistance with finding a health care provider who meets their preferences (e.g.

finding a provider who is the gender and race/ethnicity the member prefers). We hear anecdotally that some MCOs will also call to schedule the appointment for members, or do a three-way call between themselves, the member, and the provider if they think the member needs this assistance.



<sup>20</sup> This is also true of people on Minnesota Senior health Options (MSHO), a program for people over age 65 who are dually enrolled. However, people age 65+ are outside the scope of this report.

Members who have an MCO under the Families with Children or MA Adults contracts don't have access to care coordination from their MCO, but they can call the MCO help line and those staff can give them a list of providers. Call centers might not tailor the search to the member's needs. Instead, they may just give the member a list of providers in their area.

Some members are not eligible for care coordination from their MCO, but are enrolled in a 'Behavioral Health Home' or a 'Certified Community Behavioral Health Clinic' and are eligible with that health care provider.

When it comes to finding a health care provider, we often hear that finding a dentist is especially challenging. Most MCOs subcontract with Delta Dental to help members find a dentist. Other MCOs do this work themselves. However, we often hear from members that it remains difficult to find a dentist who will take MA.

**Assistance to members in the Families with Children contracts.** Thirty-six percent of members who are in for the Families with Children eligibility category say that they have difficulty finding a provider. DHS staff think that this elevated rate may be due to more people in the family, and to parents sometimes prioritizing their children's health and health care such that getting health care for their child feels much more urgent than when they're trying to access health care for themselves.

**Statewide provider directory.** A report by the AMA<sup>21</sup> notes that health care providers have contracts with many different health plans, and updating each change in clinician and address is a significant task that can fall through the cracks. They say that "Many practices have expressed a desire for health plans to align on fewer and more consistent update channels. A clear and concise workflow for updating this information would benefit all parties with greater predictability and opportunities for automation" p. 9, AMA. To this end, the Minnesota Department of Health (MDH) is beginning a feasibility assessment to determine, in collaboration with DHS, other agencies, MCOs, and health care providers, whether there is adequate support for the creation of a statewide provider directory. If they built such a tool, it would allow providers to update their information in a single, central place. It would be available to members, state agencies, as well as all health plans and health systems serving Minnesotans. MDH has indicated that they would be open to including the basic functionality needed by DHS.

However, at the time this report was being written, MDH was just beginning the feasibility assessment. If they were to move forward with this project, they would engage the partners in developing the desired specifications of such a tool, identifying sustainable funding, establishing governance, and any necessary authorization from the Minnesota Legislature. MDH estimates that it could take two or more years after enabling legislation and funding to make this happen. At this point, we do not know if MDH will move forward with building a statewide directory.

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<sup>21</sup> American Medical Association. (2020.) [Improving Health Plan Provider Directories: And the Need for Health Plan-Practice Alignment, Automation, and Streamlined Workflows \(ama-assn.org\)](https://www.ama-assn.org)

## How do FFS MA members find a provider?

When we asked members whether they had a hard time finding a healthcare provider who accepts MA in the past year, one in three (32%) said they did. This is concerning as it represents so many people. DHS has two resources for FFS MA members to help them find a provider. The first is the Health Care Consumer Support (HCCS) call center, which has about 20 staff dedicated to assisting FFS MA members.

The second is DHS' online provider directory<sup>22</sup>, which is the primary topic of this section. Call center staff note that many people have difficulty navigating to the right type of provider within the online directory as they find the search logic to be non-intuitive. This section will describe DHS' ongoing efforts to address this and other related challenges.

Recent changes in federal requirements are also driving us to make improvements in this area quickly. In 2020, the federal Centers for Medicare and Medicaid Services (CMS) released several 'Interoperability rule requirements', including requirements of provider directories. More information can be found in Appendix III. DHS and other Medicaid payers are now required to offer a provider directory which does not restrict access through user authentication. The directory must include the following elements: name of the clinic, facility or clinician, enrollment status, specialty, and address and phone number<sup>23</sup>. These fields are currently all available on DHS' provider directory.

However, the directory must also be accessible via an 'Application Programming Interface' (API). An API allows different applications to talk to each other. Right now, DHS' provider directory can only be accessed on DHS' website. It is thus not in compliance with the API requirement. At the time this report is being written, the Pharmacy Program and Medicaid Decision Support division is making changes to the scope of an RFP to get assistance with the APIs required by the interoperability rule. Once a vendor is chosen, they will begin work developing the business requirements for the provider director and all other APIs. DHS expects to have a new provider directory, complete with API, in place by the end of 2025.

"API is the acronym for application programming interface — a software intermediary that allows two applications to talk to each other. APIs are an accessible way to extract and share data within and across organizations.

APIs are all around us. Every time you use a rideshare app, send a mobile payment, or change the thermostat temperature from your phone, you're using an API." [What is an API? \(Application Programming Interface\) | MuleSoft](#)

As DHS works to meet the interoperability requirements, we are hoping to develop a tool which is much better than our current one for members and for providers. We hope to add new fields, including those not required by CMS, such as clinic hours and languages spoken. We are considering renting or buying an off-the-shelf provider directory which would meet interoperability requirements and offer a more intuitive search logic. This is in line with IT best practices which often recommend a 'rent/buy/build' approach where DHS would rent a

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<sup>22</sup> [Home page - DHS.MHCP \(state.mn.us\)](#)

<sup>23</sup> [Requirements for Provider Directory API | CMS interoperability Rule](#)

platform whenever possible, buy it if renting is not possible, and only build it from scratch when there is no other option.

As noted earlier, the Minnesota Department of Health (MDH) is beginning a feasibility assessment to determine if there is adequate support to build a statewide provider directory. MDH has indicated that if they moved forward with this project they would be open to including the basic functionality DHS needs to meet the API infrastructure requirements. However, the deadline to meet the API provider directory requirement was January 1, 2021, so we are already overdue. If this project moves forward, it will take multiple years, and MDH does not know if they will recommend moving forward with it. If they do, they will need to find funding to do so. DHS cannot wait for a statewide directory; we need to move forward with addressing the API requirements right away. DHS has released an RFP to begin doing this work.

**Current challenges and opportunities for DHS' Provider Directory.** The DHS provider directory has a variety of challenges, some of which are common to most directories and others which are specific to our tool. Given the work we need to do to meet federal requirements, this is a great time to consider how we can improve the functionality to meet member needs.

The most common challenge with provider directories is that they quickly become out to date. Clinicians listed in the directory may stop accepting MA patients but unless they notify DHS, they will remain in the directory. A

“It is a frustrating position to be in when we tell a member to call a provider and the member calls back and says that they’re no longer accepting members. Sometimes they’ll call back and have it happen again.” Darren Bursch, DHS HCCS call center manager

national study found that when patients were unexpectedly billed, it was due to errors in the provider directory 30% of the time<sup>24</sup>. A CMS audit of Medicare Advantage online provider directories found that more than half of all entries contained at least one inaccuracy<sup>25</sup>. This can be inconvenient and result in delays in care when members call the wrong number. It can also have significant financial consequences in unexpected out of pocket expenditures if the in-network information is not kept up to date. Members can also experience frustrations with trying to clear up the bills after they have received care. This is a

challenging problem to address as there is no simple mechanism to keep directories updated. However, a Provider Administrator and Business Product Owner for MPSE may be needed to keep the provider directory updated and accurate.

In 2018, DHS launched an innovative tool to make it easier for providers to update their information: the Medicaid Provider Screening and Enrollment (MPSE) tool<sup>26</sup>. New functionality continues to be added to this tool

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<sup>24</sup> Kyanko, K.A., Busch, S.H. Surprise Bills from Outpatient Providers: A National Survey. J GEN INTERN MED 36, 846– 848 (2021). <https://doi.org/10.1007/s11606-020-06024-5>

<sup>25</sup> “Online Provider Directory Review Report”, CMS, November 28, 2018, [https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider\\_Directory\\_Review\\_Industry\\_Report\\_Round\\_3\\_11-28-2018.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf)

<sup>26</sup> [Minnesota Provider Screening and Enrollment \(MPSE\) Portal / Minnesota Department of Human Services \(mn.gov\)](https://mn.gov/Minnesota-Provider-Screening-and-Enrollment-MPSE-Portal/)

over time. This tool allows providers to log in and quickly update their address and other logistical information, update their list of clinicians, and even enroll their practice in MA. Once they update MPSE, DHS staff process the changes and when that is done the provider directory is automatically updated each night. DHS staff don't think this tool has had a large impact on the accuracy of the provider directory yet as the MPSE is still relatively new and has not yet been widely advertised. DHS expects to roll out an advertising campaign before the end of 2025.

Some challenges that are common for health care provider directories have been addressed by DHS processes. The AMA report notes that many health care practices keep a clinician on their list of providers long after that clinician has left. They do this to ensure that their claims continue to be paid. However, DHS' process avoids penalizing providers in this way by asking providers when they will stop taking MA patients and documenting that as the termination 'effective date'. All claims submitted with dates of service before that date will continue to pay. This is made clear to providers when they enroll.

Another common challenge is that some practices list all of their clinicians as practicing at all sites in case a clinician practices at a different site one day (e.g. to fill in for someone). However, there are no indications this is a barrier in Minnesota. In DHS' FFS MA program, clinicians don't enroll at a particular site like they do with MCOs; they sign up and as long as they practice at a facility that is also enrolled, we pay their bills regardless of whether or not that clinician listed with that site.

DHS staff have a few concerns of their own that they are hoping to address. The first one is keeping the list of providers up to date, with special attention on dental, oral surgery, and orthodontic providers. They notice that there seem to be many oral health providers who are on the provider list, but who are either not taking MA patients or have a long waitlist. They note that it doesn't happen very often for primary care, or most other types of providers. It seems like there needs to be special attention to oral health care.

"We don't have [members] call and say 'Hey, I can't find a primary care provider.' It is the dental providers. We'll tell them we have a dental provider enrolled and then the person will call back telling us there is a waitlist or the provider doesn't take MA." Lori Shimon, Manager of Provider Eligibility, Compliance, and Provider Payments

The second concern raised by DHS staff relates to how intuitive the search tool is, something we noted earlier. When the provider directory was originally developed, it had to follow the logic DHS uses to enroll providers, which focuses on the provider's *specialty*, as well as the coding and logic in MMIS (the system used to process and pay health care claims). For example, in the current provider directory, to find a pediatrician, one must first select 'physician services', and then select a type of care such as Pediatrics. To find an urgent care provider, one must search by 'clinics' first, then search by 'physician clinic'. This logic is not always intuitive to members, so many people report that they have difficulties using the directory. In addition, the directory sometimes uses highly technical language which can be hard for non-clinicians to follow. For example, if a member is searching for a provider who offers services for people with Autism Spectrum Disorder, they cannot search for "autism" but instead must choose "Early Intensive Developmental and Behavioral Intervention". The directory language could be more 'plain language'.

