Summary of denial notice template survey feedback

June 21, 2021

BACKGROUND

In February 2021, the Health Systems Division Quality Assurance & Contract Oversight team established a workgroup with representatives from coordinated care organizations (CCOs) and dental care organizations (DCOs) to update templates for notices explaining Adverse Benefit Determinations.

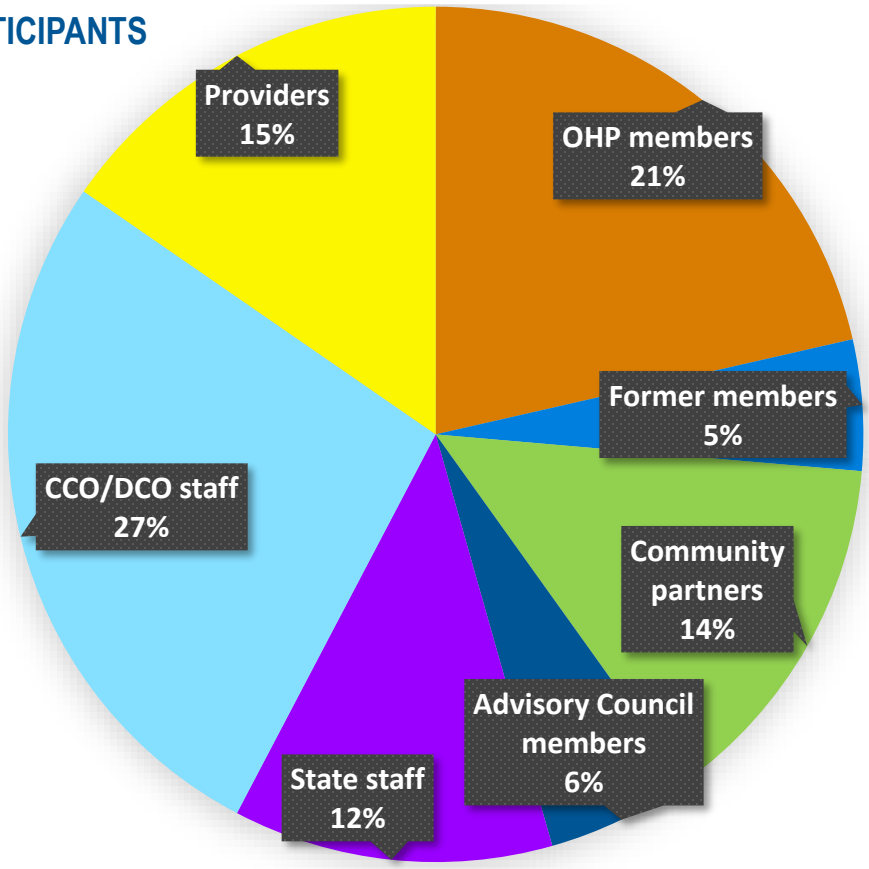
The workgroup was tasked with making sure notices are easier to understand and notices are compliant with state and federal rules and requirements. To incorporate consumer feedback, a survey was created to ask meaningful questions about the updated templates.

SURVEY SETUP AND PARTICIPANTS

The survey invitation was shared with the Community Partner Outreach Program, the Member Engagement and Outreach Committee, the Medicaid Advisory Committee, and was sent to more than 8,750 recipients via the Oregon Health Plan Member and Stakeholder distribution list.

The survey was open between May 24 and June 6, 2021. There were 196 responses collected.

SURVEY PARTICIPANTS



SURVEY STRUCTURE

The survey asked about specific sections of the letters and then presented full versions of the letters for overall feedback. Survey questions asking about ease of comprehension were presented with a four-point answer scale, from very hard to very easy to understand.

The survey avoided using Medicaid jargon like Notice of Adverse Benefit Determination (NOABD). Thus, adverse benefit determinations were referred to as “service denials.”

