Health First Colorado Explanation of Benefits

Background

The Department of Health Care Policy and Financing (the Department) is required to make available an explanation of benefits (EOB) to all Health First Colorado (Colorado’s Medicaid program) members. The EOBs will allow Health First Colorado members to see claims made on their behalf so they can discover and report administrative and provider errors or fraudulent claims. The EOBs must comply with federal requirements and those outlined in Senate Bill (SB) 16-120.

This document includes the following:

1. SB 16-120
2. Summary of Keystone Policy Center-led member and stakeholder engagement efforts—June 2017
3. Key Informant Interviews Summary—March 2017
4. Letter Member Testing Summary—March 2017
5. Stakeholder Meeting Summary—March 2017
6. Educational Material Messaging Member Testing Summary—May 2017

Federal Requirements

42 CFR 433.116 states individual notices must be provided, within 45 days of the payment of claims, to all or a sample group of the persons who received services under the plan.

- The notices must specify:
  - The service furnished
  - The name of the provider furnishing the service
  - The date on which the service was furnished
  - The amount of the payment made under the plan for the service
- The notices must not specify confidential services (as defined by the State) and must not be sent if the only service furnished was confidential
SB 16-120 Requirements

The EOBs must be made available to all Health First Colorado members and include:

- Name of the Health First Colorado member receiving services
- Name of the service provider
- Description of the service provided
- Billing code for the service
- Date of service or range of dates of services
- A clear statement that the EOB is not a bill but is only provided for information and to make sure the provider is only being reimbursed for services actually provided
- Information regarding at least one verbal and one written method for a Health First Colorado member to report errors
- Any other information the Department thinks is useful for discovering administrative and provider error or fraud
- The EOB is required for all acute care and long-term care services for which a provider is seeking fee-for-service reimbursement
- The Department shall develop the form and content of the EOB with Health First Colorado members and advocates to ensure members understand the EOB
- The Department shall work with Health First Colorado members and advocates to develop educational materials for the Department’s public website and for distribution by advocacy and non-profit organizations that explains the error reporting process and encourages Health First Colorado members to report errors
- The Department shall make EOBs available to Health First Colorado members not less frequently than once every two months, if the member received services during that time period
- The Department shall determine the most cost-effective way to produce and distribute the EOBs to Health First Colorado members
  - This may include email or web-based distribution
  - The Department has the flexibility to determine if EOBs are mailed by request only
  - The Department may include the EOBs with existing mailings or existing electronic communications
  - The Department is not required to produce a new EOB form or platform if the information required to be in the EOBs is already included in another format that is understandable to the Health First Colorado member

Launch

Due to the extension of the interChange system go-live, the EOBs that comply with SB 16-120 will not be available beginning July 1, 2017. Once launched, the EOBs will be
available in the interChange Member Portal. The Department is working to identify a launch date for the Member Portal and the SB 16-120 mandated EOBs.

The Department is also currently working to resolve policy, system and operational issues identified through internal workgroups and stakeholder engagement as they relate to the implementation of SB 16-120. Additionally, the Department is working with the Centers for Medicare and Medicaid Services on federal approvals.

As required by SB 16-120, the Department has developed a draft EOB letter and educational material messaging that include member and stakeholder feedback. Following the resolution of the identified policy, system and operational issues, additional updates may be made to the draft EOB letter and educational material messaging and resources.

As information becomes known, updates on the EOBs and information on the launch timing of the new Member Portal will be posted on Colorado.gov/hcpf.
SENATE BILL 16-120

BY SENATOR(S) Roberts, Crowder, Grantham, Jahn, Kefalas, Lambert, Lundberg, Martinez Humenik;
also REPRESENTATIVE(S) Coram, Arndt, Court, Danielson, Lontine, Ryden, Young.

CONCERNING PROVIDING AN EXPLANATION OF BENEFITS TO MEDICAID RECIPIENTS FOR PURPOSES OF DISCOVERING POTENTIAL MEDICAID FRAUD, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, add 25.5-4-300.9 as follows:

25.5-4-300.9. Explanation of benefits - medicaid recipients - legislative declaration. (1) (a) THE GENERAL ASSEMBLY FINDS AND DECLARES THAT:

(I) COLORADO'S MEDICAID PROGRAM PROVIDES CRITICAL MEDICAL SERVICES TO THE STATE'S POOREST AND MOST VULNERABLE RESIDENTS;

(II) FUNDING FOR THESE SERVICES IS PROVIDED THROUGH A

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.
FINANCIAL PARTNERSHIP BETWEEN COLORADO AND THE FEDERAL GOVERNMENT;

(III) For the 2015-16 state budget year, the General Assembly appropriated $8,891,000,000 for Colorado's Medicaid program, of which $2,508,000,000 is from the General Fund and $677,000,000 is from the Hospital Provider Fee, with the remainder from Federal money;

(IV) It is in the best interest of Colorado to do everything possible to minimize error, inefficiency, and fraud in providing Medicaid services to ensure the long-term viability of this safety net program;

(V) In the private sector, as well as the Medicare program, insurers routinely provide an explanation of benefits to their clients, listing claims submitted by providers for services rendered to the client even when the insurer is not seeking a co-payment for the service and the provider is not claiming an amount due from the client;

(VI) While creating an explanation of benefits is not without cost to the health care system, only the client receiving medical services or his or her authorized representative is in the position to verify whether the claimed medical services were actually provided and for whom they were provided, which is a necessary first step in containing health care costs;

(VII) While Medicaid clients may not appear to be affected financially by billing errors or fraudulent claims, Medicaid clients who rely on these services for survival and independence are most severely affected by the inappropriate use of scarce resources; and

(VIII) Further, Medicaid clients and Medicaid advocates for low-income and vulnerable Coloradans want the opportunity to partner with the State Department and providers to ensure a well-run and fraud-free Medicaid program in Colorado.

(b) Therefore, the General Assembly declares that
CREATING AN EXPLANATION OF BENEFITS FOR RECIPIENTS OF MEDICAID-FUNDED SERVICES IS A NECESSARY STEP IN MANAGING THE STATE'S MEDICAID PROGRAM AND IN SAFEGUARDING THE SIGNIFICANT PUBLIC INVESTMENT, BOTH STATE AND FEDERAL, IN MEETING THE HEALTH CARE NEEDS OF LOW-INCOME AND VULNERABLE COLORADANS.

(2) By or before July 1, 2017, the state department shall develop and implement an explanation of benefits for recipients of medical services pursuant to articles 4 to 6 of this title. The purpose of the explanation of benefits is to inform a Medicaid client of a claim for reimbursement made for services provided to the client or on his or her behalf, so that the client may discover and report administrative or provider errors or fraudulent claims for reimbursement.

(3) The explanation of benefits is required for all acute and long-term care services for which a provider is seeking reimbursement under a fee-for-service model.

(4) The explanation of benefits must include, at a minimum:

(a) The name of the Medicaid client receiving the service;

(b) The name of the service provider;

(c) A description of the service provided;

(d) The billing code for the service;

(e) The date of service, or range of dates for services, if multiple services are provided in a set period of time, such as personal care services;

(f) A clear statement to the Medicaid client that the explanation of benefits is not a bill, but is only provided for the client's information and to make sure that a provider is being reimbursed only for services actually provided;

(g) Information regarding at least one verbal and one written method for the Medicaid client to report errors in the explanatory statement.

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EXPLANATION OF BENEFITS THAT ARE RELEVANT TO PROVIDER
REIMBURSEMENT; AND

(h) ANY OTHER INFORMATION THAT THE STATE DEPARTMENT
DETERMINES IS USEFUL TO THE MEDICAID CLIENT OR FOR PURPOSES OF
DISCOVERING ADMINISTRATIVE OR PROVIDER ERROR OR FRAUD.

(5) THE STATE DEPARTMENT SHALL DEVELOP THE FORM AND
CONTENT OF THE EXPLANATION OF BENEFITS IN CONJUNCTION WITH
MEDICAID CLIENTS AND MEDICAID ADVOCATES TO ENSURE THAT MEDICAID
CLIENTS UNDERSTAND THE INFORMATION PROVIDED AND THE PURPOSE OF
THE EXPLANATION OF BENEFITS. THE STATE DEPARTMENT SHALL ALSO
WORK WITH MEDICAID CLIENTS AND MEDICAID ADVOCATES TO DEVELOP
EDUCATIONAL MATERIALS FOR THE STATE DEPARTMENT'S WEBSITE AND FOR
DISTRIBUTION BY ADVOCACY AND NONPROFIT ORGANIZATIONS THAT
EXPLAIN THE PROCESS FOR REPORTING ERRORS AND ENCOURAGE CLIENTS
TO TAKE RESPONSIBILITY FOR REPORTING ERRORS.

(6) THE STATE DEPARTMENT SHALL PROVIDE THE EXPLANATION OF
BENEFITS TO A MEDICAID CLIENT NOT LESS FREQUENTLY THAN ONCE EVERY
TWO MONTHS, IF SERVICES HAVE BEEN PROVIDED TO OR ON BEHALF OF THE
CLIENT DURING THAT TIME PERIOD. THE STATE DEPARTMENT SHALL
DETERMINE THE MOST COST-EFFECTIVE MEANS FOR PRODUCING AND
DISTRIBUTING THE EXPLANATION OF BENEFITS TO MEDICAID CLIENTS, WHICH
MAY INCLUDE E-MAIL OR WEB-BASED DISTRIBUTION, WITH MAILED COPIES
BY REQUEST ONLY. FURTHER, THE STATE DEPARTMENT MAY INCLUDE THE
EXPLANATION OF BENEFITS WITH AN EXISTING MAILING OR EXISTING
ELECTRONIC OR WEB-BASED COMMUNICATION TO MEDICAID CLIENTS.

(7) NOTHING IN THIS SECTION REQUIRES THE STATE DEPARTMENT TO
PRODUCE AN EXPLANATION OF BENEFITS FORM IF THE INFORMATION
REQUIRED TO BE INCLUDED IN THE EXPLANATION OF BENEFITS PURSUANT TO
SUBSECTION (4) OF THIS SECTION IS ALREADY INCLUDED IN ANOTHER
FORMAT THAT IS UNDERSTANDABLE TO THE MEDICAID CLIENT.

SECTION 2. Appropriation. (1) For the 2016-17 state fiscal year,
$38,800 is appropriated to the department of health care policy and
financing for use by the executive director's office. This appropriation
consists of $35,350 from the general fund and $3,450 from the hospital
provider fee cash fund created in section 25.5-4-402.3 (4) (a), C.R.S. To

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implement this act, the office may use this appropriation as follows:

   (a) $25,000 general fund for general professional services and special projects; and

   (b) $13,800, which consists of $10,350 from the general fund that is subject to the "(M)" notation as defined in the annual general appropriation act for the same fiscal year and $3,450 from the hospital provider fee cash fund, for Medicaid management information system maintenance and projects.