## **Recommendations for moving forward with the provider directory API**

### **Solicit feedback on the provider directory**

One of the exciting things about the API requirement is that it not only is accessible on a wide variety of devices that MA members can access, but it is also compatible with other platforms that offer innovative functionality. For example, the API could collect real-time feedback on how well the tool is functioning. Following the agile philosophy, the added functionality does not have to be developed in the initial version of the directory. In fact, it doesn't have to be built in the API at all. It can be developed in other platforms better suited for that functionality, and then linked to the API.

The API could be linked to a survey to solicit feedback on how well it is working. For example, an online survey could be sent to every 100<sup>th</sup> person who uses the tool immediately after they exit the tool. This might solicit feedback on how easy the tool is to navigate, whether they had any problems with it, and if they were able to navigate to the service they were looking for. Since this feedback will be most valuable after the initial launch of the tool, this might be a temporary add-on.

### **Enable providers to automatically update their information**

MPSE (Medical Provider Screening and Enrollment) is where DHS keeps its provider enrollment information; this is our 'source of truth' on provider enrollment for all other systems. For example, the MMIS payment system gets information from MPSE to verify that a provider is enrolled with us. The provider directory draws a list of enrolled providers from MPSE so a member can find where to go for care.

As mentioned above, providers can make updates using MPSE. However, updates to that tool do not automatically update MMIS or the provider directory. DHS staff must review and accept the changes in MPSE, and changes that have been accepted are automatically updated in MMIS and in the provider directory each night.

In an upcoming MPSE improvement project, DHS is looking into whether there are some MPSE changes which could be made by providers, and be automatically accepted, with no human oversight. For example, a clinic might be able to remove a clinician from their list of providers without the review of a DHS staff person. Planning for this is currently underway. This is an important project for staff efficiency and to enable updates to be made right away.

For health care practices that work with many payers, having MPSE linked with a statewide provider directly would be very beneficial, so providers only need to update their information in one place. At present, there is no statewide directory and MDH is only now in the planning stages of that project. However, DHS and MDH will need to keep each other apprised of their progress and the fields and specifications each will include, so the systems they are building will be compatible and able to be linked in the future. This could make it easier for providers to update all the payers they work with, and in the process could allow our provider directory to stay up to date.

## **Ensure that the least tech savvy MA members can access the directory information**

CMS requires that DHS develop an API which allows members to use any platform to access the provider directory. In effect, they are asking DHS and other Medicaid agencies to make the directory convenient and flexible for people who often already have access: people who are internet savvy.

However, DHS needs to keep in mind that many people on MA are not savvy internet users. In fact, one in four don't even have internet access at home. It is great if we can improve access for people proficient in using the internet, but we must not do so by making it even more difficult for those who are not. It requires some internet savvy for people to: 1) find a trustworthy platform, 2) download it, and 3) access the information using that platform. Many people on FFS MA will continue to benefit from a DHS-sponsored provider directory on the DHS website. This location helps them to know that the information is legitimate. For this and other reasons, DHS plans to continue housing their own provider directory.

## **Make sure that the provider directory is much easier for members to navigate**

At the time this report was being written, DHS staff in Medicaid Payments and Provider Services had not yet begun work on developing the specifications for the provider directory API. However, they have many ideas on which fields they would like to add and how people will be able to access it. As it is developed, they will need to work closely with staff in the HCCS call center to learn which of the current tool's challenges should be avoided, and which features they should seek to include (in the initial or later versions) based on member preferences.

Of central concern is the search logic. If we can find a tool with an intuitive search logic which already exists, that would be ideal. In any case, the API must be developed in a way that makes it possible for platforms to use intuitive search logic. For example, there needs to be a way to search for a nearby urgent care facility without having to guess which type of provider specialty that is associated with. Something else that would be helpful is a search bar, so if a person does not see the services they're looking for amongst the major categories then they can enter it into a search bar (e.g. search directly for pediatrician if it isn't obvious how to navigate to that type of provider). Whichever search logic is chosen, DHS should work with MA members to test it and make sure they can successfully navigate their way to the services they are looking for.

## **Provider network adequacy**

In this section, we've discussed some of the challenges of maintaining an up-to-date provider directory. A separate challenge is ensuring the right mix of providers all over the state who have signed up to take MA clients. Finding and keeping dental care providers is an ongoing challenge for the MA program. When it comes to making sure members have access to care, another concern relates to the member's own capacity to access care. For example, can they secure an appointment on their own or with help from a care coordinator, are they available during usual clinic hours, and can they use the transportation options at their disposal to get to the appointment. It can be difficult to disentangle the challenges associated with the adequacy of the DHS provider network from the challenges members experience as they try to access care. The next chapter reviews the barriers that members report they run into as they are trying to get care.

## Getting an appointment when I am available

Nearly one in five MA members (17%) said they have a hard time finding a health care provider who schedules appointments when they are available. This was true regardless of age, geographic location, race and ethnicity, and eligibility type.

Health care provider hours are often a challenge for MA members and others accessing health care. Just like most people, health care professionals often don't want to work outside the usual clinic hours of 8-5. For MA members who work, and especially those with children, it can be difficult to get to the clinic during usual hours. Many people do not have flexibility in their work schedule and they may not have sick time. Additionally, they will need to find transportation to and from the appointment during usual business hours.

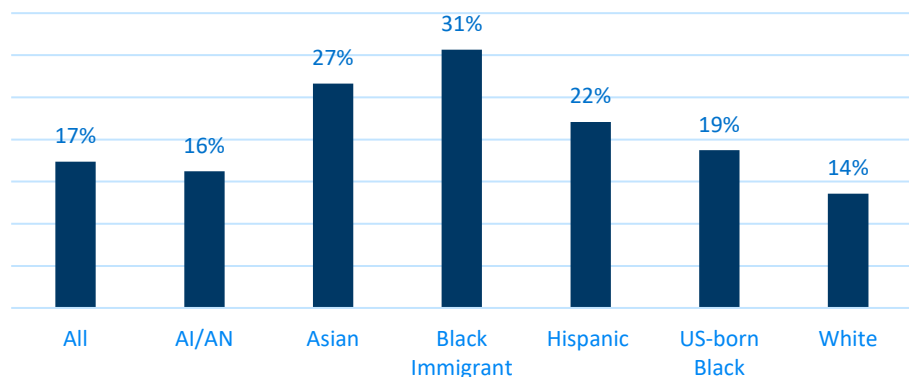
"Previous studies have shown that the vast majority of people on Medical Assistance work during the day without a flexible schedule, and may not have a lot of PTO. This can make taking your child to an appointment during the workday impossible, and many providers aren't available outside of regular work hours." P.J. Weiner, Director of Managed Care Contracting

In the last MCO contracting cycle, MCOs informed DHS on how they will encourage after-hours appointments. However, this is not something we monitor or that we request MCOs to provide updates on. We do not have recommendations on improving appointment times for FFS.

Black immigrants and Asians were most likely to say they had difficulty finding a provider who schedules appointments when they are available (31% and 27%). However, all BIPOC groups reported this more often

than did white members (14%). DHS staff wonder if this may be at least partly due to Black immigrants and Asians thinking they needed to bring someone from their social network to interpret for them at the appointment, and that is what was making it difficult to find a time that would work. Among people who say they need an interpreter, 28% say it is difficult to find a provider who schedules appointments when they are available. Among those who said they do not need an interpreter, 17% said this was difficult. Further, when we asked people who need an interpreter if they had access to one at their most recent in-person or telehealth appointment, 74% said that they did. Under state law, all Minnesota health care providers are responsible for having interpreters available at appointments when needed, and MCOs are responsible for educating members

Figure 10. Members who had difficulty finding a health care provider who schedules appointments when they are available





about this. DHS has had discussions with the Minnesota Department of Health about the lack of provider awareness of this requirement. We've discussed the possibility of offering educational opportunities, such as CLE's (Continuing Legal Education) to let people know about the experience of immigrants, and that they must offer interpreters. Interpreter services are paid for under MA, so providers do not have to bear that cost themselves.

Next, we discuss members' access to transportation to get to their appointments.

## Getting to the clinic

MA members are eligible for a transportation benefit. They can get reimbursement for mileage if they drive themselves, a volunteer driver can get reimbursement for mileage when they're driving a member, members can get bus or cab fare if they use these modes of transportation, and there are medical rides for those who need assistance (e.g. if they have mobility restrictions) or if they need medical care while being transported. The transportation benefits are based on members' mobility and access to transportation options.

MCOs are responsible for letting MCO MA members know about the transportation options they are eligible for, and for referring members to a local transportation provider if they need a medical ride. DHS is responsible for letting FFS MA members know about transportation options. Counties are the entities that provide reimbursement for mileage, bus tokens, and other fares.

We asked MA members if they have a hard time getting to the doctor's office or clinic because they do not have access to a car or public transportation (e.g. bus, train). Thirteen percent of members said they did. We also asked whether they need a ride to the doctor's office or clinic but did not know how to schedule it. Again, 13% said yes to this. However, this was not the same 13%. Here is a breakdown of how people responded to these two questions.

**80% said that neither was a problem.** Most members checked neither box on difficulty with transportation. This confirms DHS staff's sense that most people don't have a difficult time with transportation.

**6% said they had a hard time getting** to the doctor's office AND they didn't know how to schedule a ride. This population needs information on the transportation benefit, and on how to access it. All MCOs have a plan for sharing this information, whether it be through mailed flyers, emails, or other means. The main challenge is that most people don't need the transportation benefit, so providing the information to everyone is not cost-effective and sending members information on too many things can feel overwhelming to them.