TEMPLATES USED IN THE SURVEY

- Notice of Adverse Benefit Determination template with table
- Notice of Adverse Benefit Determination template without table
- Claims Notice of Adverse Benefit Determination template
- Notice of Appeal Resolution template

SUMMARY OF RESPONSES

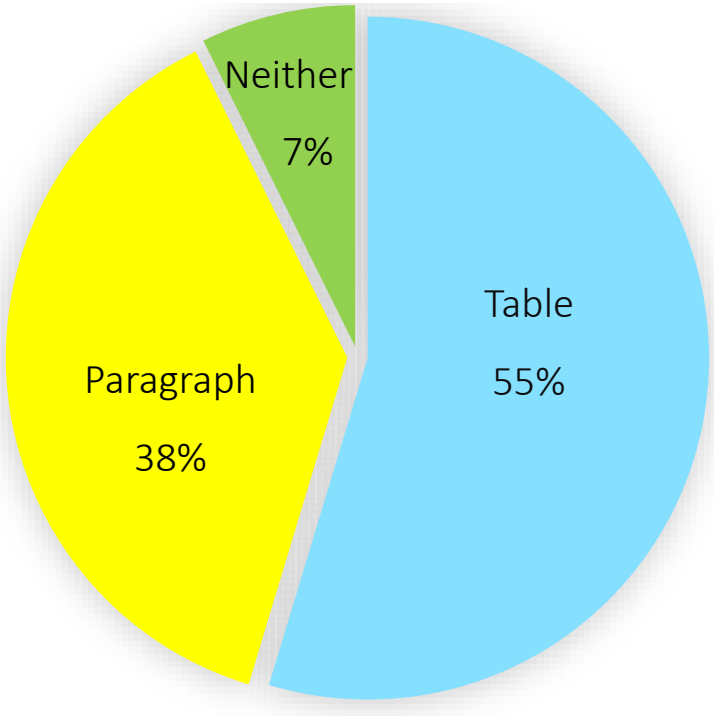
The following information is a high-level summary of all 196 responses received.

EXPERIENCE WITH NOTICE OF ADVERSE BENEFIT DETERMINATIONS (NOABDs)

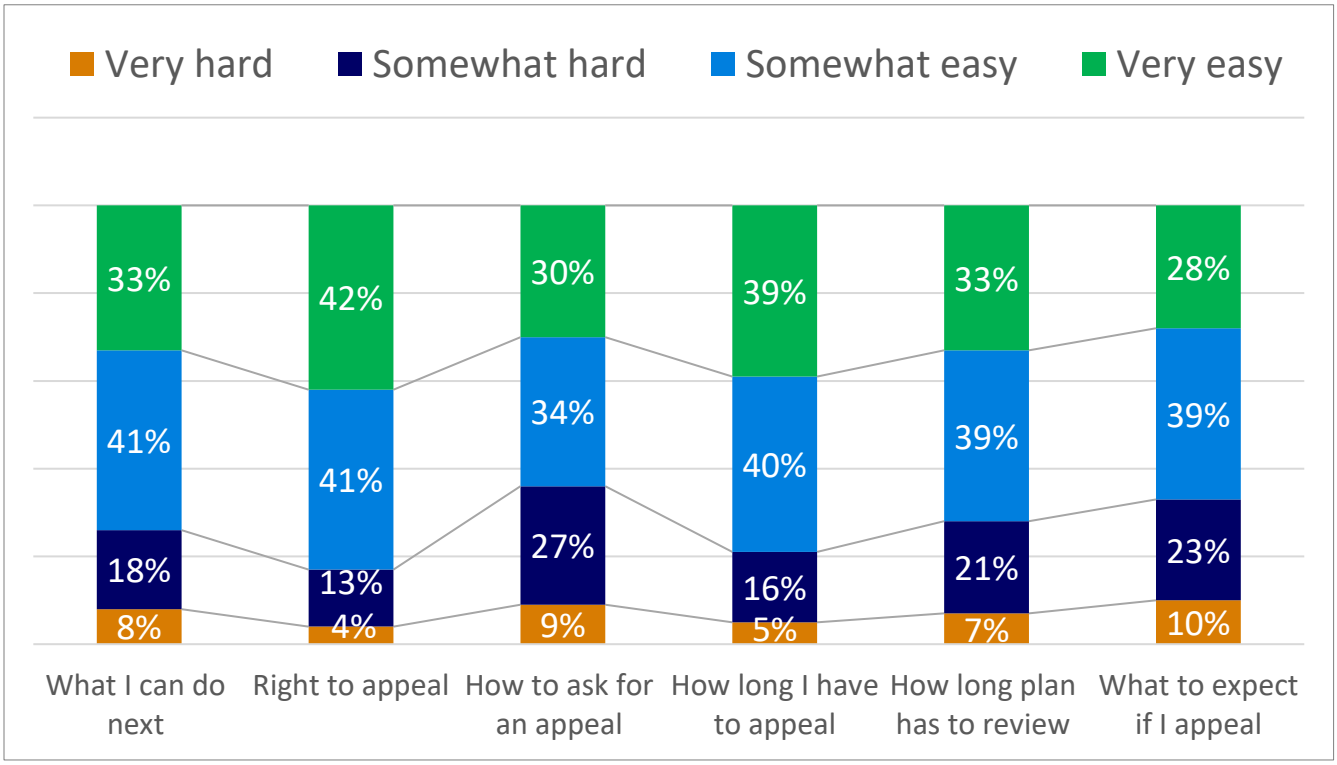
Only 45 of 196 respondents said they previously received an NOABD; 61% of those respondents said the current NOABD was easy to understand.