   (2) For the 2016-17 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive $149,200 in federal funds to implement this act. The appropriation in subsection (1) of this section is based on the assumption that the department will receive this amount of federal funds to be used as follows:

   (a) $25,000 for general professional services and special projects; and

   (b) $124,200 for Medicaid management information system maintenance and projects.

   SECTION 3. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 10, 2016, if adjournment sine die is on May 11, 2016); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take effect unless
approved by the people at the general election to be held in November 2016 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

Bill L. Cadman  
PRESIDENT OF THE SENATE

Dickey Lee Hullinghorst  
SPEAKER OF THE HOUSE OF REPRESENTATIVES

Effie Ameen  
SECRETARY OF THE SENATE

Marilyn Eddins  
CHIEF CLERK OF THE HOUSE OF REPRESENTATIVES

APPROVED 3:42 PM 6/8/16

John Hickenlooper  
GOVERNOR OF THE STATE OF COLORADO
Summary of Health First Colorado Members and Stakeholder Feedback
May 2017

The Keystone Policy Center (Keystone), a Colorado-based organization with over 40 years of experience working in stakeholder engagement and facilitation, worked with the Department on member and stakeholder engagement that informed the development of the Explanation of Benefits (EOB) letter and the educational materials that will accompany it.

Between February and May 2017, Keystone interviewed four stakeholders, held a meeting with over two dozen advocates and other stakeholders, and tested the EOB and educational materials with 37 Health First Colorado members in five communities, about a third of whom identified as having a physical, intellectual, or developmental disability. The Department also shared the EOB letter with the Member Experience Advisory Council in March.

Stakeholder feedback from the four interviews and the stakeholder meeting focused on high-level observations and concerns. Overall, the stakeholders representing the long-term care and disability communities were encouraged by the development of the EOB, and believed their constituencies would be eager to review information that helps support the Health First Colorado program. Their concerns focused on the best ways to make the EOB clear and accessible for all Health First Colorado members, including using clear, consistent layperson language in both the EOB and all educational materials. Other stakeholders expressed concerns about confidentiality and how confidential services would be defined. Some suggested that the Department make clear which services are included in the EOB and which are not. As the EOB and educational materials are rolled out, stakeholders emphasized the importance of using a number of different communication tools, and working with stakeholders, advocates, and providers to make sure they can adequately support members.

Most Health First Colorado members found the EOB letter easy to read and understood what it was asking them to do. The most common description used for the letter was “self-explanatory.” Over 90 percent of all stakeholders interviewed said that they would contact the Department if they saw an error. Confusion about the EOB letter focused on terms of art, like “claim number,” “billing code,” and “billing provider.”

Members provided very positive feedback about the educational materials, which comprised frequently asked questions and a glossary of terms, language from
which can be adapted to other kinds of communication materials. While some members found the FAQ and glossary to be long, they said that they liked the clear and simple language and the thoroughness of the document. As one member stated, “It's a lot of information, but it's all helpful information.” One member offered constructive suggestions to improve the wording of the document, much of which will be incorporated into the final materials.

Additional enhancements to the EOB letter and educational materials have focused on language consistency and clarity by limiting jargon, using layperson terms, and adding details in the educational materials; making clear that members will not get in trouble if they report an error; and clarifying that the letter does not obligate members to do anything, but that their feedback is helpful.

Both members and stakeholders encouraged the Department to make the documents available in multiple languages, and to have a dynamic approach to updating both the EOB letter and the accompanying educational materials so that feedback is incorporated as members begin engaging with and asking questions about the documents.

Detailed summaries of the feedback received in stakeholder interviews, the stakeholder meeting, and all member testing are included as attachments.
Health First Colorado Explanation of Benefits
Summary of Key Informant Interviews
March 2017

Background
The Keystone Policy Center (Keystone), a Colorado-based organization with over 40 years of experience working in stakeholder engagement and facilitation, is working with Department of Health Care Policy and Financing (the Department) on member and stakeholder engagement for development of an Explanation of Benefits (EOB) for Health First Colorado (Colorado’s Medicaid Program) members. Last year, the Colorado General Assembly passed SB16-120, which requires the Department to make such a document available beginning July 1, 2017, with the narrow purpose of identifying possible provider fraud, waste, and abuse.

As part of the implementation requirements, the Department was required to develop the EOB and supporting educational materials in conjunction with Health First Colorado members and other key stakeholders to ensure that members understand the information provided in the EOB and its purpose. The member and stakeholder engagement process will inform edits to the EOB and the development of the educational materials that accompany it.

Methodology
In February 2017, Keystone interviewed four key stakeholders recommended by the Department: Ashley Wheeland, Legislative and Political Director, Planned Parenthood; Julie Reiskin, Executive Director, Colorado Cross-Disability Coalition; Debra Judy, Policy Director, Colorado Consumer Health Initiative; and Elisabeth Arenales, Director of Health Program, Colorado Center on Law and Policy. Stakeholders did not review a draft EOB; rather, to keep the discussions high-level, Keystone focused its questions on the elements interviewees wanted to see in the EOBs, along with their concerns about the EOB. A complete list of key informant questions is available in Appendix A. The interviews lasted 30-60 minutes.

Stakeholder Feedback
Keystone asked stakeholders for feedback on the important elements of the EOB; concerns they had about the document; the value of including costs in the document; Health First Colorado member incentive for reviewing the EOBs; and strategies and messages for educating Health First Colorado members about the EOBs. Most of the stakeholders expressed views narrowly focused on the communities for which they advocate.

Key Elements of EOB
Keystone asked stakeholders about the key elements they would like to see reflected in the EOBs. When it comes to the format and the elements of the EOB, all of the stakeholders emphasized the importance of making the EOBs simple and accessible, using plain language and providing a clear explanation of why the EOB was sent. Reiskin suggested the basic information that should be included: provider name, date, type of service, and cost. When it comes to the layout of the EOB, Judy encouraged consideration of the most useful ways to bundle the services listed, to limit confusion about services that were provided in the same visit. Judy
indicated it would be useful for a long-term care Health First Colorado member to be able to track where they are with respect to the limitations on their benefits.

To help members understand what is being asked of them by the EOB, Arenales encouraged a simple explanation of what to do if the services were not received; Wheeland said that it should be clear to members exactly who they are contacting with a concern (i.e., will concerns go to the provider or to the Department?). Arenales also suggested making it absolutely clear that members are not required to take any action because they have received an EOB, saying that the Department should make clear that the document is information only (e.g., “It is important for the Department to account for the services that were submitted to us. You are not obligated to respond to this.”).

Finally, two stakeholders suggested other EOBs to use for examples of clarity. Judy noted that the Division of Insurance recently went through a similar stakeholder process in response to regulation 4-2-35, and suggested that EOBs be consistent across these different health groups. Arenales noted that in the private insurance realm, Rocky Mountain Health Plan’s EOB is clear and could provide good guidance.

Concerns about the EOB
Stakeholder concerns about the EOB focused on confidentiality and possible provider retaliation. Wheeland and her Planned Parenthood colleagues were extremely concerned about confidentiality, and encouraged the Department to make Planned Parenthood a confidential provider if possible. They also suggested an option for Health First Colorado members to suppress their own EOBs by choice. Wheeland wanted to make sure that sensitive services performed at Planned Parenthood never appear on an EOB, especially for minors or others who may not be the head of household for their Health First Colorado account. She suggested that SB 16-120 may be looking for a problem that does not exist in Health First Colorado in the same way it does for Medicare, and that the implementation of the bill is not worth putting minors and other vulnerable people at risk. Further, she wondered about the Department’s administrative capacity to fix billing errors (e.g., is it worth it for the Department to correct a double billing for a very small charge?).

Judy was similarly concerned about confidentiality, especially for dependent children. She expressed concerns about ensuring that services related to prenatal care, sexually transmitted diseases, family planning, mental health, transgender hormone therapy and surgeries, substance use, domestic violence, sexual assault, and sexual abuse screening or testing, along with drugs associated with these conditions or services, are kept confidential.

Arenales feared that members might worry about getting their doctors in trouble or that they might be punished if their reports are not anonymous. She encouraged the Department to clearly communicate that providers are not allowed to retaliate. Arenales was also concerned that members with questions would be directed to the customer service phone line, which historically requires a very long wait.
**Amount Paid to Provider**

Keystone asked stakeholders for their input on the including the amount paid by Health First Colorado to the provider in the EOB. Reiskin and Arenales were supportive of including the amount paid, so long as the difference between the cost of the service and the reimbursement rate is made clear. Reiskin said that seeing the amount of money paid for a service might help Health First Colorado members feel more accountable for their own care, could better educate them on the cost of services, and may even lead them to make different decisions about their care. Arenales noted that it could be valuable to use the EOBs to show both what the Health First Colorado program paid to the provider and what the Health First Colorado member paid to the provider in the form of a co-pay. Regardless, both stakeholders encouraged this section to be very clear, since many Health First Colorado members will not be accustomed to reviewing this kind of information.

Judy, however, expressed concern that including a dollar amount on the EOB could confuse consumers, especially because the reimbursement rate may not accurately reflect the cost of a service, or make consumers think the EOB is a bill. She suggested that any information related to reimbursement be put in educational materials instead. She also suggested that the Department train providers to talk to members about the cost of their care, rather than trying to provide this education through an EOB.

**Incentivizing Member Review of EOB**

Keystone asked about the best ways to incentivize member review and follow-up on the EOBs, when action is not technically required. Reiskin and Arenales believe that helping identify fraud, or any kind of erroneous billing in the name of Health First Colorado member, will be good incentive, especially for those in the disability community. Both also agreed that an EOB will be useful for helping Health First Colorado members keep track of their own care.

Judy was skeptical about the value of the EOB for those members who are not in the disability community, and thus was concerned about motivating those members to go into the portal to look at their EOBs.

**Communication and Educational Materials**

Keystone also sought feedback on the important messages for communication about the EOBs and the educational materials that will accompany them. Stakeholders emphasized the importance of clarity – in language and a format that makes use of white space, colors, graphics, and charts – and a friendly tone in the EOB and educational materials (e.g., “We see our clients as partners; we’re in this together. We want to keep the program and make it better and stronger. Any response you give will not affect your benefits.”). They also encouraged making the connection between these EOBs and the kind of EOBs used in private insurance, as a way of ensuring that patients understand the benefits and services they received.