The challenges with scheduling a ride have been described from the transportation providers' perspective in a recent report<sup>27</sup>. Transportation providers describe low reimbursement rates, 'dead miles' spent driving to pick up the client, a lack of accurate member phone numbers so they can confirm rides or reschedule them, or pre-paid phones where the member has zero minutes left, and a lack of modern technology such as texting to

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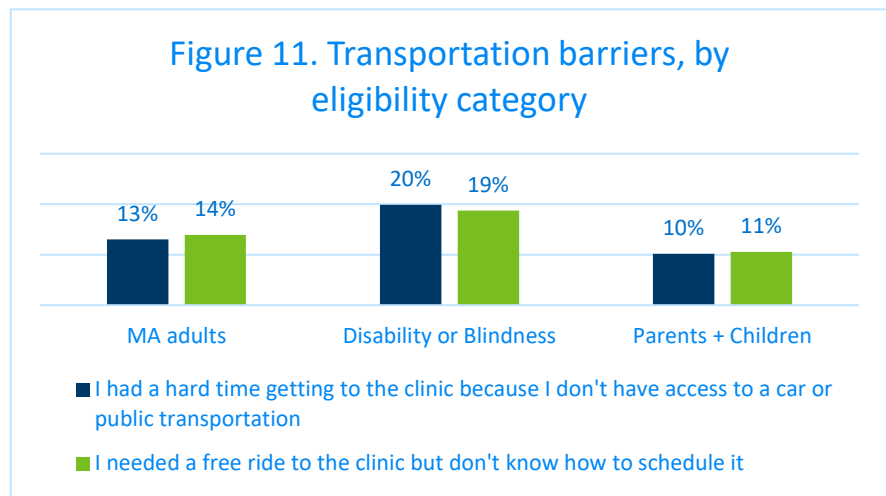
<sup>27</sup> 2021 MCO SNBC Transportation Accessibility Survey Analysis. Access survey conducted by a collaboration among HealthPartners, Hennepin Health, Medica, PrimeWest Health, South Country Health Alliance, and UCare.

schedule rides. They also mentioned a decrease in the number of volunteer drivers. DHS is discussing these and other ideas with the MCOs:

- DHS could develop online trainings for transportation providers and their drivers. Two of the topics mentioned were cultural competency and the MCO grievance process.
- MCOs could educate members on how to use the transportation benefit. Some useful topics would be: how to request a return ride, how to identify the driver/vehicle, and how to cancel rides. Providers felt that this would make it easier for them to work with members.
- MCOs should use standardized forms.

DHS has heard anecdotally that finding transportation has become more difficult since the pandemic. Some of the factors we hear about are the following: volunteer driver services ending, a shortage of drivers means that some drivers quit in pursuit of easier work, gas prices and a shortage of parts makes it hard to operate and maintain vehicles, and the Rural Urban Commuter Area payment is complex and hard to manage.

Some MA member groups experienced more challenges with transportation than others. People with a Disability is one such group, as shown in the next figure. About one in five said they had a hard time getting to the doctor's office because of access to a car or public transportation, and one in five were unsure how to schedule a free ride. DHS staff sometimes hear from People with



Disabilities that they think they're not 'disabled enough' to get a ride. However, public transportation can be too difficult for them to use. For members under the SNBC contract, Care Coordinators should be providing assistance to arrange transportation. It is therefore especially concerning that one in five People with Disabilities report that they need a ride and don't know how to schedule one.

Needing a free ride and not knowing how to schedule it was a barrier experienced by many more people of color and American Indian members than white ones. These members (were twice as likely as white members (8%) to need a free ride and not be sure how to schedule it.

Maybe surprisingly, people in rural counties were not any more likely to report transportation difficulties than people in urban counties or counties with an urban/rural mix.

It is important that members know the transportation benefit is available. Some members may just need a bus pass to help them get to an appointment. Others need more assistance.

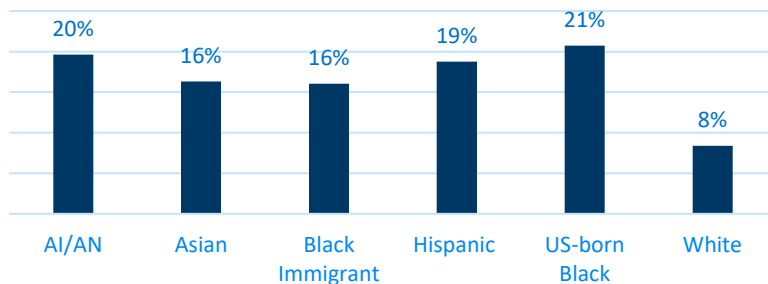
### How might MCOs identify people who would benefit from transportation assistance?

All MCOs are required by the federal government to conduct an initial enrollee screening<sup>28</sup>. DHS developed a list of questions that MCOs must ask (shown in Appendix IV), and MCOs have the option of adding questions of their own. The member's need for transportation is one of the required questions. MCOs conduct the screening using the mode of their choice. This can include a phone interview, mailing a paper screening form to members, or emailing/texting a link to an online screening form. They are required to reach out up to three times in the first 90 days. (Ongoing outreach only continues if the outreach was unsuccessful.)

Most MCOs have a response rate of fewer than 5%. However, at least one has been quite successful and has received responses from most of their members. Before this type of screening can be considered a reliable way of identifying members who need transportation or other services, DHS may need to investigate the methods the various MCOs are using. We may want to learn more about those that have high response rates and recommend their methods to others.

Once the MCO has the screening results from a member, they are required to follow up with the member and help connect them with needed resource(s). DHS does not specify how and when this is to be done, nor do we specify how exactly to track these contacts with members. MCOs provide DHS with a report on the screening results each year. It is difficult for DHS to know how well the outreach is done, and if these efforts are successful at getting members the help they need. Documentation of outreach, referrals, or care coordination in a

Figure 12. MA members that needed a free ride, but were unsure how to schedule it, by race/ethnicity



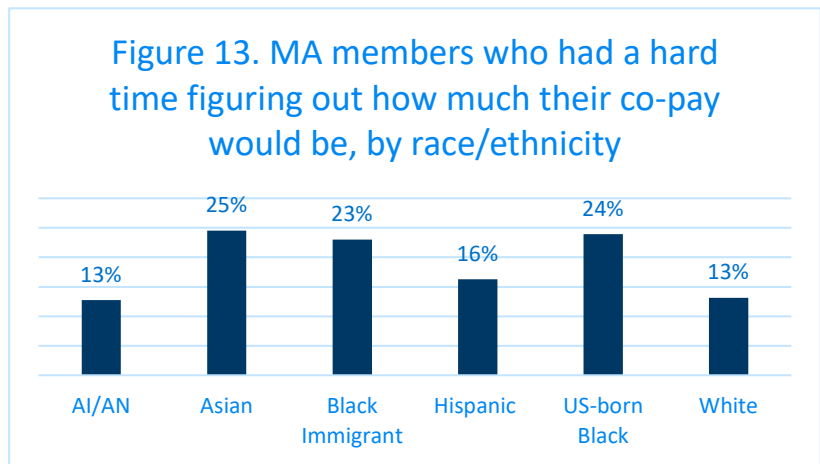
<sup>28</sup> 42 CFR §438.208(b)(3)

consistent manner across multiple organizations is always difficult to do, including in this situation. DHS is currently using the data we've received from MCOs to help us understand how to support MCOs in strengthening both their response rates and in tracking their outreach.

## Figuring out the MA benefit set

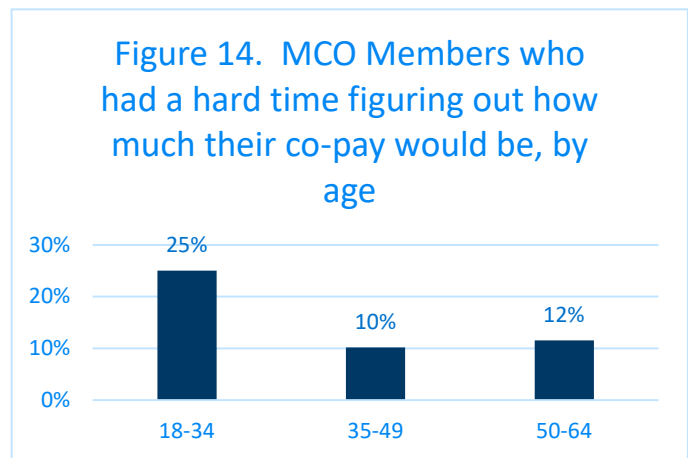
Another challenge for members can be trying to figure out which health care services they are eligible for, and how much each service will cost them. When asked if they had a hard time figuring out if MA would pay for the care they needed, nearly one-third of members (31%) said that they did. This percentage was consistent across race/ethnicity, eligibility type, interpreter status, age group, and geography. Educating members as to their benefits is a core responsibility of MCOs and DHS FFS, and this should be one of the easier ones to fulfill.

About one in six members (17%) said that they have a hard time figuring out how much their copay will be. In the 2023 Minnesota Legislative session, copays in MA were eliminated. This will start in January 2024. This makes the messaging of co-pay information a lot simpler – members simply need to be informed that there are no co-pays. However, even before the change took effect, copays were very simple – they were either \$1 or \$3. It's concerning that so many members said that this is hard to find out. We should be educating members more effectively on co-pays.



The percentage of people who were unsure of their co-pays varied dramatically by demographic group, which suggests that we may want to focus more intensive outreach on particular populations to let them know of the change. While 17% of all members said they had a hard time figuring out how much their co-pay would be, the following groups had higher rates:

- Members who use an interpreter (24%)
- Members age 18-34 (25%)
- Black Immigrants, US-Born Blacks, and Asians (23%, 24%, and 25%)
- MA Adults (20%)



## Recommendations for improving information on benefits for MCO MA members

At the time this report was being written, DHS and MCOs were focused on getting MA members renewed. Members hadn't been required to renew for the past three years due to the covid-19 Public Health Emergency, so supporting members as they renew is a heavy lift. As the first round of renewals comes to a close in summer 2024, however, it might be worthwhile to push MCOs to improve in the following areas:

- Let members know where they can find information on the services they're eligible for and what their co-pays are (\$0). MCOs provide this information in the member handbook, call center staff provide it when members call in, and some provide this information in other ways too. However, given that nearly one in three members said they had a hard time figuring out if MA will pay for the health care they need, MCOs may need to find additional ways to direct members to this information. The co-pay amount used to be included on all MA insurance cards, but this is no longer consistently done. It might be worth asking MCOs to take up this practice again.
- For English Language Learners, MCOs should make sure they know that health care providers are responsible for having interpreters available.
- Most MA members do not need assistance with transportation to their health care appointments, but for those that do, this can be a significant barrier. MCOs should make it clear to their members that this is available. They may be able to narrow down the list of people who need this information by using the MCO screening tool.