FORMAT PREFERENCE

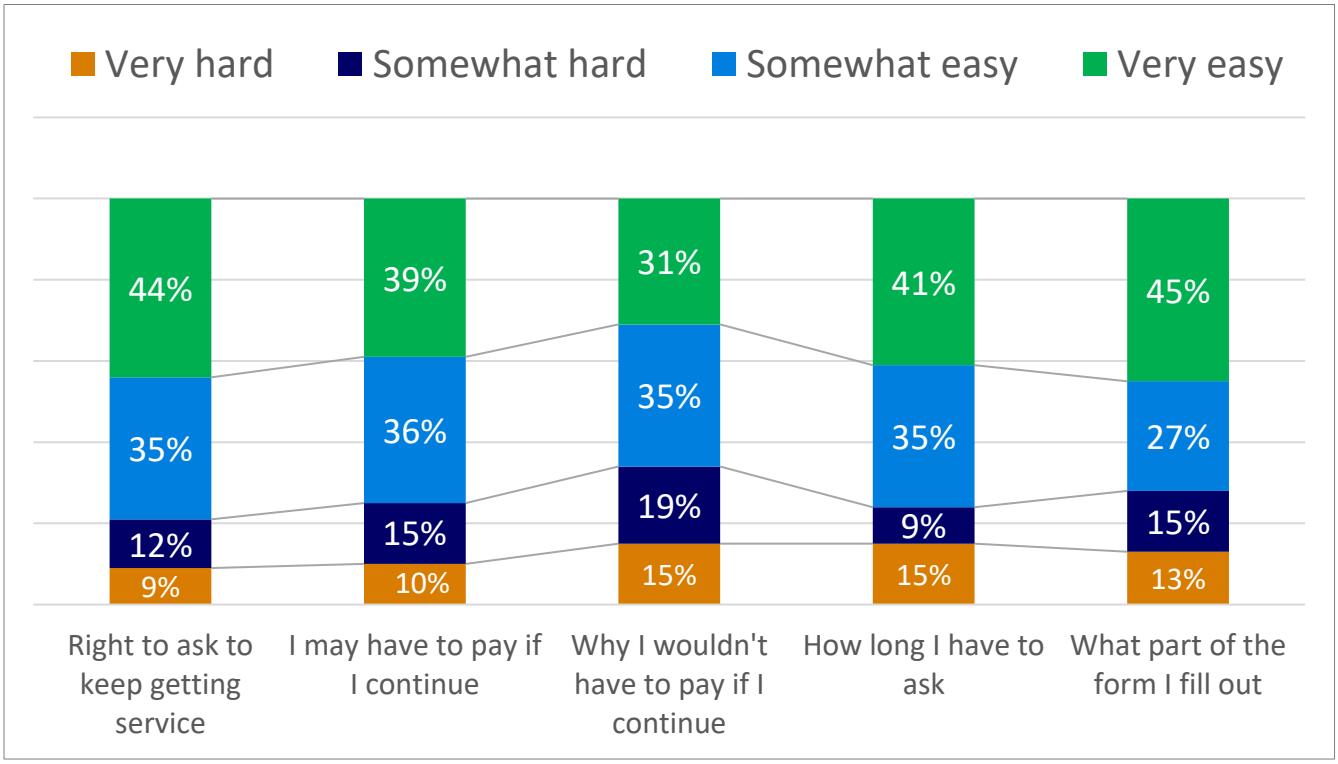
Which template is preferred: the template with information in a table or information in paragraph format?