Wheeland suggested that Keystone and the Department to work with key stakeholders (advocacy organizations, providers, counties, single entry points, community center boards, Regional Care Collaborative Organizations, case managers for the long-term care systems, and customer service and accessibility staff) on communication about the EOB, given that many
Health First Colorado members will turn to their advocacy organizations or providers for help with the EOB first.

Stakeholders agreed that an FAQ document would be a valuable educational material, and encouraged including the following questions:

- How do I request a paper copy of my EOB?
- Why is the provider listed different than the doctor I saw?
- Will my provider know if I called in?
- What is the investigative process after a call is made?
- Will there be any follow up after I submit a concern?

Arenales suggested embedding an FAQ hyperlink in the actual EOB document, since the EOB document will be electronic. Wheeland suggested that a glossary of the terms used in the EOB would also be helpful.

The stakeholders encouraged the use of a variety of communication channels, including emails, texts, Facebook, and newsletters. Wheeland emphasized the important of making the EOB accessible on a mobile device.

**Summary**

Overall, the stakeholders representing the long-term care and disability communities were encouraged by the development of the EOB, and believed their constituencies would be eager to review information that helps support the Health First Colorado program. Their concerns focused on the best ways to make the EOB clear and accessible for all Health First Colorado members. However, Planned Parenthood, and to a lesser extent the stakeholders from Colorado Consumer Health Initiative, expressed significant concerns about confidentiality, and wanted to ensure that vulnerable populations are not put at risk in order to implement SB16-120.

All explicit recommendations are documented in Appendix B.
Appendix A: Key Informant Interview Questions

1. What elements do you think are most important to be reflected in the EOB?
2. What concerns do you have about the EOB?
3. What specific components of the EOB are you comfortable with?
   a. Are there particular components that you especially appreciate?
4. Are there components of the EOB that you are not comfortable with?
   a. Do you have suggestions to remedy these concerns?
5. The EOBs will be accompanied by educational materials and a communications toolkit that may include a brochure, a flyer, website content, social media posts, and an e-newsletter. Is there any guidance we should be sure to address in these materials?
6. Is there anything we have not asked you about that you would like to share with us?
7. After the feedback from the key informants and the members is synthesized, we will hold a stakeholder meeting (with 15-30 people) to present feedback and an updated EOB to solicit additional comments. Can you suggest any other stakeholders who should be invited to that meeting?
Appendix B: Stakeholder Suggestions

The EOB should:

• Be simple and accessible
• Use plain language and a friendly tone
• Make use of white space, colors, and graphics
• Include provider name, date, type of service, and cost (including both the amount reimbursed by Health First Colorado and the copay paid by the member)
• Bundle services by visit for clarity
• Provide information that can help the long-term care population track their benefit limitations
• Explain what an individual can do if they did not receive the services listed on their EOB, but make clear that no action is required
• Make clear that providers cannot retaliate

Suggestions or concerns related to the EOB:

• Protect confidential information by ensuring that confidential services do not appear on an EOB, and/or that certain providers are confidential, and/or that members have the option to suppress certain EOBs.
• Make sure the EOB is consistent with the EOB recently developed by the Division of Insurance.
• Look to private insurance for good examples of clear EOBs.

Suggestions related to educational materials and communication:

• Information about reimbursement should be included in educational materials, not on the actual EOB.
• Draw a comparison between the Health First Colorado EOBs and the EOBs used to help patients account for services in private insurance.
• Develop an FAQ and a glossary of terms and link to them in the EOB.
• Work with key stakeholder organizations on communication about the EOBs.
• Utilize various communication methods.
• Ensure that EOBs are accessible on mobile devices.
Development of a Health First Colorado Explanation of Benefits
Summary of Member Testing on Draft EOBs
March 2017

Background
The Keystone Policy Center (Keystone), a Colorado-based organization with over 40 years of experience working in stakeholder engagement and facilitation, is working with Department of Health Care Policy and Financing (the Department) on member and stakeholder engagement for development of an Explanation of Benefits (EOB or EOB letter) for Health First Colorado (Colorado’s Medicaid Program) members. Last year, the Colorado General Assembly passed SB16-120, which requires the Department to make such a document available beginning July 1, 2017, with the narrow purpose of identifying possible provider fraud, waste, and abuse.

As part of the implementation requirements, the Department was required to develop the EOB and supporting educational materials in conjunction with Health First Colorado members and other key stakeholders to ensure that members understand the information provided in the EOB and its purpose. The member and stakeholder engagement process will inform edits to the EOB and the development of the educational materials that accompany it.

Member Testing Methodology
Between February 15 and March 9, 2017, Keystone visited five sites across the state to conduct member testing on the draft EOB letter with Health First Colorado members. Keystone interviewed 27 members total in Colorado Springs, Lamar, Rifle, Littleton, and Denver. The members represented a diverse cross section of ages and genders, and 25 percent of those interviewed identified as having a physical, intellectual, or developmental disability. The complete questionnaire is available in Appendix A, and select additional demographic information about the members interviewed is included in Appendix B.

During the 15-30 minute interviews, Keystone provided the Health First Colorado members with the draft EOB letter and asked them a series of questions about their understanding of the document. A complete script is included as Appendix C.

Below, member feedback is summarized first by location and then for all locations taken together. The detailed responses from each location are provided in Appendix D.

Colorado Springs
The five Health First Colorado members interviewed in Colorado Springs found the EOB to be clear, accessible, and easy to read. They understood most elements of the document, as well as the purpose of the document and their options if they saw an error. All of them said that they would contact Health First Colorado if they received such an EOB letter and saw services listed that they did not actually receive.

Two members did not understand who the document was from. All members were confused about the meaning of “billing provider.” Most did not accurately distinguish how to contact
Health First Colorado for questions from how to contact Health First Colorado because of an error listed in the services. While all members interviewed understood their options for action if they received the document, most did believe that there was an obligation or requirement to read the document and contact the Department if there was an error.

Several members recognized that some Health First Colorado recipients would be nervous if they received a document like this. One emphasized that the Department should make it clear that the members will not be getting in trouble, and that they are helping the Health First Colorado program. One member found the legal information at the end of the document to be confusing.

**Sample Quotes**
- “This looks self-explanatory.”
- “This is really helpful and nicely laid out in a chart. It looks easier than other forms.”
- “Knowing the cost might make us respect it a little more.”
- “People might worry that their doctor might get in trouble, or be afraid that they will lose something.”
- “I don’t like it when things are wrong. I like to have all my ducks in a row.”

**Lamar**
The six Health First Colorado members interviewed in Lamar found the EOB to be clear, accessible, and easy to read. They understood most elements of the document, as well as the purpose of the document and their options if they saw an error. All of them said that they would contact Health First Colorado if they received such an EOB letter and saw services listed that they did not actually receive.

Four of the six members interviewed did not understand what the billing provider was. While all members interviewed understood their options for action if they received the document, two believed there was an obligation or requirement to read the document and contact the Department if there was an error. Two members believed that if there was an error in their EOB, it would mean that someone had stolen their identity.

Several of the members in Lamar said that they would be motivated to report errors because they do not want anyone to be taking advantage of the Health First Colorado program.

**Sample Quotes**
- “I like the size of the print; it doesn’t look hard to read and gives a good first impression.”
- “They want to know if this information is true.”
- “I would be afraid someone was using my identity.”
- “I don’t want someone to pay for this if didn’t receive care. This has been a lifesaver for me.”
- “It is good that you are doing this. It’s aligned with what is happening in private insurance.”
Rifle
The five Health First Colorado members interviewed in Rifle found the EOB to be clear, accessible, and easy to read. Two of the members did not understand who the document was from or why they were receiving it. More than one member was confused about the meaning of billing provider, claim number, billing codes, and amounts paid. Still, all understood whom to contact if there was an error with their EOB, and all said that they would contact Health First Colorado if there was an error.

Three members worried that they might be penalized, get in trouble, or be required to pay because of an error.

Sample Quotes

- “I would wonder, ‘What the heck is this?’ but once I scanned through it I would see that it covers things pretty well.”
- “Someone might be using my Medicaid number; I don’t want to be penalized.”
- “It is fraud and I don’t want to get in trouble.”
- “This can all be overwhelming, but this document was not. I often receive documents and worry ‘Oh no, what do I owe?’.”

Littleton
All three Health First Colorado members interviewed in Littleton used a screen reader to review the EOB document. All of them said they would read the document and understood who it was from, though one did not understand why they were receiving it. They understood most elements of the document, as well as what was being asked of them and their options if they saw an error. Two of the three said that they would contact Health First Colorado if they received such an EOB letter and saw services listed that they did not actually receive.

All members could navigate the document using the screen reader, but one suggested that they would prefer to read the document in Braille, and that it should be made clearer that a Braille copy would be available. The members said that the table in the EOB document might be difficult to navigate for individuals less experienced with a screen reader, but that the table was still the best way to lay out the elements related to the services received.

Sample Quotes

- “The table would be challenging for someone who wasn’t as familiar with screen readers.”
- “I hate contacting people, but Medicaid might stop paying. I would only call if this was really urgent.”
- “I’m getting free healthcare, and if money is getting spent wrong, I won’t want that.”
Denver
One of the eight Health First Colorado members interviewed in Denver used a screen reader on their phone to read the document, and Keystone staff read the document out loud to one person. Of the eight members, six said that they would read the document and seven understood that it was from Health First Colorado. Only two, however, understood why they were receiving the EOB. When asked about why they were receiving it, most referenced the specific client testing scenario – “To have us evaluate and see how accessible it is.” – or the broader purpose of Health First Colorado – “So you can live on your own and have rides and people come in to help you.”

Most of the members understood the different elements of the chart, but no one understood what the claim number referred to. Most of the members understood their options if there was an error, but no one knew what information they needed to provide if they reported an error. Only half understood who to call with questions about the form. Still, all members said that they would contact Health First Colorado if there was an error; several mentioned that that they wanted to make sure that the program was being charged appropriately.

Sample Quotes
- “This is about the best document I’ve ever seen.”
- “You can call, email, get online if there is suspected fraud. There is a lot of great information on here as far as contacts.”
- “I would call maybe Medicaid or my clinic. But I wouldn’t know how to contact Medicaid, because I only know my doctor.”
- “I wouldn’t want the state to be charged for something I didn’t receive – that’s fraud.”
- “If there was an error, I may have taken from someone who needs services. That’s taking away from a system in place to help people who need it.”
- “If you pay part of a bill you can get in trouble because they will know you can pay and then they will kick you off Medicaid.”