DHS and MCOs regularly discuss MA members' barriers to care and how to reduce the barriers. For example, DHS is currently reviewing results of a transportation provider survey with MCOs to find new ways to alleviate transportation barriers. In the last contracts, DHS asked MCOs to describe how they will encourage after-hours access to health care. DHS and MCOs will continue work to address access barriers.

## Recommendations for improving information on benefits for FFS MA members

DHS staff should review communications to FFS members such as the MA approval letters, MA insurance cards, and information on the website to figure out how to communicate benefits and co-pay information more clearly. The following are some specific tasks we might want to prioritize.

### Share information on covered benefits

One-third of members report that they have difficulty figuring out which services are covered. This is not surprising given that we do not send them information on this. In a previous chapter we outlined how we will use multiple modes to disseminate this information. Fewer people had difficulty figuring out co-pays, but this is very simple now (there are no co-pays for MA), so this should be easy to communicate along with the covered services.

Given how many Asian, US-born Black, and Hispanic members said they didn't know their co-pays, we should also communicate with community organizations that serve these populations and let them know that co-pays are sunsetting. Survey respondents gave us a long list of organizations that they trust to help them get care, and we can use this list as a starting place to try to communicate with as many as possible.

## **Share information on transportation services**

DHS will also need to share information on who is eligible for different types of transportation assistance. This might be developed as a one-page hand-out. There were three groups which were more likely to say they lacked a way to get to the clinic and that they didn't know how to schedule a ride: American Indians, Hispanics, and US-born Blacks. DHS might make a special effort to send a transportation one-pager to these individuals, and possibly to reach out to organizations that serve these groups so they can help to spread the message on these important access services.

## **Next steps in improving access to care**

DHS is planning dramatic improvements to our systems that serve FFS members. We will be implementing a provider directory API, which should make it easier for members to find providers. We will be doing outreach to members through email, texts, and mailings, sharing basic information such as which services are covered, cost-sharing, who to call for various questions, and transportation and other benefits that can help people access care. We plan to implement all of these improvements by the end of 2025.

We expect that these improvements will address many of the problems that members described in the survey. Once the changes have been in effect for a year or two, we will conduct a new survey to re-evaluate how successful we were at improving access. In addition to looking at overall access rates, we will also look at different populations that seem to have an especially hard time accessing care. These populations may need specific interventions tailored to their needs. For example, some may need assistance with making appointments, securing transportation, or navigating Medicare and MA. Overall, we will keep trying to learn what barriers to care our members experience, we continue working to address those.

## How do members choose an MCO?

We asked members about the process of choosing an MCO. This included asking how they made the choice, what parts were difficult (if any), and what they were looking for in an MCO. We will use members' feedback to find ways to improve the process.

### How did members choose an MCO?

The first questions we asked were about the process of choosing an MCO. We included all members who were enrolled with an MCO.<sup>29</sup> The first two questions are below.

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**Once you were notified that you were enrolled in MA, you may have been asked to choose a health plan (e.g., Blue Cross, Health Partners). DHS is planning to develop an online tool to help MA enrollees choose a health plan that fits their needs. Your responses to the next set of questions will help DHS design that tool.**

14. When you chose your current health plan under MA, how did you choose? **(CHECK ONE)**

<sup>1</sup> I do not currently have a health plan under MA

<sup>2</sup> I did not choose a health plan but a health plan was assigned to me by the MA office

<sup>3</sup> I picked a plan without much background information ➡

<sup>4</sup> I picked a plan recommended to me by my friends, family, or someone I trust ➡

<sup>5</sup> I picked a plan after reviewing their websites and determining the one that best fits my needs ➡

<sup>6</sup> I do not remember how I chose my health plan ➡

14a. Choosing a health plan can be difficult. Please mark any of the following statements that were true for you while you were choosing a health plan. **(CHECK ALL THAT APPLY)**

<sup>1</sup> It was hard finding information on the health plans

<sup>2</sup> It was hard figuring out which health plans would let me see my doctor or other health care providers I've seen in the past

<sup>3</sup> It was hard to fill out the form where I chose my health plan

<sup>4</sup> It was hard to follow the process for mailing the form where I chose my health plan

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<sup>29</sup> Methodology note: The survey was completed in March and April of 2022, and we pulled data on who had an MCO from records in March 2022, so the information should be current as of when they took the survey. Nevertheless, 2% of members with an MCO said they did not have an MCO. We decided to include their responses because they are impacted by the requirement to choose an MCO even if they didn't realize they have one. On a related note, this chapter includes people who are in a county with more than one MCO in 2022 (these people had a choice of MCOs) as well as people who had only one MCO in their county (these people didn't have a choice for this plan year). We included both groups because the percentage of people who were in 'one-MCO counties' was relatively small. Also, many people stay with the same MCO year after year, so they may be in a 'one-MCO county' in 2022, but went through the process of choosing their MCO in a previous year when they did have a choice.

Conducting the competitive bidding process, contracting with MCOs, and overseeing multiple MCOs are time intensive processes, but DHS hopes that allowing MA members to choose their MCO will support them in getting the health care they need. Our first question asks how members made that decision. These responses suggest that many people do not take full advantage of this choice. In fact, nearly forty percent of members put little or no effort into choosing their current MCO and may have not even made the choice themselves.

- 26% stated that they did not choose a health plan but a health plan was assigned to them
- 13% said they picked their health plan without much background information.

Another nearly forty percent of members put some effort into finding an MCO that is right for them.

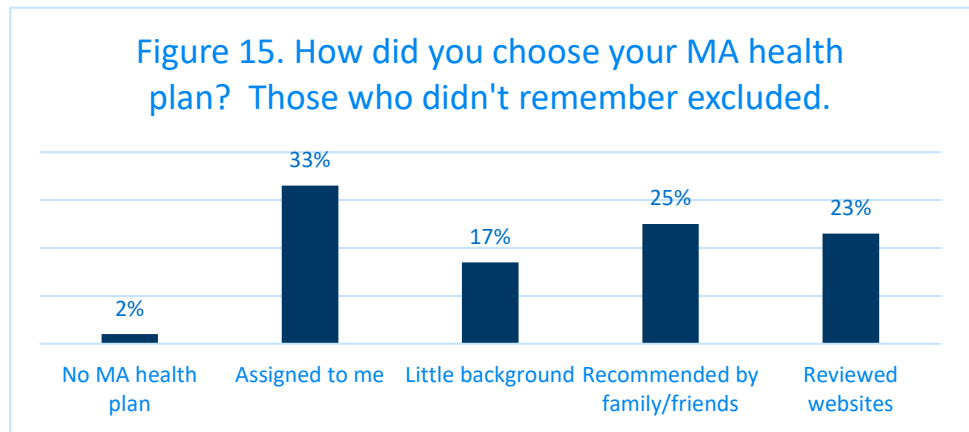
- 20% picked a plan that was recommended by family, friends, or someone they trust.
- 18% chose their MCO by reviewing the plans' websites and determined what fit their needs.

An additional 21% did not remember how they selected their MCO, so we don't know what their process was.

### How do members choose an MCO? Reporting only on members who told us how they made the choice

It is problematic to exclude the 21% of members who said they didn't remember how they chose, as that represents so many people. However, the following analyses do just that, to give a better picture of the processes of those who could remember.

As shown in the figure, the most common way members said they chose an MCO was that one was assigned to them. It is difficult to interpret this finding. Members are asked to choose an MCO every year, and we tell them that if they do not fill out the annual form, then they will remain with the MCO they currently have. We suspect that many people who say an MCO was assigned to them are simply continuing with an MCO that they are satisfied with. One member told a DHS staff that when she got the MCO Choice letter she thought "This is the plan I want so I don't have to do anything." And she was right.



About one in four members said they chose their MCO by getting recommendations from family and friends, and another one in four reviewed websites to make the decision. We are hoping that members do these at least the first time they choose an MCO.



The most concerning response here might be that 17% said that they chose an MCO with little background. However, many MA members are healthy and may need nothing more than primary care, so they may not feel the need to put a lot of effort in finding just the right MCO.

Having access to the internet at home did not significantly increase the likelihood of using websites to choose an MCO. Nineteen percent of those with internet access used websites, compared to 14% of those who did not have access at home. Nearly one-third of members (31%) without internet access said that their MCO was assigned to them, compared to one-fourth (25%) of those with access to the internet at home.

Despite our difficulty in interpreting this question, it is still clear that some people are not actively choosing their MCO. This might be fine, especially for people without the need for specialty or complex care. Nevertheless, it is possible that some members run into difficulties during the process of choosing an MCO. Those difficulties are the topic of the next section.

### **Which aspects of choosing an MCO was difficult?**

The next question asked members which parts of the process of choosing an MCO they had difficulty with<sup>30</sup>. We discuss each one, starting with the ones that more members said were difficult.

**Figuring out which MCOs would let them see their doctor.** Nearly half of members (47%) said they had a hard time figuring out which health plan would let them see their doctor or a provider they had seen in the past.

More urban members (34%) than rural members (19%) said they have a hard time figuring out which MCO will allow them to see their provider. This may be due to the greater number of options to choose from for urban members in both providers and MCOs.

DHS has changed the way we let members know which providers are in network for each MCO. Initially, counties mailed out an abbreviated list of covered primary care providers and their associated clinics developed by each MCO, that included the providers in each county or region of counties. This alone had a significant cost in postage, especially for counties with many providers and many MCOs.

Even more recently, DHS was required to ensure that each MCO was offering full provider directories. Many members say that they like having a hard copy of this information. However, it was very expensive to provide the entire directory as a mailing. Also, it is impossible to keep the provider information up to date once we have sent it out, so it becomes obsolete almost immediately.

DHS does not offer members an online tool to search for providers and determine which MCOs have them in network. Instead, DHS directs members to the website of each MCO, where they can find that MCO's provider search tool. Finding one's providers this way can be very time consuming, especially for people with complex

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<sup>30</sup> This is question 14a. This was only asked of members who chose options 3-6 on question 14 (they indicated that they chose an MCO).

conditions who have established relationships with multiple health care providers. They may have to search for each provider on the websites of each MCO they're considering to find out if that provider is covered.

DHS has proposed building an online search tool where members could enter the name of their doctor, and then they would be able to see which MCO's have them in network. This would be on one website, making it easy to compare across MCOs. MDH is considering building a statewide provider directory, which would allow for this option too. However, as described in an earlier chapter, they were still assessing the feasibility of such a project when this report was being finalized, so a statewide directory is years away if it does happen.