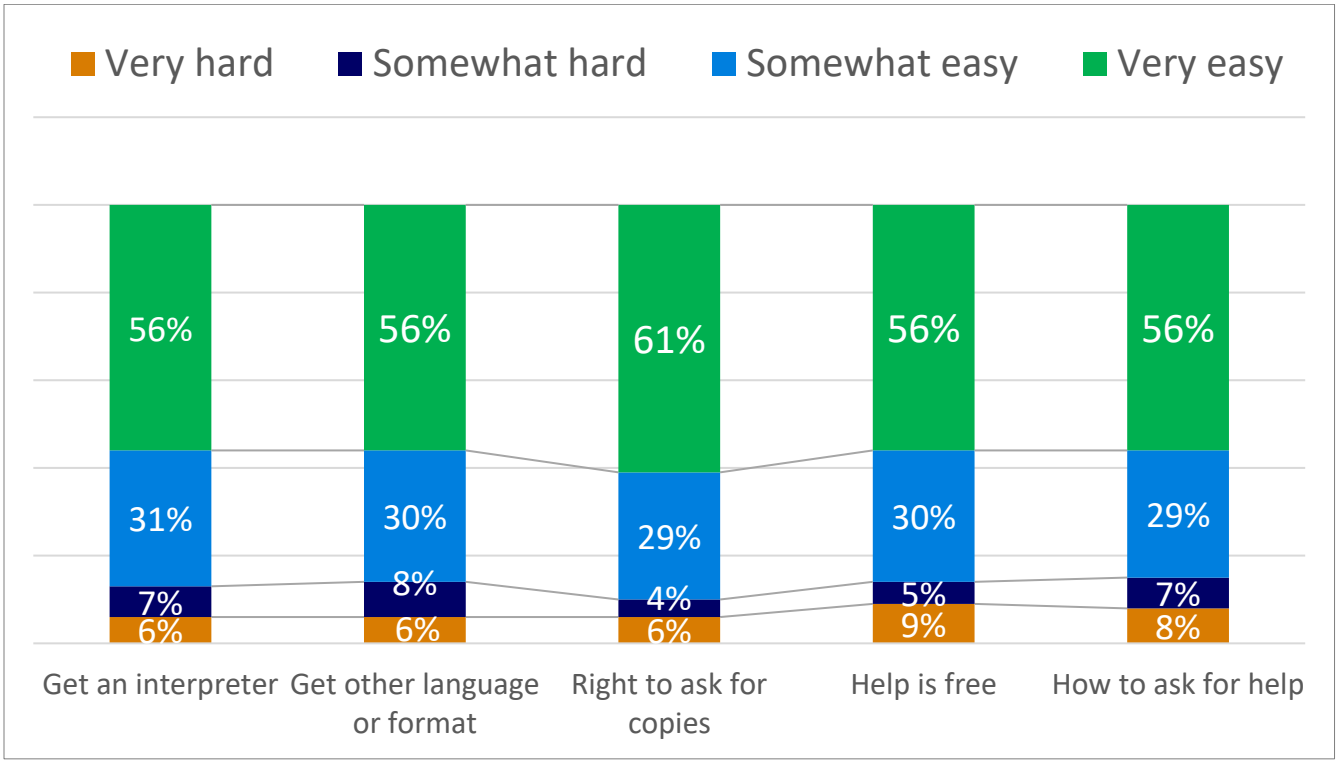
HOW EASY IS IT TO UNDERSTAND APPEALS INFORMATION?



HOW EASY IS IT TO UNDERSTAND INFORMATION ABOUT CONTINUATION OF BENEFITS?



HOW EASY IS IT TO UNDERSTAND HOW TO GET HELP?