Summary of Feedback from All Locations and Planned Incorporation of Feedback
Across all locations, most members said they would read the document (93 percent) and that it looked easy to read (85 percent). Those using screen readers flagged possible challenges in navigating the chart embedded in the EOB, and suggested making clear that Braille copies would be available to members who requested them. Most members also understood that the document was from Health First Colorado (81 percent) and two-thirds understood that they were receiving the document so that they could review the services for which Health First Colorado paid on their behalf. Many described the letter as “self-explanatory.”

Almost all members (85 percent or more) understood the sections of the EOB that referred to their service date(s), the list of providers, the billing code, the description of services, and the amount that Health First Colorado paid. But fewer than half of members understood to what the billing provider or claim number referred.
Most members (93 percent) understood that they were being asked to review the EOB letter, but most also believed that they were obligated to report errors with the letter, which is not accurate. Most understood how to contact Health First Colorado if there was an error or if they had a question, and almost every member (96 percent) said they would contact Health First Colorado if they received such a letter and found an error. Several members expressed a desire to help Health First Colorado ensure that resources are not being wasted. Others, however, worried that they or their doctor might get in trouble or that they might lose services if they reported an error. Few of the members interviewed focused on the fact that the letters were designed to help identify fraud.

Based on this feedback, Keystone has identified the following key updates to the EOB letter:
- Add a sentence on the purpose of the letter as it relates to fraud, waste, and abuse
- Clarify that there is no obligation to do anything with the letter, even if there is an error
- Clarify that Braille copies are available.

In addition, Keystone identified several priorities for the educational and communications materials that will be developed to support the EOB letter:
- Background information on the purpose of the letter.
- Additional explanation of the terms used in the letter.
- Information on how Health First Colorado determines what to reimburse.
- Information about what might happen after a member reports services they did not receive, including that retaliation is illegal.

Next Steps
Keystone will present the summarized feedback from the member testing at a stakeholder meeting on March 20. Together with the feedback from stakeholder interviews and from the stakeholder meeting, as well as the feedback from member testing of the Spanish language version of the letter, Keystone will work with the Department to make updates to the EOB letter and develop draft educational materials, which will also be tested with members. The final EOB letter, educational materials, and communication toolkit will be finalized by July 1, 2017.
Appendix A: Demographic Questionnaire

Please tell us about yourself. Your answers are anonymous and confidential.

1. What benefit programs are you enrolled in? Please check all that apply.
   - □ Health First Colorado (Colorado’s Medicaid Program)
   - □ Health First Colorado (Colorado’s Medicaid Program) Long Term Care & Waiver Programs
   - □ Health First Colorado (Colorado’s Medicaid Program) Medicaid Buy-In for Adults
   - □ Health First Colorado (Colorado’s Medicaid Program) Medicaid Buy-In for Kids
   - □ Other __________________________

2. Are you or anyone in your household the following? Please check all that apply.
   - □ Adult without dependent children
   - □ Parent of dependent children
   - □ Pregnant woman
   - □ Currently receiving both Health First Colorado and Medicare
   - □ Individual with physical, intellectual or developmental disability

3. Where do you go for help about your benefits? Please check all that apply.
   - □ Local County Department of Human/Social Services
   - □ Application Assistance Site
   - □ Health Clinic or Hospital
   - □ Health First Colorado Member Contact Center
   - □ Colorado.gov/PEAK
   - □ PEAKHealth Mobile App
   - □ Other __________________________

4. Age?
   - □ Under 18 years old
   - □ 18-24 years old
   - □ 25-34 years old
   - □ 35-44 years old
   - □ 45-54 years old
   - □ 55-64 years old
   - □ Over 65 years old

5. Gender?

6. County you live in:
Appendix B: Select Demographic Detail about Member Interviewees

*Note: All details were self-reported.*

<table>
<thead>
<tr>
<th>City</th>
<th>Interviewees</th>
<th>18-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
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<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Lamar</td>
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<td>2</td>
<td>3</td>
<td>0</td>
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<td>1</td>
</tr>
<tr>
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<td>0</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Littleton</td>
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<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Denver</td>
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<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>27</strong></td>
<td><strong>5</strong></td>
<td><strong>9</strong></td>
<td><strong>4</strong></td>
<td><strong>6</strong></td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>Interviewees</th>
<th>Male/Female</th>
<th>HFC &amp; Medicare</th>
<th>Disability</th>
<th>Screen Reader</th>
<th>Parent of Dependent Children</th>
<th>Adult w/o Dependent Children</th>
<th>Pregnant Woman</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO Springs</td>
<td>5</td>
<td>3/2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Lamar</td>
<td>6</td>
<td>0/6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Rifle</td>
<td>5</td>
<td>1/4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Littleton</td>
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<td>1/2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Denver</td>
<td>8</td>
<td>3/5</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>27</strong></td>
<td><strong>8/19</strong></td>
<td><strong>5</strong></td>
<td><strong>7</strong></td>
<td><strong>4</strong></td>
<td><strong>13</strong></td>
<td><strong>9</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>
Appendix C: Member Testing Interview Guide

Approach

- We will conduct usability testing, meaning we will test if people can read, understand, and use the content in our sample Explanation of Benefits. We will also explore effective communication pathways and educational materials needed.

Goals

- Can participants read and understand the draft Explanation of Benefits?
  - Do participants understand who sent the EOB?
  - Do participants understand the purpose of the EOB?
  - Do participants understand key messages in the EOB?
    - That the EOB is not a bill
    - What is listed in the EOB?
    - Why they are receiving the EOB?
  - Do participants understand what actions are needed?
    - The request to review the EOB for accuracy
    - The request to contact Health First Colorado if they did not receive any of the services listed
- What are the areas of confusion (if any)?
- Are the notices accessible?
Introduction

Thank you for participating in today’s testing. My name is ______________________________. I am working with the Medicaid program to make sure a new document they are developing is easy to understand. Today we’re going to look at a sample of that new document, which will be used to help identify fraud, waste, and abuse in the Medicaid program. We want to make these documents the best they can be for people who will get them.

Soon, I am going to hand you a document and ask you to read parts of the document and answer questions. As we go, I’d like you to think out loud as much as possible. Anything you say will help us. And don’t worry about getting something wrong. Your answers will help us learn how to make the documents better. We need your honest reactions. The more you tell me, the more it will help us to make the documents the best they can be.

We’ll be here for about an hour, and I’ll be taking notes as we go. If you need to take a break at any time, just tell me. If you have any questions, just ask. I may not be able to answer right away, because we are interested in what happens when people don’t have someone sitting next to them to help, but if you still have questions when we’re finished, I’ll try to answer them. Remember, we’re testing the documents, not you. So whatever happens as we look at them will help us.

At the end of our time together today, we’ll give you $25 for your time and participation. We’ll ask you to sign a receipt, but we won’t use your name in our notes or when we report what we learn today. At the end, we’ll also ask you to write some information on a form. You won’t give your name on the form.

I am going to be recording the interview for accuracy. I will only refer to it later to make sure I got everything right during our conversation. Are you comfortable with me recording the interview? [Do not record if they are uncomfortable.]

Do you have any questions before we start? [Pause for questions.] Great! Let’s begin.
## Questions & Purpose

<table>
<thead>
<tr>
<th>Question</th>
<th>Purpose</th>
</tr>
</thead>
</table>
| 1. Let’s start with this document. Let’s assume you got this. What you do if you got this document? What is your first impression? You don’t have to read the whole thing just yet. \textit{[Probes: Does it look easy or hard to read? Why?]}. | - Ice breaker. Assures the participant there aren’t any wrong answers.  
- Understand first impressions of EOB |
| 2. Now please read the document – take your time.                        | - Give participant time to thoroughly review the EOB.                    |
| 3. Who is it from?                                                       | - Do members know who sent the notice?                                  |
| 4. Why are you receiving this?                                           | - Do members understand the purpose of the EOB?                         
- Note if there is confusion about whether the document is a bill or they owe money |
| 5. What do these mean? [Point to various elements of the EOB – the billing provider, the claim number, the service dates, the list of providers, the billing code, the description, the amount paid.] | - Do members understand the EOB?                                       |
| 6. Are you required to do anything because you received this letter?     | - Do members understand that they are supposed to review the EOB for accuracy? 
- Do they understand that there is no action taken if the document is correct? 
- Do they realize that even if they see an “error,” reporting is optional? |
| 7. If you did not receive the services listed in the document, what are your options? | - Do they realize that even if they see an “error,” reporting is optional? 
- Do members understand the pathway for reporting a potential billing issue? |
| 8. What is this information for? [Point to the list of ways to contact Health First Colorado.] | - Do they understand that they can contact Health First Colorado online, by email, by phone, by mail, or by fax? |
| 9.   | What number would you call if:  
|      |   • You wanted to tell Health First Colorado that you didn’t receive one of the services?  
|      |   • You were confused about why you received the letter? | Do they understand whom to contact with what questions? |
| 10.  | What information would you have to provide to Health First Colorado if you had to contact them? | Do they understand what must be provided when they contact Health First Colorado? |
| 11.  | If you received this document and it did **NOT** correctly list the services you received, would you contact Health First Colorado? Why or why not? | Are members motivated to contact Health First Colorado if the document is not correct?  
|      |   • Are the reasons they would or would not follow up? | What are the reasons they would or would not follow up? |
| 12.  | What other information could we provide you to help you understand this document? | Identify common questions and concerns for use in communication tools and educational materials. |
| 13.  | And finally, is there anything else you would like to say about this document? | Open ended feedback and suggestions from members |
| 14.  | **[If member is not using a screen reader, skip.]** Are there any issues to reading this document on a screen reader besides what we’ve already talked about? | Are there any screen reader technology issues that didn’t come up during the interview |
### Appendix D: Detailed Question Responses

Note: The chart lists the percentage of respondents who knew the correct answer to the question. The lightest blue boxes indicate questions that one-third or fewer of members answered correctly. The medium colored blue boxes indicate questions that over one-third to two-thirds of members answered correctly. The darkest blue boxes indicate questions that over two-thirds of members answered correctly.