In a Participant Expert Panel (PEP) meeting in February 2022, MA and Minnesota Care members described what it is like to choose a health plan. There was a lot of discussion on how helpful it would be to have an online provider search tool.

Another member said that when she started to dig into choosing a health plan, she had to make a list of all of her doctors, medications, and equipment and had to call each plan and go through the full list to see what was covered and what was not. It was a lot of work. An online provider search tool would save her time by making it easier to find her providers.

**Finding information on the MCO.** About one-third (35%) of members said they had a hard time finding information on the MCOs. This was consistent across all demographic groups. Each MCO has extensive information on their MA plan on their website. However, DHS does not provide a direct comparison between plans.

In the same PEP meeting as above, we asked members what they are looking for when they're comparing health plans. As expected, they mentioned searching for their providers such as doctors, clinics, and dentists. However, they also mentioned that they need to know which services and goods are covered, such as over-the-counter medications, equipment, and personal care items (e.g. disposable briefs). Wellness programs (e.g. Silver Sneakers) and incentives for preventive care were also of interest. One member recommended that DHS show the differences between plans to make it easy to contrast and compare.

### **Filling out the MCO choice form and sending it in**

One in four members has a difficult time either filling out the form, sending it in, or doing both. Fourteen percent said it was difficult to *fill out the form* where they chose their health plan, and 15% found *the process of mailing the form* to be difficult. DHS has been working on making the form easier to fill out over the past couple of years. Only five percent checked both boxes. It seems like we can improve both parts of this process.

Provide business reply envelopes. The MCO choice packet currently includes a return envelope, but postage is not paid on it, so members need a stamp to send it back. Today, many people pay their bills online, and who communicate electronically and do not need stamps. For these members, requiring them to stop at a post office or buy stamps online may delay them returning the packet. We used to provide business reply envelopes in the packets, making it very easy for members to mail it back to us. We should do this again.

Send multiple communications in different modes about the MCO choice form. In the PEP meeting referenced earlier, we asked what this process for filling out the form was like. One member said that he liked how Hennepin County does it. He said that Hennepin County texted, emailed, and mailed him materials and

reminders about the process. First, he received text messages that a packet would be coming in the mail. Then, when he received the packet, he saw that there was a deadline, filled it out immediately and mailed it in. As described in a policy brief<sup>31</sup>, audiences need to see a message multiple times across different channels (website, social media, text messaging, mail, etc.) to improve the chance they will remember and respond. DHS has email addresses and phone numbers where they can receive text messages from many members currently, and this will increase as the renewals continue. We could use this to provide reminders to members to help them to complete the MCO choice process.

### **How do members want to submit documents such as the MCO choice form?**

MA members choose their MCO using a process done entirely on paper. DHS mails the MCO choice form<sup>32</sup> to members, along with information on which MCOs they can choose. Once they have filled this out, they can either send it through the mail or drop it off at their county or tribe.

As we saw in the previous section, about one in four members finds it difficult to fill out the MCO choice form, follow the process for sending it in, or both of these. We didn't ask them how they want to do this process. However, in another section of the survey we asked a related question that may provide some insight into this. This question relates to applying for and renewing one's MA.

9. What would be the easiest way for you to submit documents (e.g., paystubs) when applying for or renewing MA? **(CHECK ONE)**
- <sup>1</sup> Send the document via US mail
  - <sup>2</sup> Scan the document or take a picture on your phone and send it via email
  - <sup>3</sup> Scan the document or take a picture on your phone and upload it to a phone app or website
  - <sup>4</sup> Submit the paper document to a local county or tribal worker

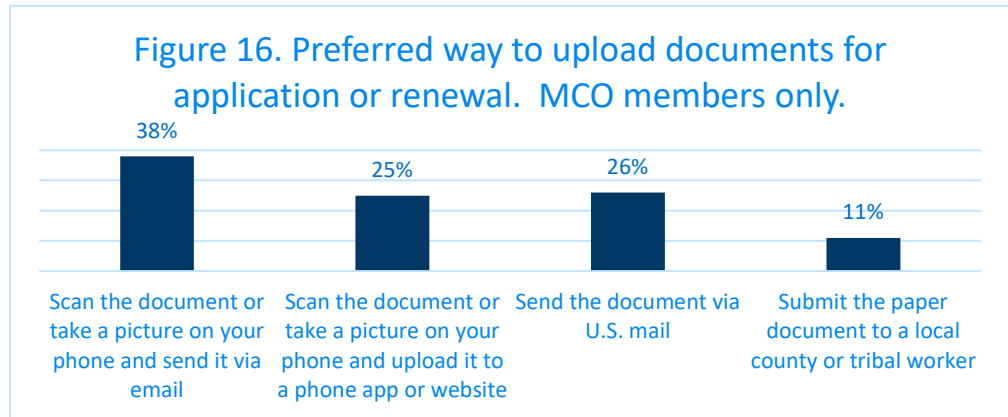
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<sup>31</sup> [State Strategies for Sequencing Enrollee Communications When Medicaid Continuous Coverage Ends](#)

Aug. 3, 2022, State Health & Value Strategies, Princeton University; Julie Bataille and Kevin Caudill, GMMB

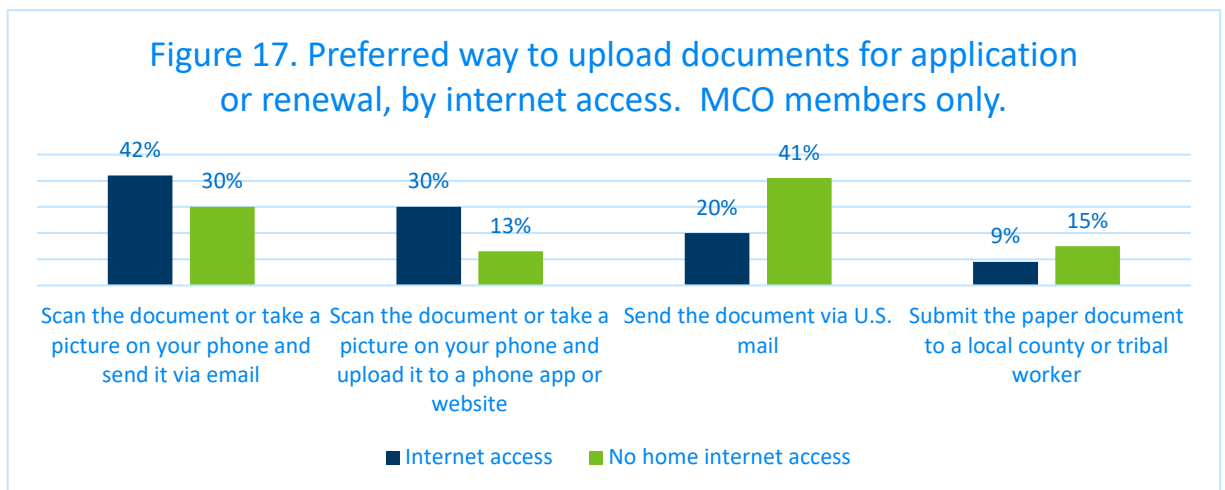
<sup>32</sup> Here is an example of a MCO Choice form: [DHS-6451-ENG \(Special Needs BasicCare \(SNBC\) Choice Form\) \(state.mn.us\)](#)

Members varied in their preferences. Over one-third preferred one of DHS' current options: sending them through the mail or giving them directly to a county or tribal worker. However, two-thirds would prefer to upload them electronically.



As expected, those with home internet access greatly preferred the electronic modes, while those without home internet show a preference for paper mail or in-person modes.

To meet the needs of all members, we will need to create an online option while maintaining traditional submission options.



### Create an online MCO Choice form

One way to make this process easier would be to create an online form that members could use to indicate which MCO they want to enroll with. We could offer this as an online option on a computer. We could also offer a phone option, which would be useful for members without home internet access. The next sections describe what it might take to make this happen. Investigate the possibility of adding the MCO choice process as a last step in the enrollment process.

DHS is looking into the possibility of adding the MCO choice process as the last step in the enrollment process. When members fill out the enrollment form, we have their attention as they are motivated to get enrolled, and if we added the MCO choice form as one more part of the process, we may get a better response. However, not all members need to choose an MCO, and some people are not allowed to choose an MCO. There would therefore need to be a way to bypass the MCO choice step. We would also need a separate process for the Annual Health Plan Selection, as this happens every year, and is not tied in any way to the application process.

## **A common Electronic Document Management System**

Creating an online MCO Choice Form would not be a difficult task. The difficulty lies in the fact that although DHS has for decades overseen counties and tribes doing the work of reviewing MA applications and enrolling members, we have never had a shared Electronic Document Management System (EDMS) so we can see the documents members send to counties and tribes, and they can see the documents that members send to us. DHS' EDMS is FileNet, a robust and expensive system. Hennepin County is the only Minnesota county which also uses FileNet, but our agencies do not allow access to the other's data. Sharing data with Hennepin would be a huge undertaking, even with the same system, as over time DHS and Hennepin County have developed definitions and taxonomies independent of each other, and they do not match. One or both would need to be reworked if we were to share systems.

Most other Minnesota counties use an EDMS other than FileNet. If we wanted to develop a statewide EDMS for all of us to use, it would be frustrating for each agency to walk away from the investments they've made in their own system and start using a new one. Further, their workflow and processes may be interlinked with their EDMS system, and changing systems may require changing their processes and workflow.

Five counties (with relatively small MA caseloads) have no EDMS system. They receive emails in their MN-IT email when DHS forwards a document to them. Someone on their staff must open the email, print it out, and then save it in the right paper folder and notify the worker to review the new document. These counties might have the most to gain with the least effort from using a statewide EDMS.

DHS should have instituted a statewide EDMS twenty years ago when we started using one. DHS' eligibility systems are the most significantly hindered by the lack of a common EDMS, as the counties and some tribes do the lion's share of eligibility determinations, but DHS manages the online eligibility system of MNSure and operates call centers. The MCO MA process would also gain from a common EDMS system, though there are workarounds that would also be sufficient (described in the next section).