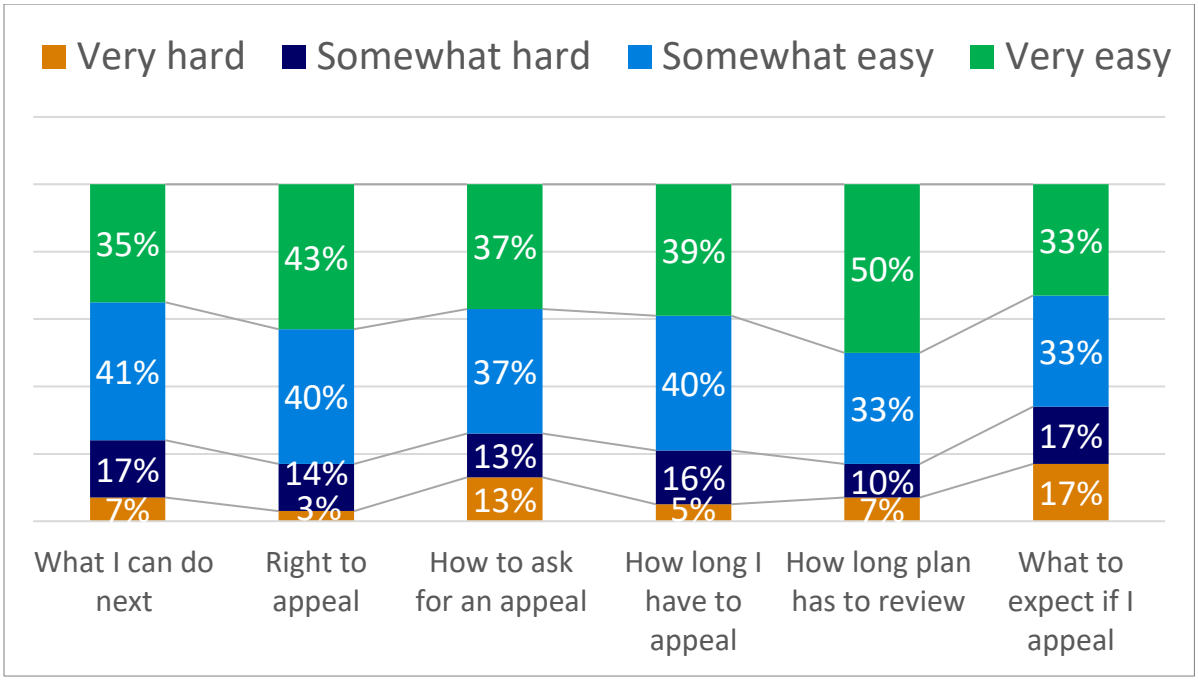
KEY POINTS IN COMMENTS

- There should be online or email options for appeals and help.
- All pertinent information should be on the first page.
- Too many words, not enough visual explanations.
- Table format is easier to understand, but still need introductory text.
- Important dates and deadlines should be more obvious.
- Add phone numbers whenever calling is mentioned.
- Include links and QR codes for rules, forms, etc.
- Include a glossary.
- Confusion about why there is so much information included.

FOCUS ON MEMBER RESPONSES

About 21% of survey respondents identified as Oregon Health Plan (OHP) members. The following responses have been filtered from the larger group to focus on member feedback about the new NOABD template.

HOW EASY IS IT TO UNDERSTAND APPEALS INFORMATION?



