

State of Colorado
Office of the State Auditor

Medicaid Client Correspondence
Performance Audit

Department of Health Care Policy and Financing

September 2020



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September 2, 2020

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of Medicaid client correspondence at the Department of Health Care Policy and Financing, as required by Section 25.5-4-213, C.R.S., which requires the State Auditor to conduct a performance audit of Medicaid client correspondence. The State Auditor contracted with Sjoberg Evashenk Consulting, Inc., to conduct this audit. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

Respectfully submitted,

A handwritten signature in blue ink that reads "George J. Skiles".

George J. Skiles
Principal

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REPORT HIGHLIGHTS

AUDIT CONCERN

The Department of Health Care Policy and Financing (Department) has taken several steps since the passage of Senate Bill 17-121 to improve Medicaid client correspondence; however, further improvements are needed to ensure that correspondence is understandable and that Medicaid clients and applicants have accurate and complete information about their eligibility and benefits.

KEY FINDINGS

Our review of a sample of 100 notices that were sent to Medicaid clients between October 1 and December 31, 2019, identified 67 notices with one or more problems with the accuracy, completeness, and/or understandability of the correspondence. Specifically:

- 25 sampled notices contained inaccurate due dates, including due dates that afforded clients fewer than the required minimum number of days to take action about their eligibility or benefits (e.g., provide information or documentation or file an appeal).
- 8 sampled notices provided incomplete or contradictory information about the clients' eligibility or benefits status, increasing the potential that a client may misunderstand their approved benefits.
- 8 sampled notices included incomplete or outdated employment and income information, which could lead clients to take unnecessary steps to submit information that the Department and counties already have.
- 40 sampled notices included incomplete contact information for the clients' county eligibility site, potentially impeding clients' ability to seek clarification or resolve discrepancies.

Client notices also included elements that could contribute to client confusion or misunderstanding, such as manually-typed county caseworker notes in English that were included in a Spanish-translation notice or duplicative instructions.

BACKGROUND

Administered by the Colorado Department of Health Care Policy and Financing, Colorado's Medicaid Program is a federal-state program that provides health care coverage and services to eligible low-income families.

The Department issues a variety of notices to communicate with Medicaid applicants and clients about their eligibility and benefit determinations and to request information and supporting documentation.

As a result of an interim study committee convened to address concerns about confusing, inaccurate, and incomplete correspondence, the General Assembly enacted Senate Bill 17-121, which laid out its intent that the Department take steps to ensure the ongoing improvement of Medicaid client correspondence.

RECOMMENDATIONS

- Develop and implement a systematic approach to identify problems in correspondence and prioritize improvements, including identifying all templates used to generate Medicaid client correspondence; expanding routine monitoring activities to include the systematic testing of correspondence sent to clients; and evaluating, prioritizing, and implementing appropriate remedies.
- For identified problems, implement necessary programming changes to the Colorado Benefits Management System (CBMS) and improve guidance and training to county caseworkers, as appropriate.

The Department agreed with the recommendations.

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Medicaid Client Correspondence

Colorado Medicaid

Medicaid is a federal-state program that provides health care coverage and services to eligible low-income families. Medicaid is administered at the federal level by the Centers for Medicare and Medicaid Services (CMS) under Title XIX of the Federal Social Security Act, and administered at the state level by Colorado's Department of Health Care Policy and Financing (Department) under Colorado Revised Statutes. Colorado's Medicaid program is branded and marketed under the name "Health First Colorado."

According to Department data, Colorado's total Medicaid client caseload was about 1.3 million members as of May 31, 2020, which is about 21 percent of Colorado's population. For Fiscal Years 2020 and 2021, the General Assembly appropriated about \$7.9 billion and \$9.0 billion, respectively, for authorized medical services provided to Medicaid-eligible clients. Medicaid is funded jointly with state and federal funds. The federal matching rate varies depending on the services being provided and the populations being served, but ranges from 50 to 100 percent.

Individual applicants qualify to receive Medicaid benefits and services if they meet established criteria in federal and state law. Eligibility criteria is based on factors such as the applicant's income, state residency, age, citizenship or immigration status, household composition, and pregnancy status. In Colorado, the responsibility for determining applicants' eligibility for Medicaid benefits is shared between the State and local county departments of human/social services. Some other entities such as community mental health centers and hospitals have also been certified by the Department to accept and process Medicaid applications.

The Colorado Benefits Management System (CBMS) is the statewide data system through which all applications are processed and eligibility determinations are made for public benefits such as food, cash, and medical assistance, including Medicaid. Medicaid applications completed online through the State's Program Eligibility and Application Kit (PEAK) website are automatically transferred to CBMS. For all other Medicaid applications, county caseworkers collect applicants' information and enter it directly into CBMS. CBMS is automated to conduct real-time verifications of each applicant's identity, social security number, citizenship, immigration status, and income through electronic interfaces with other data sources. The State contracts with a private contractor, Deloitte Consulting, LLC, to operate and maintain CBMS.