<table>
<thead>
<tr>
<th>Question</th>
<th>CO Springs</th>
<th>Lamar</th>
<th>Rifle</th>
<th>Littleton</th>
<th>Denver</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you do if you got this document?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>75</td>
<td>93</td>
</tr>
<tr>
<td>Who is it from?</td>
<td>60</td>
<td>100</td>
<td>60</td>
<td>100</td>
<td>88</td>
<td>81</td>
</tr>
<tr>
<td>Why are you receiving this?</td>
<td>100</td>
<td>100</td>
<td>60</td>
<td>67</td>
<td>25</td>
<td>67</td>
</tr>
<tr>
<td>What do these mean?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing provider</td>
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<td>33</td>
<td>40</td>
<td>67</td>
<td>75</td>
<td>44</td>
</tr>
<tr>
<td>Claim number</td>
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<td>67</td>
<td>20</td>
<td>100</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Service date(s)</td>
<td>100</td>
<td>100</td>
<td>80</td>
<td>100</td>
<td>88</td>
<td>93</td>
</tr>
<tr>
<td>List of people who provided the care, services, or items</td>
<td>100</td>
<td>67</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>93</td>
</tr>
<tr>
<td>List of billing codes</td>
<td>100</td>
<td>100</td>
<td>60</td>
<td>100</td>
<td>88</td>
<td>89</td>
</tr>
<tr>
<td>List of descriptions</td>
<td>100</td>
<td>83</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>96</td>
</tr>
<tr>
<td>List of amounts paid</td>
<td>100</td>
<td>100</td>
<td>60</td>
<td>67</td>
<td>88</td>
<td>85</td>
</tr>
<tr>
<td>Are you required to do anything because you received this letter?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>75</td>
<td>93</td>
</tr>
<tr>
<td>If you did not receive the services listed in the document, what are your options?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>75</td>
<td>96</td>
</tr>
<tr>
<td>What is [the list of ways to contact Health First Colorado] for?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>88</td>
<td>96</td>
</tr>
<tr>
<td>What number would you call if you wanted to tell Health First Colorado that you didn’t receive one of the services listed in the document?</td>
<td>80</td>
<td>100</td>
<td>80</td>
<td>100</td>
<td>88</td>
<td>89</td>
</tr>
<tr>
<td>What number would you call if you were confused about why you received this letter?</td>
<td>40</td>
<td>100</td>
<td>100</td>
<td>67</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>What information would you have to provide to Health First Colorado if you had to contact them?</td>
<td>100</td>
<td>83</td>
<td>80</td>
<td>67</td>
<td>0</td>
<td>59</td>
</tr>
<tr>
<td>If you received this document and it did not correctly list the services you received, would you contact Health First Colorado? Why or why not?</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>67</td>
<td>100</td>
<td>96</td>
</tr>
</tbody>
</table>

What other information could we provide you to help you understand this document?

**Colorado Springs:**
- “People will be afraid that this could backfire and won’t even open it. Make it as inviting as possible, even on the envelope.”
- “If I have a provider, lead with the provider, because I recognize them. It would get my attention if it had the hospital and the provider listed. The billing code, etc. doesn’t mean anything. Only the provider and the hospital mean anything to me.”

**Lamar:**
- “Some people might find a pamphlet helpful.”

**Rifle:**
- “Elaborate in the letter why/how fraud could be an issue.”
- “The ‘Amount Paid’ portion of letter is confusing. What might not have been paid? Is there additional cost/responsibility for the member?”

**Is there anything else you would like to say about this document?**

*Colorado Springs*
- “Make it really clear that you won’t get in trouble, that you’re helping us. Is there a way to incentivize filling it out? Gift card? Free something?”
- “The legal stuff at the bottom may be confusing.”
- “I might go to the hospital first if they saw an error.”

*Lamar*
- “If non-English speaker received this document, they would see services/amount and would be worried that they owed that amount.”

*Rifle*
- “It’s great to have a record of what happened/appointments.”

*Denver*
- “It would be easiest if you could just mark off yes and no to the providers if you received the services.”
- “Consider adding ‘Did you receive these services?’ at the top of the second page.”

**Are there any issues to reading this document on a screen reader besides what we’ve already talked about?**

*Littleton*
- “I would rather see this in Braille.”
- “Everything is here; the only challenge is the navigation piece.”
- “The table would be challenging for someone who wasn’t as familiar with screen readers.”
- “The table could be an issue, but it’s more about knowing how to use a screen reader. Without a table, it would be a jumbled mess, so the table should stay.”

*Denver*
- “For people with print impairment or without internet access, they might need a Braille copy.”
- “Code the logo.”
Development of a Health First Colorado Explanation of Benefits
Stakeholder Meeting Summary
March 20, 2017

Background
The Keystone Policy Center (Keystone), a Colorado-based organization with over 40 years of experience working in stakeholder engagement and facilitation, is working with Department of Health Care Policy and Financing (the Department) on member and stakeholder engagement for the development of an Explanation of Benefits letter (EOB or EO letter) for Health First Colorado (Colorado’s Medicaid Program) members. Last year, the Colorado General Assembly passed SB16-120, which requires the Department to make such a document available beginning July 1, 2017, with the narrow purpose of identifying possible provider fraud, waste, and abuse.

As part of the implementation requirements, the Department was required to develop the EOB and supporting educational materials in conjunction with Health First Colorado members and other key stakeholders to ensure that members understand the information provided in the EOB and its purpose. The member and stakeholder engagement process will inform updates to the EOB and the development of the educational materials that accompany it.

On March 20, 2017, Keystone and the Department convened over two dozen stakeholders to provide an overview of federal and state EOB requirements; provide an overview of the process for and findings from stakeholder interviews and member testing; solicit stakeholder feedback on the EOB letter; solicit stakeholder input on educational materials and communication needs; and review the next steps in the EOB development process.

Meeting Presentations
The meeting began with introductions and an overview of the purpose of the meeting.

Federal and State Requirements
Department staff presented an overview of the federal and state requirements that drove and informed the development of the draft EOB letter. Per 42 CFR 433.116 – FFP for Operation of Mechanized Claims Processing and Information Retrieval Systems, the EOB letter must specify the service furnished; the name of the provider furnishing the service; the date on which the service was furnished; and the amount of the payment made under the plan for the service. The EOB letter must not specify confidential services (as defined by the state) and must not be sent if any service furnished was confidential. The Centers for Medicare & Medicaid Services gives the state the flexibility to define confidential services, but expects that claims will be excluded from EOBs only for particularly sensitive services for which disclosure violates a member’s right to privacy, e.g., family planning services or venereal disease treatment.

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1 The draft EOB is included as Appendix A. A graphic summarizing the feedback process is included as Appendix B.
2 The meeting agenda is included as Appendix B.
3 A complete list of meeting attendees is included as Appendix C.
Department staff explained that Colorado SB 16-120 requires the Department to make EOB letters available to Health First Colorado members beginning July 1, 2017. The EOB statements must be distributed at least every two months and the Department may determine the most cost effective means of sending out the statements, including email or web-based distribution, with mailed copies sent by request only. The bill also specifies the information to be included in the EOBs:

- The name of the Health First Colorado member receiving the service
- The name of the service provider
- A description of the service provided
- The billing code for the service
- The date of service or range of dates of services
- A clear statement that the EOB is not a bill but is only provided for information and to make sure the provider is only being reimbursed for services actually provided, so members may discover and report administrative or provider errors or fraudulent claims for reimbursement
- Information regarding at least one verbal and one written method for a Health First Colorado member to report errors
- Any other information the Department thinks is useful for discovering administrative and provider error or fraud

Prior Stakeholder and Member Feedback

The Department used these federal and state requirements to inform the development of a draft EOB. Keystone staff used this draft EOB letter when interviewing key stakeholders and Health First Colorado members.

Between February and March 2017, Keystone interviewed four key stakeholders who had been involved in the development of SB 16-120. Those interviews focused on high-level observations and concerns. Overall, the stakeholders representing the long-term care and disability communities were encouraged by the development of the EOB, and believed their constituencies would be eager to review information that helps support the Health First Colorado program. Their concerns focused on the best ways to make the EOB clear and accessible for all Health First Colorado members. However, other stakeholders expressed concerns about confidentiality and how confidential services would be defined.

Between February and March 2017, Keystone also tested the EOB letters with Health First Colorado members across the state, interviewing 27 members in five cities (Colorado Springs, Lamar, Rifle, Littleton, and Denver). The members reflected a diverse cross section of the Health First Colorado community; 18 percent of interviewees were receiving both Health First Colorado and Medicare and 25 percent identified as having a physical, intellectual, or developmental disability. During the testing, Keystone requested that each member review the EOB letter as though it was directed at them, and then asked a series of scripted questions that focused on understanding of the elements of the EOB; the purpose of the EOB; and the action required of the member (if any).
Most members said they would read the document (93 percent) and that it looked easy to read (85 percent). Those using screen readers flagged possible challenges in navigating the chart embedded in the EOB, and suggested making clear that Braille copies would be available to members who requested them. Most members also understood that the document was from Health First Colorado (81 percent) and two-thirds understood that they were receiving the document so that they could review the services for which Health First Colorado paid on their behalf. Many described the letter as “self-explanatory.”

Almost all members (85 percent or more) understood the sections of the EOB that referred to their service date(s), the list of providers, the billing code, the description of services, and the amount that Health First Colorado paid. But fewer than half of members understood to what the billing provider or claim number referred.

The majority of members (93 percent) understood that they were being asked to review the EOB letter, but most also believed that they were obligated to report errors with the letter, which is not accurate. Most understood how to contact Health First Colorado if there was an error or if they had a question, and almost every member (96 percent) said they would contact Health First Colorado if they received such a letter and found an error. Several members expressed a desire to help Health First Colorado ensure that resources are not being wasted. Others, however, worried that they or their doctor might get in trouble or that they might lose services if they reported an error. Few of the members interviewed focused on the fact that the letters were designed to help identify fraud.

From this feedback prior to the March 20, 2017 stakeholder meeting, Keystone identified several key changes for the EOB letter:

- Add a sentence on the purpose of the letter as it relates to fraud, waste, and abuse
- Clarify that there is no obligation to do anything with the letter, even if there is an error
- Clarify that Braille copies are available.

On March 14, 2017, Department staff shared the EOB letter with the Member Experience Advisory Council, who offered the following suggestions:

- Emphasize that the EOB is for covered services only
- Do not say “us” or “we” in place of “Health First Colorado”
- Use numbering on the list of what is in the letter on the first page and match those numbers with the information on the chart on the second page, and/or put the descriptions and the chart on the same page
- Define the billing code
- Be consistent in use of terms (e.g., both “claim ID” and “claim number” are used in the draft)

---

4 Member Experience Advisory Council: [http://www.colorado.gov/hcpf/mfac](http://www.colorado.gov/hcpf/mfac)
Keystone also identified priorities for the educational and communications materials that will be developed to support the EOB letter:

- Background information on the purpose of the letter
- Additional explanation of the terms used in the letter
- Information on how Health First Colorado determines what to reimburse
- Information about what might happen after a member flags services they did not receive, including that retaliation is illegal

**Stakeholder Meeting Q&A**

While stakeholder attendees were encouraged to ask questions throughout the formal presentations, the question and answers have been consolidated and organized here for clarity.