One first step DHS might institute to move us towards a common EDMS system might be to map out the data security and data privacy requirements necessary for a common system, and consult with counties and tribes to develop a taxonomy that makes sense for people doing the work of eligibility determinations and that would work with DHS' eligibility systems. Then we could find out which (if any) counties are interested in moving in this direction. At that time, we could make the revisions necessary, and provide access to these counties and tribes. This would be a long and painful process for DHS and for these counties. We may revise our EDMS for MA only, or we may do it for other programs that DHS oversees and counties and tribes administer (cash and food assistance, child care assistance program, child protection). If DHS is to continue overseeing eligibility, MCO choice, and other tasks, while the counties and tribes administer them, it is hard to imagine continuing on this path indefinitely, never developing a common EDMS. Now might be the time to start this work.

## **A workaround to develop an online MCO Choice Form without the benefit of a common EDMS**

Creating an online MCO Choice form would be more streamlined if we had a common EDMS. Without one, it requires a complex set of softwares with interfaces to connect them, and multiple points at which human beings need to review documents. However, it is still possible. It would be easier to do today than it was a few years

ago as DHS' MCO division recently created a similar process for getting updated address changes from members. We could use this same pattern of softwares and connections as a template for creating a MCO Choice form. Briefly, here is how this workaround might go:

- DHS could build an MCO choice form in Adobe Experience Manager (AEM), an electronic forms tool. The form may interface with MNEIAM, to pull very limited data from MMIS, using our service account access.
- DHS sends the form to the member through the US Mail. We would include the form both on paper to mail back, and a link to the website where the form is located. It might be possible to piggy-back on the approval letter process, such that we send out their MCO choice form in the same packet when they receive their DHS insurance card (which includes a member ID).
- For members who want to fill this out online, they can use their computer or smartphone to go to the website, and enter their member ID number. AEM might use MNEIAM to search MMIS for this person's county and eligibility type, and find the MCOs that they can choose from. These choices would show up on the website, and the member would be asked to choose one MCO.
- Once the member fills out the form, it would be stored in DHS' FileNet. It needs to be sent to the county or tribe that administers their MA. To do so, we might have FileNet automatically send the form to the right county or tribe using their MN-ITS County Mailbox.
- Once the county or tribe receives the form, in most cases, one of their staff would need to open the form and save the information in MMIS, as well as saving the form in their own EDMS. Larger counties sometimes automate this process, while a few smaller counties may print it and save it in paper folders.

For members who have an email address on file, the process could be even easier for them. We could send them an email requesting that they fill out the MCO Choice Form, and include with it a personalized link to the form, so they do not need to indicate their member ID – it would be pre-programmed. This option could be built into the process from the beginning, or launched later on.

Ideally, DHS would begin work on a statewide EDMS. However, if this is not possible, we should use the pattern of software and interfaces we developed to get address updates from members to the counties and tribes, to implement an online MCO choice form.

### What's important to members when choosing a health plan?

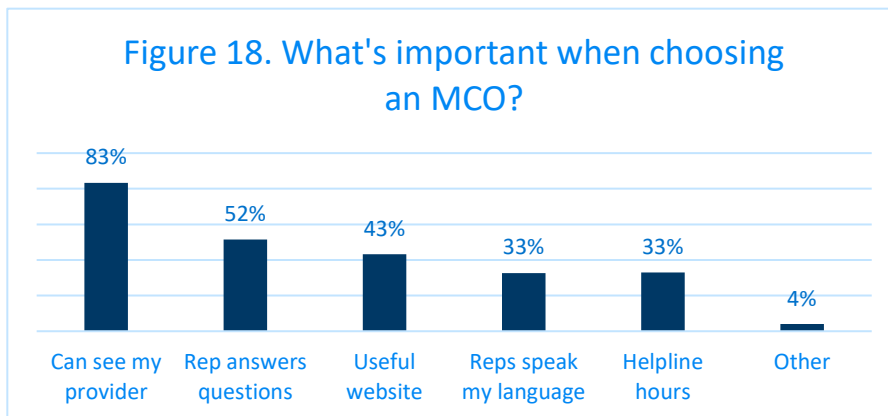
Whether or not members took an active role in choosing their MCO, we wanted to know what they look for in one. We gave them a list of five things that they could check. Many checked multiple boxes.

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15. Which of the following are important to you when choosing a health plan? **(CHECK ALL THAT APPLY)**

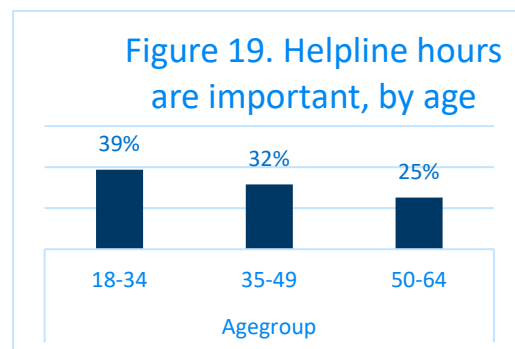
- <sup>1</sup> I can see my doctor or another health care provider who has treated me before
  - <sup>2</sup> Representatives from the health plan speak my language
  - <sup>3</sup> The health plan's helpline has hours that meet my needs
  - <sup>4</sup> I can find what I need on the health plan's website
  - <sup>5</sup> The health plan representative answers my questions when I contact them
  - <sup>6</sup> Other (please specify: \_\_\_\_\_)
-

As we expected, the most important thing to members when choosing an MCO, was that they could see their doctor or another health care provider they had seen before. A large majority of members (83%) checked this box. This was important to people in all demographic groups though it was most important for American Indian/Alaska Native members (89%). Members who use an interpreter were the least concerned that they can go to their provider (70%).



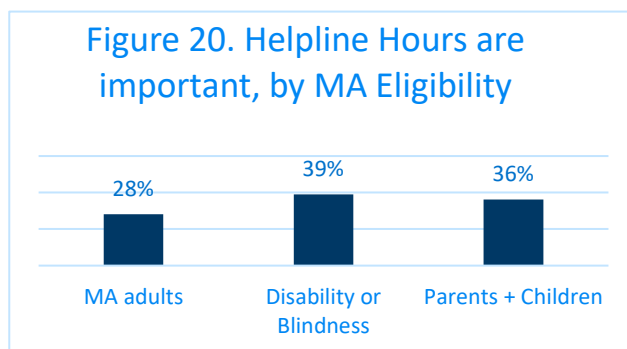
The second most common response (a distant second) was that members wanted to know that representatives can answer their questions. Just over half (52%) of members indicated this, and it was consistent across all demographic groups.

Third most important to members was that they can find what they need on the MCO's website; 43% of members selected this. However, members age 18-34 were more than twice as likely than those age 50-64 to say they wanted the website to have what they needed (52% and 25% of members, respectively). This emphasizes the growing importance of effective online communication for younger generations of MA members, as well as future generations.



One-third (33%) of members said that it was important that representatives of the health plan speak the same language as they do.

One-third also said that the hours the helpline are available is important. Helpline hours was most important to those who were eligible due to disability (39%), as well as to 18-34-year-olds (also 39%). The helpline hours were least important to those who used an interpreter (21%).



Four percent of members checked the 'other' box, indicating that something else was important to them. There were some common themes in their write-in comments on what is important to them.

The most consistent theme was ensuring that all the services they needed, or wanted, were covered (27 comments). Another common theme was clarity and consistency in coverage within and between plans. For example, one member mentioned that a medication was no longer covered when they had to switch health plans due to moving. Another member said they were

concerned that their health plan no longer contracted with MA. Prescription coverage was another common theme.

Other themes that emerged were alternative or traditional medicine, dental, mental health coverage, special needs, transportation, location, health improvement incentives, cost, and customer service. Other responses focused on plan credibility, flexibility, trust, and communication.

## Recommendations

The MA renewal process has been an opportunity to try new modes of communicating with members, and we can use what we have learned in the MCO choice process. Communicating with members using more modes of communication provides one such opportunity.

**Use email and text-compatible phone numbers to let members know that the MCO choice form is ready to be filled out.** When it is time for members to choose an MCO, DHS sends them one packet through the US Mail, asking them to choose an MCO, and mail a form indicating their choice back to us. However, we could use other modes such as email, texts, and even calling people on the telephone. DHS has the email addresses and text-compatible phone numbers for many members, and this contact information will be even more widely available to DHS as the post-pandemic renewal process continues. We could text or email members a quick note that MCO choice materials will soon arrive in the mail, and once the materials have been sent, we could send a quick reminder to complete them.

**Include business reply envelopes in MCO Choice packets.** Fifteen percent of members found *the process of mailing the MCO choice form* to be difficult. Including a postage paid business reply envelope could make it easier for these members to mail the form in.

This chapter also describes many opportunities to improve the access members have to information needed to make an informed decision on which MCO is the best fit for them. Online tools and forms would be especially valuable if they were all located on the same site so everything can be done in one place.

**Create an online provider-MCO search tool.** The most important online tool might be one that allows members to enter their provider's name and then search to see which MCOs allow them to see that doctor. Four out of five members said that being able to go to their provider is an important factor in choosing an MCO, and nearly half said they have difficulty figuring out which providers each MCO includes in their network. This is clearly a part of the process in need of attention.

**Create an online MCO choice form.** This might be especially valuable to more internet-savvy members, including the younger adult members. Ideally, DHS would begin work on a statewide EDMS and this would allow DHS as well as counties and tribes immediate access to each agency's forms, including the MCO choice forms. However, if a statewide EDMS is not possible, we should use the IT process we developed to get address updates from members to DHS and then to the counties and tribes. We can replicate that process to implement an online MCO choice form that can also be shared with counties and tribes.



The last three recommendations would have cost implications, and the last two would require initiation as IT projects. However, together, these improvements would make it easier for members to make an informed choice on which health plan will best fit their needs, as well as to let DHS know of their choice. These are areas that many MA members find to be difficult and are worth the effort to improve.

## Conclusion

MA members have differing access to the internet and to electronic devices. To serve them all adequately, DHS must offer multiple communication modalities so each can choose the ones that they are comfortable with and have access to. DHS has the following ideas for improving this access.

### Improving access to information and health care for MCO MA members

Overall, there is a relatively good fit between the MCOs' modes of sharing information with members, and members' communication preferences. Most MA members want to access information online, and all MCO's have their plan benefits on their website. About four in five members want to call someone on the telephone when they need help finding an answer to their question, and each MCO has a call center to meet this need. One-third of members want to get help with their questions by using email, and this is an option with all MCOs. The communication modes that most people want to use to find the answers to their questions are already in place.