Client Communications

To communicate with Medicaid applicants and clients about their eligibility and benefit determinations, the Department issues a variety of communications, or notices. Between October 1 and December 31, 2019, the Department sent more than 1 million client correspondences to approximately 476,000 households. State statute [Section 25.5-4-212(2), C.R.S.] defines “client correspondence” as any communication of which the purpose is to:

- Provide notice of an approval, denial, termination, or change to an individual’s Medicaid eligibility.
- Provide notice of the approval, denial, reduction, suspension, or termination of a Medicaid benefit.
- Request additional information that is relevant to determining an individual’s Medicaid eligibility or benefits.

The majority of client correspondence is generated through CBMS and falls into one of four primary types:

NOTICE OF ACTION

Individuals applying for Medicaid receive a letter, or Notice of Action, informing them of their eligibility approval or denial. Those individuals who apply for Medicaid on the basis of disability, or who require long-term care services, also receive a separate letter informing them whether or not they meet the applicable disability or level-of-care requirements. Medicaid clients also receive a Notice of Action informing them of any changes in their eligibility and/or benefit status, such as during the annual redetermination period and when they no longer qualify for Medicaid.

VERIFICATION CHECKLIST

Individuals applying for Medicaid receive a letter, or Verification Checklist, requesting additional information or documentation (e.g., proof of income or identification) if the Department cannot verify information provided by the applicant through various interfaces or other resources. Medicaid clients also receive a Verification Checklist during the annual renewal process if information has not been re-verified by the client since their enrollment or if any new information related to the client’s income and household composition are reported after an enrollment.

ELIGIBILITY & VERIFICATION SYSTEM NOTICE — INCOME LETTER

Medicaid applicants and clients receive a letter, or Income Letter, requesting an explanation and proof of income documentation if there is a discrepancy of 10 percent or more between the income information self-reported by the applicant or client and income data from the Income and Eligibility Verification System (IEVS). The Department uses the IEVS to retrieve and verify applicants' self-reported income information against wage data from the Colorado Department of Labor and Employment.

REDETERMINATION, RECERTIFICATION, AND REASSESSMENT NOTICE — ANNUAL RENEWAL LETTER

Medicaid clients receive a letter, or Annual Renewal Letter, 60 days prior to their annual renewal date requesting that the client review, confirm, and provide updated information and documentation for the purpose of re-determining the client's eligibility status for the new year.

CBMS is programmed to generate notices based on specific schedules and triggers (e.g., an approaching annual renewal date triggers an Annual Renewal Letter, a change in a client's eligibility status triggers a Notice of Action). In some cases, multiple notices may be issued. For example, during the annual renewal period, members generally receive three notices: Annual Renewal Letter, Verification Checklist, and Notice of Action. If there are income discrepancies, the client will also receive a fourth notice, the Income Letter.

Each notice generated by CBMS contains information that is populated in two ways. First, standardized, or *static*, fields are generated through the use of a core set of templates created by the Department that contain standard language relevant to the nature and purpose of the correspondence. These templates provide the framework for the specific notices each client receives from the Department and do not change from one notice to the next. Second, CBMS populates standard notices with client- or case-specific information through *dynamic* fields, which include information such as the effective date of the client's eligibility or case notes entered manually by a caseworker.

Throughout this report we use the terms "correspondence" and "notice" interchangeably.

Audit Purpose, Scope, and Methodology

The Colorado Office of the State Auditor (State Auditor) contracted with Sjoberg Evashenk Consulting, Inc., to conduct this performance audit of Medicaid client correspondence, as required by Section 25.5-4-213, C.R.S. Audit work was performed from February through August 2020. We appreciate the cooperation provided by the Department during the course of this audit.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on the audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The overall objective of this audit was to evaluate the Department's efforts to improve the accuracy, completeness, and understandability of correspondence being sent to Medicaid clients, thereby achieving the legislative intent and goals outlined in Senate Bill 17-121 (discussed in more detail in the next section).