**Elements of the EOB**

- Q: Will the services list be clear names of procedures, or will it be a code or some other oblique descriptor of the services?
  - A: The billing description or code description will be what is in coding manuals.
- Q: What is the benefit of having the price on the EOB?
  - A: The amount that Health First Colorado paid for services must be on the EOB per federal law.
- Q: It would be helpful to reconcile the elements required by federal and state law and between those requirements.
  - A: The EOB given to meeting participants is annotated and indicates which elements are required by which law. See Appendix A.
- Q: Will it be clear how to contact the Department with general questions that don’t necessarily relate to the EOB letter or specific claim?
  - A: Yes, the document has a footer that directs members to a general contact number for the Department for questions about the EOBs.

**Confidentiality**

- Q: Will the letters be issued to minors?
  - A: If a mailed letter is requested, the letter will be sent to the individual, whether that person is a minor or adult. On the yet to be launched Member Portal, the head of household can see everything for the individuals in the household, and individuals in the household can see only their own information.
- Q: Is information about confidential services available to heads of households by other means?
  - A: No. An EOB will not be generated for visits/appointments where confidential services are rendered, even if some services rendered are not confidential.
- Q: Is it possible to treat adults and minors differently when it comes to confidential services?
  - A: The Department will bear that request in mind.
- Q: Where can we find the list of confidential services that won’t be included?
  - A: That list is not yet publicly available, but the Department staff will consider making it available and discuss the suggestion with their legal counsel.
Generally, confidential services include reproductive health, sexually transmitted disease treatment and detection, domestic violence, etc. The Department welcomes stakeholder suggestions for the services that should be considered confidential.

**Communication and Education**
- Q: Will the documents be accessible via the PEAKHealth app?
  - A: No. They will be available through the new Member Portal.
- Q: Medical icons can be useful for helping individuals with disabilities follow and understand a document like this.
  - A: The Department will work to incorporate icons where possible in the letter.
- Q: Can you make sure these documents are distinguished from Colorado Benefits Management System letters to limit confusion?
  - A: Unlike the Colorado Benefits Management System letters, the EOB letter will not be mailed unless a hard copy is requested, but the goal is to make clear that this is not a letter that requires a response from members and will not impact their eligibility.
- Q: Will county staff be trained on how to deal with and answer questions about the new EOB letters?
  - A: Yes. The Department is working to develop materials for the counties and other organizations who could get EOB questions.
- Q: Will the educational materials discuss the purpose of the letter as it relates to administrative error versus fraud?
  - A: The Department would like feedback from stakeholders and members on how valuable it is to make this purpose clear.

**Other**
- Q: If an EOB is not generated, will Health First Colorado still pay the related claim?
  - A: Yes, Health First Colorado will still pay the claim.
- Q: How long will it take to generate the EOB?
  - A: An EOB will be generated and made available in the Member Portal after the claim is paid. As a reminder, Providers have up to 120 days to submit a claim.
- Q: How will services be handled when some are bundled or part of capitated funding?
  - A: EOBs will not be generated for those visits. EOBs are only generated for fee-for-service claims.
- Q: Is there language in the letter that protects providers from disgruntled members?
  - A: Not currently, but stakeholders should let the Department know if that information should be added as well as provide suggestions for language.

**Stakeholder Feedback from Breakout Discussions**
After the presentations on the background of the EOB and summaries of the feedback received to date, Keystone staff split the meeting attendees into three groups for breakout discussions that allowed for additional feedback on the letter and educational materials and communication about the EOB.
Additional Updates to the EOB Letter
Meeting attendees reemphasized the importance of clarifying certain elements of the EOB letter, encouraging Keystone and the Department to ensure that the letter uses consistent language and layperson terms. They also suggested linking the billing codes with a description of the service so that members can cross-check the accuracy of the code.

Meeting attendees also suggested several additions to the letter: a column indicating what a service would normally cost (in comparison to what Health First Colorado paid); a sentence clarifying that there is no obligation to report an error even if the letter contains one; a sentence about the letter’s goal of identifying fraud, waste, and abuse; and a watermark that says “This is not a bill.”

Attendees encouraged the Department to make sure the EOB letters are available in multiple languages, and to make the other language options clear to members.

Educational Materials
Meeting attendees suggested that all educational materials be brief (never more than two pages), bulleted, and available in large font for individuals over the age of 65. Attendees suggested including brochures and posters among the materials developed, and using the television screens in safety net clinics, which could display information about the EOBs.

Attendees suggested taking advantage of the fact that the EOB letters will be available electronically to use hyperlinks or hovering explanations to better explain terms used in the document. They also encouraged Keystone to develop an annotated EOB letter that provides detailed information about each part of the EOB; this annotated guide could be accessible in the same place that members view the EOB letter and/or linked in the EOB. Alternatively, attendees said it might be useful for the Department to include FAQs as the final page in the EOB letter so that they are easy to reference in either the electronic or mailed version of the document. They recommended that the FAQs include an explanation of how a member will know if they have an EOB that is available to view.

Participants asked that the educational materials clarify how certain things are listed in the EOB, e.g. why the provider listed might be different from the person the member visited, why service descriptions might be shortened, why the member co-pay is not included in the EOB, etc.

Attendees also encouraged Keystone to include a clear explanation of what kinds of services are included in the EOB, since the EOB is only for covered services that are non-confidential. They recommended that the materials focus on what services are included in the EOB letters rather than listing the services that are not. The meeting attendees said the educational materials should make clear that the EOB letters will not provide a comprehensive list of all the services provided to them (i.e., they should review the list of services in the EOB and alert the Department if something is listed that they did not actually receive; they do not need to alert the Department if a service that they did receive is not on the list).
Finally, meeting attendees suggested that educational materials explain what happens after a member reports an error to the Department: What is the process? What kind of errors would trigger a fraud investigation? What would be asked of the member if there was a fraud investigation?

**Communication**
When it comes to communication with members, meeting attendees encouraged Keystone and the Department to use a variety of communication tools, including hard copies of resources that can be made available at clinics and community organizations and electronic communication like emails, text messages, and web content.

Participants were curious about how the new Member Portal would interface with the PEAK website and PEAKHealth mobile app with respect to the EOB. They encouraged the Department to connect the dots and use the PEAK website and PEAKHealth app to make announcements or include ads about the EOB, along with clarifying that these online resources are not the same and that both will continue to exist.

**Supporting Stakeholder and Provider Education and Communication**
All participants agreed that Keystone and the Department will need to provide community and stakeholder organizations (including county eligibility technicians) and providers with materials that facilitate member education about the EOB, as members may ask these organizations or their providers for help before contacting the Department.

**Confidentiality**
Meeting attendees continued to express concerns about confidentiality during the breakout sessions. They suggested that members should be able to suppress EOBs proactively (even for non-confidential services) or that EOBs be suppressed by provider. They also worried that heads of household could request EOBs for confidential services even if they were not originally generated, and asked about how information about EOBs and confidentiality would be communicated to minors.

**Other**
Attendees encouraged the Department to implement a quality control process to spot check the EOBs generated and how/whether they are accessed and used.

**Summary and Next Steps**
After brief summaries of the breakout sessions were presented, Keystone and Department staff explained the next steps for finalizing the EOB letter and developing accompanying educational and communication materials. Over the next several months, Keystone and the Department will consider stakeholder and member feedback as they update the EOB and develop educational materials and a communication plan for members, stakeholders, and providers. Throughout, member feedback will be prioritized. Once draft educational materials are available, Keystone and the Spring Institute (the vendor developing Spanish language materials and conducting Spanish language client testing) will test materials with members and modify them accordingly.
Educational materials will be dynamic, and will be updated when the Department observes trends and frequent questions that have not yet been addressed.
February 2, 2000

Jane Doe
123 Elm Street
Denver, CO 80203

Dear Jane Doe,

Our records show that you recently received care, services or items from a Health First Colorado (Colorado’s Medicaid Program) doctor or other provider. Please let us know if you did not receive the care, services or items listed in this letter. This is not a bill.

This letter lists:

- The name of the doctor or other provider who billed us. This may be the place where you received care, services or items, such as a clinic or hospital.
- The date(s) you received care, services or items.
- The name of the doctor or other provider who provided your care, services or items. This may not be the same as the billing provider.
- The billing code for your care, services or items.
- A short description of your care, services or items.
- The amount we paid to your doctor or other provider. You do not have to pay this amount.

Questions about this letter? HealthFirstColorado.com/Explanation-of-Benefits
Call 1-800-221-3943/State Relay 711
### Explanation of Benefits

**Member's Name:** Jane Doe  
**Member's Health First Colorado ID:** X123456  
**Billing Provider:** Primary Care Clinic  
**Claim Number:** 654321  
**Service Date(s):** 01/01/2000

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<th>Billing code</th>
<th>Description</th>
<th>Amount we paid</th>
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<td>FLU VACC IV/3 NO PRESERV ID</td>
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If you did not get the care, services or items listed above, contact us:

- **Online:** [CO.gov/HCPF/How-Report-Suspected-Fraud](CO.gov/HCPF/How-Report-Suspected-Fraud)
- **Email:** [ReportProviderFraud@hcpf.state.co.us](mailto:ReportProviderFraud@hcpf.state.co.us)
- **Phone:** Fraud Hotline at 1-855-375-2500/ State Relay 711
- **Mail:** Colorado Department of Health Care Policy & Financing  
  Attn: Program Integrity Section  
  1570 Grant Street  
  Denver, CO 80203

**Fax:** 303-866-4411

Questions about this letter? HealthFirstColorado.com/Explanation-of-Benefits  
Call 1-800-221-3943/State Relay 711
Explanation of Benefits

Page 3

Please provide the information below when you contact us:

- Member’s name
- Member’s Health First Colorado ID
- Billing Provider’s name
- Who provided your care, services or items
- Claim ID
- Service date(s)
- Why you believe you did not receive the care, services or items listed in this letter

If you want a paper copy of this letter sent to you or you have questions about this letter, contact the Health First Colorado Member Contact Center:

1-800-221-3943/State Relay 711

Thank you,

Health First Colorado

Nondiscrimination Notice

The Colorado Department of Health Care Policy and Financing does not discriminate on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability in any of its programs, services and activities.

For further information about the Department’s policy, to request free disability and/or language aids and services, or to file a discrimination complaint, contact: 504/ADA Coordinator, 1570 Grant St, Denver, CO 80203; Phone: 303-866-6010, Fax: 303-866-2828, State Relay: 711, Email: hcpd ada@state.co.us. Additional information is also available at: https://www.colorado.gov/hcpf/nondiscrimination-policy or https://www.colorado.gov/hcpf/americans-disabilities-act.