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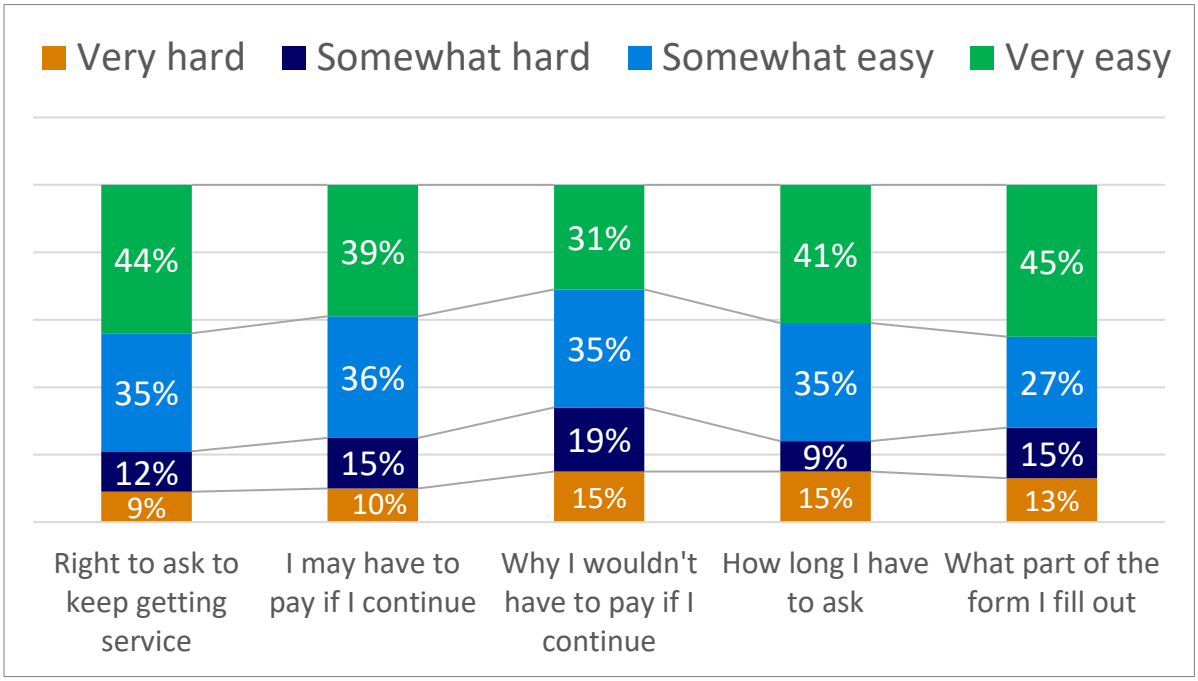

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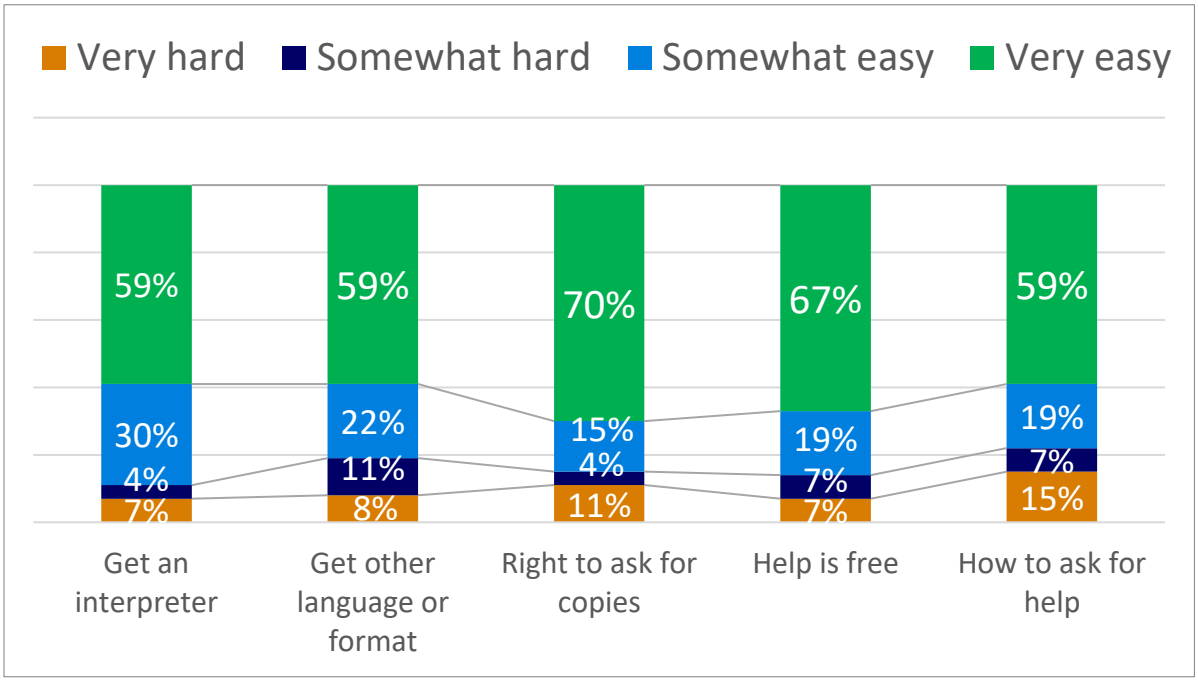

SELECT COMMENTS

The survey included opportunities to make comments, suggest changes, and ask questions in each section. The following is a selection of comments from the 196 respondents.