There may be a few gaps which could be addressed. For example, members without internet access need ways to access information. DHS could look into which communication modes each MCO uses to share this information with members, and whether they let members know that they can always request information on paper. Of special interest might be People with Disabilities. When asked how they want to find answers to their questions about MA coverage, 32% of people in this eligibility category only wanted information via paper materials and didn't select online or app options. They appear to have a stronger preference (or need) for traditional communication modes. DHS might start with the contracts for People with Disabilities to find out if MCOs provide them with information through the mail, or if MCOs explicitly tell them that they can request information on paper. DHS might also encourage MCOs to share information on the new co-pays (\$0). For example, MCOs could include this information to all insurance cards.

### Improving access to information and health care for FFS MA members

There are significant gaps in FFS MA members' ability to find the information they need. Right now, the best resource for FFS MA members to learn about their benefits is the Health Care Consumer Support (HCCS) call center. When we asked members how they would like help with finding information on their benefits, 78% said they would like to talk with someone over the phone. This confirms the value of the HCCS to members. However, the HCCS should not be the only source of information for members.

DHS has a webpage with information on FFS MA, but it can be difficult to find. Many people also want information in the form of paper booklets. However, at present, we do not send any benefits information to FFS members through the mail.

In order to improve the access FFS members have to information on their benefits, we plan to develop the following materials in the next two years:

- A short 'Member Summary'.
- Short descriptions of specific covered services.

- A detailed 'Member Handbook'.

These materials will then need to be disseminated to FFS MA members. We plan to upload these materials to a FFS MA webpage and make that page easy to find. We will also send FFS MA members an 'Introduction to FFS MA' letter and let them know where to find the materials. To do this, we will use the lowest cost mode of communication that members have requested. This will probably be email first, text if email is not available, and then US Mail when they have no other option.

DHS is also beginning work on a provider directory 'Application Programming Interface' (API) which will allow different applications to talk to each other. As part of this process, we will work to make the directly search logic more intuitive and easier to navigate. We will also look into whether we can make it easier for providers to update their information.

## **Improving the process of choosing an MCO**

The process for choosing an MCO can be challenging for some members. Nearly half said it was difficult to figure out which MCOs would let them see their doctors, and one in three had a hard time finding information on the MCOs. About 15% said it was also hard to fill out the form, and to follow the process of mailing it. The following are some solutions that would make this easier:

- Create an online provider-MCO search tool.
- Use text messages to let members know that the MCO choice form is ready to be filled out.
- Create an online MCO choice form.
- Include business reply envelopes in MCO Choice packets.

## **Next steps**

Many members told us that it can be challenging to find the information they need on their MA benefits. Some are proficient at using the internet. For these members, we should offer fast, efficient ways to communicate with us online. Other members prefer traditional modes of communication, and so paper materials and telephone options are also needed. This report provides guidance on information and communication gaps as they are perceived by members, as well as recommendations for addressing these gaps.

## Appendix 1: Access to health care section of the survey

Once you were notified that you were enrolled in MA, you may have been asked to choose a health plan (e.g., Blue Cross, Health Partners). DHS is planning to develop an online tool to help MA enrollees choose a health plan that fits their needs. Your responses to the next set of questions will help DHS design that tool.

14. When you chose your current health plan under MA, how did you choose? **(CHECK ONE)**

- <sup>1</sup> I do not currently have a health plan under MA
- <sup>2</sup> I did not choose a health plan but a health plan was assigned to me by the MA office
- <sup>3</sup> I picked a plan without much background information ➡
- <sup>4</sup> I picked a plan recommended to me by my friends, family, or someone I trust ➡
- <sup>5</sup> I picked a plan after reviewing their websites and determining the one that best fits my needs ➡
- <sup>6</sup> I do not remember how I chose my health plan ➡

14a. Choosing a health plan can be difficult. Please mark any of the following statements that were true for you while you were choosing a health plan. **(CHECK ALL THAT APPLY)**

- <sup>1</sup> It was hard finding information on the health plans
- <sup>2</sup> It was hard figuring out which health plans would let me see my doctor or other health care providers I've seen in the past
- <sup>3</sup> It was hard to fill out the form where I chose my health plan
- <sup>4</sup> It was hard to follow the process for mailing the form where I chose my health plan

15. Which of the following are important to you when choosing a health plan? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> I can see my doctor or another health care provider who has treated me before
- <sup>2</sup> Representatives from the health plan speak my language
- <sup>3</sup> The health plan's helpline has hours that meet my needs
- <sup>4</sup> I can find what I need on the health plan's website
- <sup>5</sup> The health plan representative answers my questions when I contact them
- <sup>6</sup> Other (please specify: \_\_\_\_\_)

### Getting answers to your questions

There may be times when you have questions about your MA coverage. You might be wondering where you can go to receive health care (such as clinics or hospitals), what services are covered in your plan (such as counseling, medicine), and how much your co-pay will be.

16. If you need to search for this kind of information on your own, how would you like to find it? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Use a website
- <sup>2</sup> Use an app on your phone or tablet
- <sup>3</sup> Use a paper booklet that lists services and providers covered in your area

17. If you can't find the information on your own and you need help, how would you like to receive help? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Use an online chat box
- <sup>2</sup> Write an email
- <sup>3</sup> Talk with someone over the phone
- <sup>4</sup> Talk with someone through a video call like Zoom
- <sup>5</sup> Talk with someone in-person at their office

## Getting the health care you need

The next questions are about your experiences getting health care. In this survey, when we say health care, we mean visits to your doctor, dentist, mental health provider, substance use counselor, physical therapist, or another person who provides a health care service to you.

19. People sometimes have problems getting health care. For each of the items listed below, please tell us if any of these have been a problem for you getting the health care you need in the past year.

**(CHECK ALL THAT APPLY)**

- <sup>1</sup> I had a hard time finding a health care provider who will accept MA
- <sup>2</sup> I had a hard time finding a health care provider who schedules appointments when I am available
- <sup>3</sup> I had a hard time figuring out if MA will pay for the health care I need
- <sup>4</sup> I had a hard time figuring out how much my co-pay will be
- <sup>5</sup> I had a hard time getting to the doctor's office or clinic because I do not have access to a car or public transportation (e.g., bus, train)
- <sup>6</sup> I needed a free ride to the doctor's office or clinic, but I did not know how to schedule it

20. If you or someone in your household was experiencing a mental health or substance use crisis, what would you do to find help? **(CHECK ALL THAT APPLY)**

- <sup>1</sup> Call 911
- <sup>2</sup> Call my doctor or clinic
- <sup>3</sup> Call my health plan
- <sup>4</sup> Call the mobile crisis line
- <sup>5</sup> Go to the emergency room
- <sup>6</sup> Call my community or spiritual leader
- <sup>7</sup> Other (please specify: \_\_\_\_\_)

## Appendix II: Methodology

This section describes the methodology used in the survey of MA enrollees and was written by Wilder Research.

DHS prioritized six topic areas to incorporate into the survey, including:

- MA application process
- Accessing health care
- Health care quality and treatment plans
- Cultural responsiveness and discrimination
- Financial well-being
- Telehealth

To develop the survey tool, DHS gathered input from researchers, directors, and managers within DHS's Health Care Administration (HCA) and Community Supports Administration (SCA), as well as other subject matter experts. Additionally, Wilder provided feedback on drafts of the survey tool.

To translate the web survey into Spanish, Somali, and Hmong, Wilder worked with a translation vendor. DHS programmed all versions of the survey into their survey software program, SNAP.

The mailed materials, the survey and a proposal outlining the survey methodology were submitted to the DHS Institutional Research Board (IRB). After reviewing the application, the IRB identified several required changes to the project. After these changes were addressed, the project received IRB approval.

To determine the sample for the survey, DHS identified three priority variables from the MA enrollee database:

- Prior telehealth utilization: enrollees who received behavioral health services via telehealth, enrollees who received only physical health services via telehealth (no behavioral health services), and enrollees who had not received any telehealth services
- Eligibility type (i.e., the reason someone is eligible for Medical Assistance): MA Adults, Families and children, and Aged, Blind and Disabled enrollees
- Race/ethnicity: Asian or Pacific Islander, Black immigrants, Black non-immigrants, Hispanic, Native American, and white. DHS had a specific interest in assessing the differences between enrollees who identify as Black and are immigrants and enrollees who identify as Black and were born in the U.S. Note that in order to sample by race/ethnicity, there can only be one race/ethnicity category assigned to each respondent. Accordingly, all enrollees sampled for this study only had one race/ethnicity category assigned to them. While enrollees can select all racial or ethnic groups that they identify with, DHS assigned each enrollee to the racial/ethnic category that is least common in the population.

Using data from these variables, Wilder created a sample of 18,036 individuals, such that there were 334 enrollees in 54 total groups (i.e., one group for each possible combination of the above variables). Enrollees in each group were randomly sampled.

DHS then identified and removed household duplicates and individuals who had no valid address, no forwarding address according to the National Change of Address System, and no email address, resulting in a total of 17,817 individuals in the sample.

Invitations to complete the survey were sent in the following sequence:

- Invitation #1 sent on March 9, 2022: letters with the link to the web survey were mailed to all enrollees in the sample. Email invitations were also sent to METS-enrolled enrollees who had an email address on file.
- Invitation #2 sent on March 16, 2022: postcards with the link to the web survey were mailed to all enrollees in the sample. Follow-up email invitations were also sent to enrollees with email addresses. These were sent one week after the first invitation.
- Invitation #3 sent on March 30, 2022: a printed paper copy of the survey and letters with the link to the web survey were mailed to all enrollees who had not yet completed the survey and had valid mailing addresses (i.e., prior mailings were deliverable). One final email invitation was also sent to enrollees who hadn't yet completed the survey and had email addresses. These were sent two weeks after the second invitation.

All invitation materials noted that enrollees who completed the survey would receive a \$15 Target or Walmart gift card, and that the survey would take about 20-30 minutes to complete. Additionally, the materials stated that survey responses are confidential and won't be shared outside the Wilder Research and DHS teams working on the project, that participation will not affect MA or other program eligibility, and that the survey must be completed by the person the invitation was sent to. Materials also included a survey access code that enrollees had to use to access the web survey, allowing Wilder and DHS to connect their survey responses to MA administrative data.

The web survey was open until Monday, May 2, 2022, and the last day Wilder accepted surveys was May 6, 2022.

As Wilder received completed mailed surveys, Wilder staff entered them into a tracking file, cleaned the responses as needed, and entered the data. Once all the mailed surveys were entered, DHS sent Wilder the web survey responses for the telehealth and demographics questions. Wilder then combined the files and removed duplicate responses, for a total of 2,985 responses.

