2016 Interim Study Committee on Communication between HCPF and Medicaid Clients

Members of the Committee

Representative Dianne Primavera, Chair
Senator Kevin Lundberg, Vice-Chair

Senator Larry Crowder
Senator Linda Newell
Representative Jessie Danielson
Representative Lois Landgraf

Legislative Council Staff

Bill Zepernick, Principal Fiscal Analyst
Elizabeth Haskell, Senior Research Analyst
Anne Wallace, Research Analyst

Office of Legislative Legal Services

Brita Darling, Senior Attorney

October 2016

2016 Interim Study Committee on Communication between HCPF and Medicaid Clients

Committee Charge

The Interim Study Committee on Communication between the Department of Health Care Policy and Financing (HCPF) and Medicaid Clients (Interim Study Committee) was created pursuant to Interim Committee Request Letter 2016-04, as approved by the Legislative Council on April 29, 2016. The committee is charged with studying the following policy issues:

- the current form and content of letters that are sent to Medicaid clients by HCPF;
- the frequency with which letters are sent to Medicaid clients by HCPF; and
- whether such letters can be simplified and the content made more clear so as to improve the information that is communicated to Medicaid clients.

Committee Activities

The Interim Study Committee met four times during the 2016 legislative interim. The committee heard testimony from stakeholders including:

- HCPF;
- the Center for Health Literacy;
- the Colorado Department of Human Services (CDHS);
- the Office of Information Technology (OIT);
- the state's health insurance exchange, Connect for Health Colorado;
- Medicaid client representatives from the Colorado Cross-Disability Coalition (CCDC) and the Colorado Center on Law and Policy (CCLP); and
- county departments of human services.

Current department initiatives related to Medicaid client correspondence. Representatives from HCPF described ongoing initiatives related to Medicaid client correspondence. HCPF provided an overview of their points of contact with Medicaid clients, and described how HCPF receives feedback from clients regarding notices. HCPF explained that the office uses a joint noticing system for clients who receive public benefits other than Medicaid, and noted the advantages and limitations of the joint noticing system. HCPF staff discussed federal requirements for eligibility and noticing for public benefit programs in Colorado.

HCPF partnered with the Center for Health Literacy to study and make adjustments to the language used in notices to HCPF clients and this project is nearing completion. The updated language for the notices is expected to be implemented in spring of 2017. Representatives described the client feedback they have received on the revised notices, explaining that while clients feel their comprehension of the notices have improved, the notices are too lengthy, and some clients are not familiar with medical and insurance-related terms.

A representative from Connect for Health Colorado discussed their initiatives toward improving client communication, including the use of social media to familiarize clients with health insurance terms.

Colorado Benefits Management System (CBMS). Representatives from the Office of Information Technology (OIT) explained how CBMS generates many different types of notices to clients regarding public benefits. OIT staff testified on the evolution of CBMS and major changes and upgrades to the system in recent years. Representatives discussed the accuracy of the data used in the notices and how improvements to the CBMS system are initiated, prioritized, and financed.

Client perspectives on Medicaid correspondence. CCDC and CCLP representatives testified regarding their experiences with Medicaid correspondence. Medicaid clients gave an overview of the different types of communications they receive regarding Medicaid and other public benefits. Clients noted that there are issues with Medicaid letters beyond the comprehension of notices. These challenges include receiving notices with incorrect or missing information, receiving notices after a deadline, receiving multiple letters, confusion between state and county agencies, and not receiving assistance or follow-up in a timely manner. Representatives explained that information on the appeals process for Medicaid rulings is unclear and confusing. In addition, client representatives noted that the issues with Medicaid correspondence are magnified for the disability community, as they often rely on Medicaid for everyday care.

County departments of human services. Representatives from various county departments of human services testified regarding their challenges with client correspondence, as county staff are directly engaged with Medicaid clients in the eligibility determination and case management process. Difficulties for counties include an increasing caseload for county workers, workload generated by confusing letters generated by CBMS, ensuring staff is properly trained, and insufficient county administrative funding. County representatives discussed data collected about client correspondence issues and workload, and noted that there have been various improvements to CBMS in recent years that have increased the efficiency of the Medicaid notices.

Committee Recommendations

As a result of committee discussion and deliberation, the Interim Study Committee recommends the following four bills for consideration in the 2017 legislative session. It also approved one committee letter.

Bill A — Technical issues filing Medicaid appeals. Bill A clarifies that Medicaid benefits must automatically continue without requiring an affirmative request by a client who is appealing a termination or reduction in benefits. HCPF must send the recipient written confirmation of the continuing benefits. The electronic filing form for appeals must include a check box or other method to opt out of continuing benefits, to request an accommodation for submitting an appeal or participating in a hearing, and to request dispute resolution. The electronic appeals website must additionally allow for the attachment of as many documents as necessary to support the appeal.

Bill B — Medicaid appeal review legal notice requirements. Bill B requires administrative law judges to review the legal sufficiency of Medicaid notices of action when a client appeals a termination or reduction in benefits (adverse action). The legal review of notices will take place at the start of an appeal. If the administrative law judge determines that the notice is not legally sufficient, he or she shall inform the client that the adverse action may be set aside. The client may then ask the administrative law judge to decide the case in his or her favor on the basis of the insufficient notice. Alternately, the client may waive his or her

defense on the basis of insufficient notice and request that the appeal proceed to a hearing on the merits of the case. Administrative law judges must inform clients that HCPF may issue a legally sufficient notice in the future and that the client may be required to repay any benefits received, as provided under current law, if the adverse action is upheld after the new notice is issued.

Bill C — Audits of Medicaid client correspondence. Bill C requires the Office of the State Auditor (OSA) to conduct performance audits of client communications concerning eligibility for Medicaid programs. These audits will be conducted in 2020 and 2023, with any future audits occurring at the discretion of the state auditor. These audits will encompass communications generated both in and outside of (CBMS). The performance audits will determine whether client communications comply with state and federal requirements, and they will review the understandability, readability, and accuracy of client communications. As a part of these audits, OSA will review available county data related to confusing communications received by Medicaid clients. The OSA will report audit findings and recommendations to various legislative committees.

Bill D — Improve Medicaid client correspondence. Bill D requires HCPF to engage in an ongoing process to create, test, and improve Medicaid client communications. HCPF must ensure that communications with clients are accurate, readable, understandable, and consistent. Contact information for client questions, and, to the extent practicable, legal, privacy, and educational information must be provided separately from the main content of the correspondence. In all communications regarding denial, reduction, suspension, or termination of benefits, the following must be included:

- an understandable explanation of denial, reduction, suspension, or termination;
- detailed information on the client's household composition and income sources; and
- a specific description of any information or documents needed from the client.

When modifying Medicaid communications, HCPF is required to test the changes and solicit feedback from clients and stakeholders. HCPF is also required to appropriately prioritize communications that only affect a small number of clients or vulnerable populations. HCPF is encouraged to promote client communications electronically and through mobile applications. As a part of HCPF's annual presentation made to General Assembly, it must present information on its ongoing process to improve client communications.

Committee Letter A — Align public assistance eligibility. This letter requests that the federal government find ways to align eligibility requirements for public assistance programs to decrease confusion among clients who are applying for multiple programs.