Complaints can also be filed with the U.S. Department of Health and Human Services Office for Civil Rights at https://oocrportal.hhs.gov/ocr/smartscreen/main.jsf.

Questions about this letter? HealthFirstColorado.com/Explanation-of-Benefits

Call 1-800-221-3943/State Relay 711

Commented [DC12]: SR 16-120

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Feedback Process

1. Stakeholder interviews
2. Test EOB letter with English & Spanish speakers
3. Identify EOB letter learnings from member feedback
4. Stakeholder meeting
5. Incorporate EOB letter learnings
6. Develop EOB educational materials
7. Test EOB educational materials with English & Spanish speakers
8. Incorporate EOB educational material learnings
9. Finalize EOB letter and educational materials
Stakeholder Meeting
Development of a Health First Colorado EOB
March 20, 2017 | 10 a.m.-12 p.m. Mountain Time

In Person: 303 East 17th Avenue | 11th Floor, Room ABC | Denver, CO 80203
Remote: 1-877-820-7831; Passcode: 815942 | Webinar:
https://cohcpf.adobeconnect.com/r3svr7huie6/

10:00 a.m. Welcome and Introductions

10:10 a.m. Background & Overview
- Federal and state requirements
- Process for development of Explanation of Benefits (EOB)
- Q&A

10:40 a.m. Key Takeaways from Stakeholder & Member Engagement

10:55 a.m. Breakout Discussions & Feedback
- Additional feedback on the EOB letter
- Member communication
- Educational materials

11:50 a.m. Next Steps

12:00 p.m. Adjourn
**Attendance List**

*Indicates a stakeholder who attended by phone*

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<tr>
<th>Stakeholders</th>
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<tbody>
<tr>
<td>Sarah Barnes</td>
<td>Colorado Children's Campaign</td>
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<tr>
<td>Bre Benbenek*</td>
<td>Spring Institute</td>
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<tr>
<td>Ryan Biehle*</td>
<td>Colorado Academy of Family Physicians</td>
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<td>Stephanie Brooks</td>
<td>Covering Kids &amp; Families</td>
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<td>Amber Burkhart</td>
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<td>Mirna Castro</td>
<td>Servicios de la Raza</td>
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<td>Cara Cheevers</td>
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<td>Candie Dalton</td>
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<td>Tara Gale</td>
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<td>Deb Galecki</td>
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<td>Alice Gibbs</td>
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<td>Kate Hayes*</td>
<td>Planned Parenthood</td>
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<td>Phyllis Hirschfeld</td>
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<td>Debra Judy</td>
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<td>Patrick Kelly</td>
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<td>Andrea Loasby</td>
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<td>Julie Reiskin*</td>
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<td>Paula Ring</td>
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<td>Mallory Huggins</td>
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<td>Mike Saccone</td>
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Development of Health First Colorado Summary of Recent Services Letter

Summary of Member Testing on Draft Letter and Educational Materials

May 2017

Background
The Keystone Policy Center (Keystone), a Colorado-based organization with over 40 years of experience working in stakeholder engagement and facilitation, is working with Department of Health Care Policy and Financing (the Department) on member and stakeholder engagement for development of a Summary of Recent Services letter (formerly known as the Explanation of Benefits or EOB letter) for Health First Colorado (Colorado’s Medicaid Program) members. Last year, the Colorado General Assembly passed SB 16-120, which requires the Department to make such a document available, with the narrow purpose of identifying possible provider fraud, waste, and abuse.

As part of the implementation requirements, the Department was required to develop the Summary of Recent Services letter and supporting educational materials in conjunction with Health First Colorado members and other key stakeholders to ensure that members understand the information provided in the letter and its purpose. The member and stakeholder engagement process will inform edits to the Summary of Recent Services letter and the development of the educational materials that accompany it.

Member Testing Methodology
On May 18, 2017, Keystone visited Atlantis Community, Inc. to conduct member testing on the Summary of Recent Services letter and draft educational materials – frequently asked questions (FAQs) and a glossary – associated with the letter. Keystone interviewed 10 members at Atlantis.1 The members represented a diverse cross section of ages and genders, and 60 percent of those interviewed identified as having a physical, intellectual, or developmental disability. The complete demographic questionnaire used for testing is available in Appendix A, and select additional demographic information about the members interviewed is included in Appendix B.

During the 30-minute interviews, Keystone provided the Health First Colorado members with the draft Summary of Recent Services letter and asked them a series of questions about their understanding of the document. Then, Keystone presented the members with the FAQ and glossary document (referred to as either “educational materials” or “FAQ/glossary document” hereafter) and asked a series of questions about that document. A complete script is included as Appendix C.

1 Due to timing constraints at Atlantis (the document was read out loud to two members; one member with a visual impairment and the other member requested that the document be read out loud), two Health First Colorado members were not tested on the FAQ and glossary document. Thus, eight total members were interviewed about the FAQ and glossary document. One member participated in the previous round of testing on the EOB at Atlantis, and therefore they were only tested on the FAQ and glossary document during this round of testing. Thus, nine members were tested on the new Summary of Recent Services letter. Finally, due to double booking, two members were interviewed at the same time.
Member feedback is summarized below. The detailed responses from each location are provided in Appendix D.

**Feedback on the Summary of Recent Services Letter**

Keystone tested the Summary of Recent Services letter with nine Health First Colorado members before testing the educational materials. As in past testing, members found the Summary of Recent Services letters to be clear, accessible, and easy to read. They understood most elements of the document, as well as the purpose of the letter and their options if they identified an error. All but one member said that they would contact Health First Colorado if they received such a letter and identified services listed that they did not actually receive.

One member also asked how members who do not have Internet access will access the Summary of Recent Services letters. They suggested that members have the option to request that all letters are mailed to them.

Several members talked about soliciting help with the letter from other people. Three members interviewed said that if they received a Summary of Recent Services letter, they would give the letter to a family member or Atlantis employee to help them read it. Similarly, almost half of the members said they would ask a family member or Atlantis employee if they were confused about why they received the document. One member made clear that they would only reluctantly call the HCPF Member Contact Center for help, saying “I would try going to the website first, or ask a co-worker [at Atlantis]. I would treat the 800 number as the last resort. I might event call the county before I called HCPF.”

Members generally found the chart listing their care, services, or items to be clear, though one did not understand what the claim number or billing code meant. One member suggested including the co-pay that the member is responsible for as part of the chart.

While almost all members said that they would report any errors on a Summary of Recent Services letter, one member clarified that while they would want to report errors, if they went to do their due diligence and it was difficult to do so (e.g., they had to wait on hold for a long time), they might stop trying. This member encouraged HCPF to make reporting as easy as possible. The member who said they would not report said that if it was their money in question, they would report an error, but realistically, since it is HCPF’s money in question, they would not take the time to report an error.

**Suggested Edits**

Members suggested the following additional edits to the Summary of Recent Services letter:

- Ensure that the link in the footer goes to the Summary of Recent Services letter landing page rather than the HCPF home page.
- Consider writing “PAID” after every dollar amount in the Explanation of Benefits chart.
- Edit the section explaining how to request a paper copy to reflect that some people may already be viewing a paper copy of the letter.
Sample Quotes

- “I love that it says, ‘THIS IS NOT A BILL’ upfront. It’s helpful and I know not to freak out.”
- “I would give this to someone else to read for me.”
- “It’s laid out nicely. I like the bold print.”
- “I would give it to [and Atlantis staff person] to help or examine the items and figure out if I got them.”
- “How can I say yes or no [about whether I’ve received services] when it’s giving me the codes without a cheat sheet? I can’t relate. What the heck – how am I supposed to understand without a cheat sheet?”
- “Someone is taking things away from me. If someone used a disabled person’s money, they need to be reported. We already have trouble keeping what we do have.”

Feedback on Educational Materials

Of the eight members who reviewed the educational materials, all said that they would read them and found them easy to read. While some found the document long, most said that that it helped explain the Summary of Recent services letter in simple terms. As one member stated, “It’s a lot of information, but it’s all helpful information.”

When asked what they liked about the FAQ/glossary document, members said they liked that the document was written in clear and simple language and that it was thorough. One member found that their specific question about billing codes was answered by the glossary.

One person with a physical disability found the page-turning challenging, but acknowledged that this problem would be eliminated if they were viewing the document online. Otherwise, no one identified anything that they found difficult to understand about the FAQ/glossary document.

All but one member said that they would prefer that the Summary of Recent services letter and the FAQ/glossary document be part of the same document, especially online. One member suggested that the documents should be mailed out together the first time they are sent to members, and then be available online, with the FAQ/glossary as hyperlink in the Summary of Recent Services letter, thereafter. This member also encouraged HCPF to allow interested members to sign up for email alerts when new Summary of Recent Services letters are available.

Several members suggested that both documents be available in languages other than English and Spanish, at least for the three most common languages spoken in Denver.

One member encouraged HCPF to ensure that the FAQs are regularly updated.

Suggested Edits

Members suggested the following additional edits to the FAQ/glossary document:

- Consider making clear in the Summary of Recent Services letter that a member will not be blamed or punished by Health First Colorado or their provider if they report an error.
• Clarify the question about why the member might not recognize the doctor listed in the chart.
• Consider adding a note about what might not be in the chart (e.g., confidential services) to the Summary of Recent Services letter.
• Add an email address that members can contact with questions so that they don’t always have to go through the Member Contact Center.
• Include examples to clarify answers where possible.
• Add a question explaining how much time a member has to follow up with HCPF if there is an error.
• Provide a link to a “cheat sheet” that lists service descriptions and billing codes, if available.

Sample Quotes
• “I like the glossary. I would want to keep this. It’s better than just looking at the document. It’s in very simple terms.”
• “The questions are good. The answers are short and not confusing. It’s better than the Social Security letters.”
• “It’s explanatory. It’s clear even for people who can’t read well.”
• “If I did start getting this document, it would be the least confusing letter I receive.”

Next Steps
In coordination with HCPF staff, Keystone will update the Summary of Recent Services letter and FAQ/glossary document according to the feedback provided at testing, as well as additional internal feedback from HCPF. Keystone and HCPF will finalize the draft Summary of Recent Services letter and educational materials by July 1, 2017.
Appendix A: Demographic Questionnaire

Please tell us about yourself. Your answers are anonymous and confidential.