To calculate the response rate, enrollees were removed from the overall sample denominator if their mailed letter was undeliverable and their email invitation was undeliverable or they did not have an email address. The final denominator used to calculate the response rate was 16,412, and the final response rate was 18%.

Wilder then weighted the dataset to produce reliable estimates of population parameters for each of the sampling areas: prior telehealth utilization, eligibility category and race/ethnicity. For this study, survey weights were calculated using the method of iterative proportional fitting, commonly referred to as "raking." The weights were put through a series of quality control checks to identify extreme outliers (weights were truncated so no single respondent counts too strongly in the analysis) and to avoid any computational or procedural errors. Wilder then generated frequencies and crosstabs to produce the findings included in this report.

## Appendix III: Interoperability rule

DHS staff are aware that we need to communicate more effectively with MA members, and we are working on improving this when there is time, in between all of the work that is required to run the program. In 2020 CMS passed a federal ‘interoperability and patient access rule’ which requires Medicaid agencies to allow their members access to their own data and to ensure that different human services systems interface. This section describes how we might use the interoperability requirements and our work to fulfill them to push forward the improvements in communication that MA members told us they need as part of the survey.

“Interoperability... is the ability of different systems, devices, applications or products to connect and communicate in a coordinated way, without effort from the end user. Functions of interoperable components include data access, data transmission and cross-organizational collaboration regardless of its developer or origin.” [What is interoperability? | Definition from TechTarget](#)

### Background on the rule

DHS must implement several major interoperability requirements for MA and MNCare. Some of them have a due date which has passed, so different program areas in DHS are working hard to develop plans for and implementing these changes so we are fully in compliance with CMS. Here are the major requirements for DHS<sup>33</sup>:

**Patient access API.** DHS must implement a secure way for patients to easily access information about their own health status, services, and insurance. This must be available thru a third-party application of their choice. We must provide an ‘Application Programming Interface’ (API), a software that allows members to access information on their digital devices using a portal other than one created by DHS. The process is shown in the next figure.

“API is the acronym for application programming interface — a software intermediary that allows two applications to talk to each other. APIs are an accessible way to extract and share data within and across organizations.

This rule seeks to achieve the following vision: Every person receiving healthcare has a right to access their health care information in ways that make sense to them, regardless of their plan, health care provider, or payer. This rule requires payers and other entities to standardize their data and make it available for use by many applications so people can have a high quality experience.

APIs are all around us. Every time you use a rideshare app, send a mobile payment, or change the thermostat temperature from your phone, you’re using an API.” [What is an API? \(Application Programming Interface\) | MuleSoft](#)

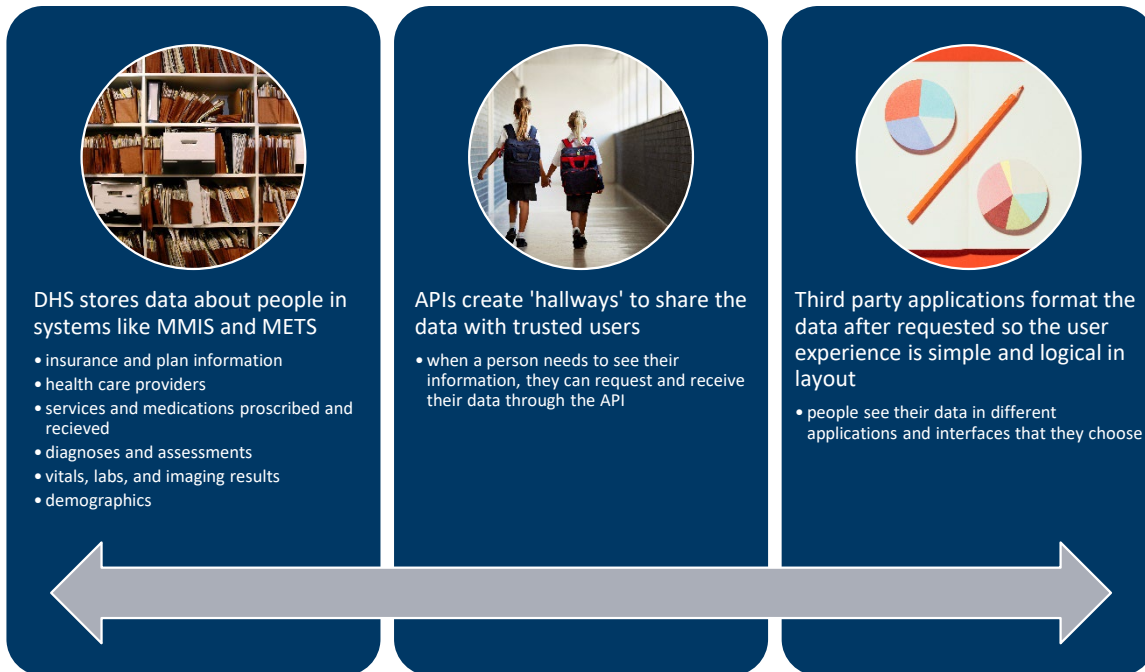
To do this, we need to create a set of technical endpoints for processing data requests.

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<sup>33</sup> This is taken from [Interoperability and Patient Access Fact Sheet | CMS](#).



Figure 21. Graphic representation of an 'Application Programming Interface' (API).



**Payer-to-payer data exchange.** Medicaid health plans are required to make the above data easily available to a member, but is also required to make it available to another payer at the member's request. This allows the new payer to access their current and past clinical records to allow for better continuous care. At present, DHS is not required to do this for FFS MA members<sup>34</sup>. We expect it to be part of the new rule that goes into effect on January 1, 2026.

**Provider Directory API.** DHS is also required to offer a provider directory that members can access via an API. It must not be in a patient portal which restricts access through user authentication. The directory must include elements such as:

- Name of the clinic, facility or clinician
- Enrollment status
- Specialty
- Address and phone number<sup>35</sup>

All of these requirements are currently being met with the provider directory, with the exception of the API. The provider directory is currently only available on the DHS website, and not on a smartphone, tablet, or device other than a computer or laptop.

<sup>34</sup> [Interoperability and Patient Access Final Rule FAQ Document MASTER OGC OCR CMCS CPI \(cms.gov\)](#)

<sup>35</sup> [Requirements for Provider Directory API | CMS interoperability Rule](#)

These requirements are also on the health plans that serve MA and MNCare.

**Improving the Dually Eligible Experience by Increasing the Frequency of Federal-State Data Exchanges.** DHS is also required to “exchange enrollee data for individuals dually eligible for Medicare and Medicaid, including state buy-in files and “MMA files” (called the “MMA file” after the acronym for the Medicare Prescription Drug, Improvement and Modernization Act of 2003) from monthly to daily exchange to improve the dual eligible beneficiary experience, ensuring beneficiaries are getting access to appropriate services and that these services are billed appropriately the first time, eliminating waste and burden.”<sup>36</sup> We are in compliance with this requirement.

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<sup>36</sup> [Interoperability and Patient Access Fact Sheet | CMS.](#)

# Appendix IV: MCO Enrollee Screening

The following shows the questions MCOs must screen members for. They may add their own questions too.

[Date]

**Please take a few minutes to fill out this survey.**

This survey will assist <MCO> in connecting you to health care services. Based on your responses <MCO> may contact you for additional information.

If you have questions about this survey, please call <MCO customer service phone number>. Thank you.

This survey is for <member name> who is enrolled in the <MCO> Medical Assistance Program.

Member Information – Please cross off and list information that is not correct below.

<MCO> ID: <Member ID number>
Date of Birth: <Date of Birth>
Address: <insert address on file> Address if different than listed above: _____
Phone Number: <Phone number> _____

Name of person completing form \_\_\_\_\_

Date \_\_\_\_\_

Relationship to Member \_\_\_\_\_

Telephone number of person completing form if different than above?

\_\_\_\_\_

If you choose not to complete this survey, check this box and return in the enclosed envelope. <input type="checkbox"/>
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**Please answer the following questions:**

1. Do you need interpreter services?

Yes If yes, what language \_\_\_\_\_  No

2. In general, how would you rate your physical health?

Good  Fair  Poor  No Concern

3. Are you pregnant?

Yes If yes, estimated due date \_\_\_\_\_  No

4. Have you seen a <doctor/qualified health care provider/physician> in the past year for routine health care?

Yes If yes, # of visits \_\_\_\_\_  No

Would you like someone to contact you to assist you in setting up a medical appointment?

5. Have you been to the emergency room in the past year?

Yes If yes, # of visits \_\_\_\_\_  No

Would you like someone to contact you to assist you in setting up a follow-up medical appointment?

6. Have you seen a dentist in the past year?

Yes If yes, # of visits \_\_\_\_\_  No

Would you like someone to contact you to assist you in setting up a dental appointment?

7. Do you have any medical conditions that need regular care or prescription medications?

If yes, check all that apply:

- Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD)
- Anxiety
- Asthma
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Problems
- High Blood Pressure
- Other \_\_\_\_\_
- None

8. Are you currently experiencing pain?

Yes  No

If yes, how often?

- Occasionally
- Daily
- Weekly

8.a. Are you taking any medications for your pain?

- Yes  No

If yes, what are they?

- Prescribed drugs by a doctor:

Name(s) \_\_\_\_\_

- Any other drugs, not prescribed by a doctor:

Name(s) \_\_\_\_\_

9. Do you use street drugs, misuse prescription drugs, or feel you drink a lot of alcohol?

- Yes  No

If yes, how often?

- Occasionally
- Daily
- Weekly

9a. Would you like to be contacted regarding your drinking or drug use?

- Yes  No

10. Would you like to be contacted regarding mental health services?

- Yes  No

11. Do you need help setting up transportation to your medical appointments?

- Yes  No

12. What is your current living situation?

- I have a steady place to live
- I have a steady place to live, but I'm concerned with the condition of it
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (Choose this answer if you are temporarily staying with others or are living outside or in a hotel, shelter, car, bus or train station, etc.)

13. Do you feel physically and emotionally safe where you currently live? If you need help immediately, please

contact your local law enforcement or human service agency.

- Yes  No

14. In the last 30 days, did you ever eat less than you felt you should because you didn't have enough money for food?

Yes  No

14.a. Do you have access to the food you need?

Yes  No

15. <Additional MCO specific question(s)>

Thank you for completing this survey. Please mail back in the enclosed envelope.

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