COMMENTS FROM OHP MEMBERS:

- "A telephone number, email (if available) and QR code should be added for easy access to contact if electronic contact is available for this."
- "Honestly without the table my eyes wanted to stop reading immediately. The first version with the table gave me the basic info I needed instantly. For rules, there should be a link to a handbook and the section it's under added along with contact information and a QR code if possible."
- "If the letter I received was just like the [survey] letter, I would not have to call being upset."
- "Am I supposed to know who my authorized representative is? Right there that's confusing. Is that someone from OHP? A family member? I have no idea. Am I expected to ask my provider to do an appeal and if so do they know how to do this? What does that conversation look like?"

OVERALL COMMENTS ABOUT FASTER APPEALS:

- "From an equity perspective, I would guess that people from marginalized or underrepresented communities may be much less comfortable requesting a 'faster appeal,' even if their need is greater.
- "Explain what to do if you miss a deadline."
- "Authorized representative might need definition."

- “Include a box that defines hearing, appeal, etc.”
- “More spacing between the bullet points; bold the phone numbers and time limits, possibly use WHO can request a fast appeal? HOW can you request a fast appeal? WHEN will you know if you are approved for a fast appeal?”

OVERALL COMMENTS ABOUT APPEAL RESOLUTION:

- “Can you indicate what kinds of records you looked at? My health records from the provider involved in the related service? Other types of records?”
- “Maybe change to “You asked us to take another look and reconsider we would pay for this service on __ by __. This letter explains what we decided about your request for us to reconsider paying for the service after the original decision we made of not to pay for this service.”
- “Mention the people reviewing are independent from those who made the original decision.”
- “Change first two sentences to ‘On x date, we got your appeal request. You wanted us to change a decision we made.’"

OVERALL COMMENTS ABOUT CONTINUED BENEFITS:

- “Some people don’t get their mail within 10 days.”
- “Screenshot box 8 page 4 [of the Request to Review form].”
- “Explain ‘if you have been getting this service.’ Does it mean up until it was just denied? got it sometime in the past? This has NEVER been clear.”
- “For many people filling out the right section is difficult. If you can color code a section. The yellow font for fast track, the blue fount for continuing service, etc.”

OVERALL COMMENTS ABOUT CLAIM DENIAL:

- “How do I know if I signed a valid waiver? Where would I go to find out?”
- “Why tell us that we might have to pay the bill, but not to pay the bill until we talk to you, when you just told us you cannot pay the bill? Should we pay a bill that we receive after we get your denial letter, or call you?”
- “If a provider tells me it is a covered service and it is not I shouldn't have to pay the bill.”
- “DO NOT PAY--THIS IS NOT A BILL. We are sending this as a courtesy (or something like this to emphasize that person does not need to pay)”

OVERALL COMMENTS ABOUT GETTING HELP:

- “Put this information at the beginning of the letter.” “How many people who need the help offered would get this far?”
- “Consider: ‘You can get free help or ask questions by calling...’ versus ‘If you need help.’”
- “Nothing in here that would address someone who has challenges with reading. What if they just want to talk to a human being who can help them navigate the process?”

- “Most of us have been on hold for up to 40 minutes on OHP customer service lines. Is there a way to leave a message? For those of us with children who need a lot of attention 40 minutes is a really long time.”
- “Include TTY information.”

CONCLUSION

The survey results contain valuable insight from Oregonians using OHP, community members, advocates, providers and other staff. Applicable comments and suggestions will be incorporated into the new templates when appropriate. Survey data will be shared for transparency and to ensure any insights captured are available to plans, partners and other stakeholders.

Thank you to all respondents, workgroup participants, and stakeholders who made this project possible.