1. What benefit programs are you enrolled in? Please check all that apply.
   - Health First Colorado (Colorado’s Medicaid Program)
   - Health First Colorado (Colorado’s Medicaid Program) Long Term Care & Waiver Programs
   - Health First Colorado (Colorado’s Medicaid Program) Medicaid Buy-In for Adults
   - Health First Colorado (Colorado’s Medicaid Program) Medicaid Buy-In for Kids
   - Other _______________________

2. Are you or anyone in your household the following? Please check all that apply.
   - Adult without dependent children
   - Parent of dependent children
   - Pregnant woman
   - Currently receiving both Health First Colorado and Medicare
   - Individual with physical, intellectual or developmental disability

3. Where do you go for help about your benefits? Please check all that apply.
   - Local County Department of Human/Social Services
   - Application Assistance Site
   - Health Clinic or Hospital
   - Health First Colorado Member Contact Center
   - Colorado.gov/PEAK
   - PEAKHealth Mobile App
   - Other _______________________

4. Age?
   - Under 18 years old
   - 18-24 years old
   - 25-34 years old
   - 35-44 years old
   - 45-54 years old
   - 55-64 years old
   - Over 65 years old

5. Gender?

6. County you live in:
Appendix B: Select Demographic Detail about Member Interviewees

*Note: All details were self-reported.*

<table>
<thead>
<tr>
<th>Age of Members Interviewed (of 10 Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Demographic Details (of 10 Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male/Female</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>2/8</td>
</tr>
</tbody>
</table>
Appendix C: Member Testing Interview Guide

Approach
• We will conduct usability testing, meaning we will test if people can read, understand, and use the content in our sample Summary of Recent Services (SRS). We will also test a draft educational material that includes FAQs and glossary terms, and assess whether it can provide quick answers to common areas of confusion in the SRS.

Goals
• Can participants read and understand the draft SRS?
  o Do participants understand who sent the SRS?
  o Do participants understand the purpose of the SRS?
  o Do participants understand key messages in the SRS?
    ▪ That the SRS is not a bill
    ▪ What is listed in the SRS?
    ▪ Why they are receiving the SRS?
  o Do participants understand what actions are needed?
    ▪ The request to review the SRS for accuracy
    ▪ The request to contact Health First Colorado if they did not receive any of the services listed
• What are the areas of confusion (if any)?
• Does the FAQ/glossary document address the areas of confusion?
• What outstanding questions do members have even after reviewing the FAQ/glossary document?
• Are the documents accessible?
<table>
<thead>
<tr>
<th>Questions &amp; Purpose</th>
<th>Question</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Let’s start with this document. Let’s assume you got this document. What would you do if you got this document? What is your first impression? [Probes: Does it look easy or hard to read? Why?]</td>
<td>• Ice breaker. Assures the participant there aren't any wrong answers. &lt;br&gt; • Understand if members will read the SRS based on their first impressions &lt;br&gt; • Understand first impressions of SRS</td>
</tr>
<tr>
<td>2.</td>
<td>Who is it from?</td>
<td>• Do members know who sent the SRS?</td>
</tr>
<tr>
<td>3.</td>
<td>Why are you receiving this?</td>
<td>• Do members understand the purpose of the SRS? &lt;br&gt; • Note if there is confusion about whether the document is a bill or they owe money.</td>
</tr>
<tr>
<td>4.</td>
<td>What would you do if you were confused about why you received the document?</td>
<td>• Do members understand that there is a specific number to use if they have a question about the letter, rather than if they identify an error?</td>
</tr>
<tr>
<td>5.</td>
<td>I know this might seem simple, but please walk me through what each part of this chart means.</td>
<td>• Do members understand the SRS? &lt;br&gt; • Do they seem to understand the layperson explanations better than the terms of art that were confusing for members reviewing the original EOB?</td>
</tr>
<tr>
<td>6.</td>
<td>What are you supposed to do after you read the document?</td>
<td>• Do members understand that they are supposed to review the SRS for accuracy? &lt;br&gt; • Do they understand that there is no action taken if the document is correct? &lt;br&gt; • Do they understand that they are encouraged but not required to contact Health First Colorado if there is an error?</td>
</tr>
<tr>
<td>7.</td>
<td>What is this information for? [Point to the list of ways to contact Health First Colorado.]</td>
<td>• Do they understand that they can contact Health First Colorado online, by email, by phone, by mail, or by fax?</td>
</tr>
<tr>
<td>Question</td>
<td>Additional Questions</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>What information would you have to provide to Health First Colorado IF you had to contact them?</td>
<td>• Do they understand what must be provided when they contact Health First Colorado?</td>
<td></td>
</tr>
<tr>
<td>If you received this document and it did NOT correctly list the services you received, would you contact Health First Colorado? Why or why not?</td>
<td>• Are members motivated to contact Health First Colorado if the document is not correct?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• What are the reasons they would or would not follow up?</td>
<td></td>
</tr>
<tr>
<td>What would you do if you got this document? What is your first impression? You don’t have to read the whole thing just yet.</td>
<td>• Understand if members will read the FAQ/glossary document based on their first impressions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Understand first impressions of FAQ/glossary document</td>
<td></td>
</tr>
<tr>
<td>Does this document affect your understanding of the other document you just read? How?</td>
<td>• Do members quickly identify any ways in which the educational document helps them understand the SRS?</td>
<td></td>
</tr>
<tr>
<td>OPTIONAL: If they didn’t get all the questions correct or were confused about certain elements, go back and ask those questions again, noting if they answer the questions differently and/or quickly find answers to their questions in the FAQ/glossary document.</td>
<td>• Understand if the FAQ/glossary document helps them understand items in the SRS about which they were originally confused</td>
<td></td>
</tr>
<tr>
<td>What, if anything, do you like about the FAQ/Glossary document?</td>
<td>• Are there elements that members find helpful in the FAQ/glossary document?</td>
<td></td>
</tr>
<tr>
<td>What, if anything, do you find difficult to understand about the FAQ/glossary document?</td>
<td>• Are there confusing or unhelpful elements in the FAQ/glossary document?</td>
<td></td>
</tr>
<tr>
<td>Do you have any additional questions about either document that I showed with you today?</td>
<td>• Are there key points of confusion that neither document is addressing?</td>
<td></td>
</tr>
<tr>
<td>Would you prefer that a document like this [point to the FAQ document] be part of the first document I showed you [point to the SRS], or separate?</td>
<td>• Does it seem members would be more likely to read this document if it’s attached to the SRS, or separate?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Response</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>17.</td>
<td>What other information could we provide you to help you understand this document?</td>
<td>• Identify common questions and concerns for use in communication tools and educational materials.</td>
</tr>
<tr>
<td>18.</td>
<td>And finally, is there anything else you would like to say about either document?</td>
<td>• Open-ended feedback and suggestions from members</td>
</tr>
<tr>
<td>14.</td>
<td>[If client is not using a screen reader, skip.] Are there any issues to reading these documents on a screen reader besides what we’ve already talked about?</td>
<td>• Are there any screen reader technology issues that didn’t come up during the interview?</td>
</tr>
</tbody>
</table>
Appendix D: Detailed Question Responses

Note: The first chart lists the percentage of respondents who answered the question correctly. The lightest blue boxes indicate questions that one-third or fewer of members answered correctly. The medium colored blue boxes indicate questions that over one-third to two-thirds of members answered correctly. The darkest blue boxes indicate questions that over two-thirds of members answered correctly.

<table>
<thead>
<tr>
<th>Binary Questions</th>
<th>Percentage Who Answered Correctly</th>
</tr>
</thead>
<tbody>
<tr>
<td>What would you do if you got this document?</td>
<td>67</td>
</tr>
<tr>
<td>Who is it from?</td>
<td>89</td>
</tr>
<tr>
<td>Why are you receiving this?</td>
<td>67</td>
</tr>
<tr>
<td>What would you do if you were confused about why you received the document?</td>
<td>56</td>
</tr>
<tr>
<td>What does each element of this chart mean?</td>
<td>89</td>
</tr>
<tr>
<td>What are you supposed to do after you read the document?</td>
<td>89</td>
</tr>
<tr>
<td>What is [the list of ways to contact Health First Colorado] for?</td>
<td>89</td>
</tr>
<tr>
<td>What information would you have to provide to Health First Colorado if you had to contact them?</td>
<td>89</td>
</tr>
<tr>
<td>If you received this document and it did not correctly list the services you received, would you contact Health First Colorado? Why or why not?</td>
<td>89</td>
</tr>
<tr>
<td>After handing the member the educational materials: What would you do if you got this document?</td>
<td>100</td>
</tr>
</tbody>
</table>

Open-Ended Questions

Does this document affect your understanding of the other document you just read? How?
- “It helps explain some questions I didn’t know I had.”
- “It provides the more narrow info.”

What, if anything, do you like about the FAQ/Glossary document?
- “I like Question 7 [explaining why I might not recognize the doctor or other provider’s name] and Question 8 [about the short descriptions and billing codes]. I like the glossary. I would want to keep this. It’s better than just looking at the document. It’s in very simple terms.”
- “I love the explanations; those are critical. The print is good.”
- “The questions are good. The answers are short and not confusing. It’s better than the Social Security letters.”
- “The different ways to contact are good.”
- “There aren’t a lot of big words. That’s the most important.”
- “It’s explanatory. It’s clear even for people who can’t read well.”
- “I like everything. It goes over everything.”

What, if anything, do you find difficult to understand about the FAQ/glossary document?
- “I had to flip the pages [which was difficult because of a physical disability]. It will be good when it’s online.”

Do you have any additional questions about either document that I shared with you today?
- --
Would you prefer that a document like this [point to the FAQ document] be part of the first document I showed you [point to the SRS], or separate?
About 88 percent of members interviewed said that they would prefer the Summary of Recent Services letter and the FAQ/glossary to be part of the same document. Comments included:

- “Especially for online, they should be together. Don’t send them together if it’s paper; that’s too much.”
- “It seems stupid to make it separate; you need to put the money to use elsewhere.”

One member had more nuanced comments:
- “The first time you send the documents, you should send them together. But don’t send them together every time. After the first time, you can just include the hyperlink. If you really want as many eyes as possible, you should mail the Summary of Recent Services letter with the FAQ the first time, make clear how they will be made available in the future, and then offer an option to sign up to get emails emailed directly to them.”

What other information could we provide you to help you understand this document?
- “It’s self-explanatory. There’s not much more that they can do. It’s detailed so we can understand.”
- “I understood them. I get these occasionally already.”
- “It’s clear and straightforward.”

And finally, is there anything else you would like to say about either document?
- “It is good to know that they have an app.”
- “If I did start getting this document, it would be the least confusing letter I received.”
- “You should have this in other languages – at least the three most common languages in Denver.”
- “This should be available in other languages. It’s only fair.”
- “It is difficult to navigate from the HCPF main page, so you should direct people to the exact page they need in the footer (rather than just the generic HCPF page).”
- “Make sure the FAQ is updated regularly.”
- “Include information about how long a person has to follow up with HCPF if there is an error.”