To accomplish the audit objective, we performed the following audit work, as required by Sections 25.5-4-213 (2) through (4), C.R.S.:

- Reviewed Medicaid client correspondence generated through CBMS, as well as correspondence that was not generated through CBMS, to determine whether it satisfies federal and state requirements related to the sufficiency of any notice. Specifically, we reviewed standard templates being used by the Department as of December 31, 2019, for Medicaid client correspondence.
- Reviewed the accuracy of client correspondence at the time it is generated, including the accuracy of client income and household composition that is communicated electronically. Specifically, we selected and reviewed a nonstatistical random sample of 100 notices (25 notices from each of the four primary categories of correspondence) that were generated by CBMS and sent to Medicaid applicants and clients between October 1 and December 31, 2019. The results of our sample testing cannot be projected to the population. However, the results are valid for the purpose of identifying examples of problems with notices that were sent to Medicaid clients and applicants. Along with the other audit work performed, the results of our sample testing provide sufficient, reliable evidence as the basis for our conclusions, findings, and recommendations.
- Identified, if possible, the source of inaccurate information, including computer system or interface issues, county input error, or applicant error, when we identified information in client correspondence that was inaccurate at the time the correspondence was generated.
- Reviewed available customer service contact data related to confusion about correspondence received by Medicaid clients or applicants. Specifically, we reviewed the results of two departmental research projects related to Medicaid correspondence. One project was used to convene stakeholders, develop plain language best practices, and identify correspondence requiring improvement. The second project collected information about correspondence-related complaints and concerns from an estimated 2,000 Medicaid client interactions involving 29 counties between 2018 and 2019.

- Reviewed the Department’s client correspondence testing process prior to implementing new or significantly revised communications and the results of this testing, including client comprehension. Specifically, we reviewed procedures established for use by the Member Experience Advisory Council when reviewing and testing correspondence—this council has met periodically since 2018 and has revised two standard templates (the Income Letter and the Verification Checklist) and three other correspondence templates using this process; the Department’s Member Correspondence Standard Operating Procedures, which remained in draft form as of the end of the audit period; and the Plain Language Readability Guidelines and Checklists, which are used by Department staff when developing and revising correspondence templates.

The scope of this performance audit did not include correspondence or communications with Medicaid clients that fall outside of the statutory definition of “correspondence” established in Section 25.5-4-212(2), C.R.S., nor did it include a review of correspondence that was generated prior to January 1, 2018 [see Section 25.5-4-212(3), C.R.S.]. The scope of this audit also did not include work related to the Department’s system of internal controls, as it was determined not to be significant to the audit objectives.

A draft of this report was reviewed by the Department. We have incorporated the Department’s comments into the report where relevant and appropriate. The written responses to the recommendations and the related implementation dates are the sole responsibility of the Department.

Continued Improvements to Medicaid Client Correspondence Are Needed

During the 2016 Legislative Interim, the General Assembly convened an Interim Study Committee on Communication between the Department of Health Care Policy and Financing and Medicaid Clients (Study Committee) to address concerns raised by stakeholders about confusing, inaccurate, and incomplete information in the Department’s correspondence with Medicaid clients. The Study Committee evaluated the form and content of correspondence sent to Medicaid clients, the frequency with which correspondence is sent, and whether correspondence could be simplified and the content made clearer so as to improve the information that is communicated to Medicaid clients.

As a result of the Study Committee’s work, the General Assembly enacted Senate Bill 17-121—codified in Section 25.5-4-212, C.R.S.—that laid out the General Assembly’s intent that the Department take steps to ensure the ongoing improvement of Medicaid client correspondence.

How Were the Results of the Audit Work Measured?

The General Assembly declares in statute [Section 25.5-4-212(1), C.R.S.] that:

- “Accurate, understandable, timely, informative, and clear correspondence...is critical to the life and health of [M]edicaid recipients...”
- “Unclear, confusing, and late correspondence...causes an increased workload for the [S]tate, counties administering the [M]edicaid program, and nonprofit advocacy groups assisting clients.”
- “Improving [M]edicaid client correspondence is critical to the health and safety of [M]edicaid clients and will reduce unnecessary confusion that requires clients to call counties and the...[D]epartment or file appeals.”

Medicaid client correspondence must provide accurate information about the applicant, client, and/or household, and any decision affecting eligibility, benefits, or services, including an approval, denial, termination, suspension of eligibility, or a denial or change in benefits and services. If eligibility or benefits are denied or otherwise suspended, reduced, or terminated, the correspondence must include a specific and plain-language explanation of the basis for the denial or change in benefits. The correspondence must also include, if applicable, a description of the action(s) applicants and clients must or may take in response to the correspondence, as well as a description of any necessary information or documents requested from the applicant or client. The client must be provided a reasonable opportunity period to provide requested information or documents [see Section 25.5-4-212(3), C.R.S., 42 CFR 435.917, and 42 CFR 435.956].

Medicaid client correspondence must also be accessible to and understandable by applicants and clients. This includes ensuring that correspondence uses person-first, plain language; includes the date of the correspondence and a client greeting; uses the same and commonly used terms throughout the correspondence; is translated into other languages (e.g., Spanish); and includes explanations of the determinations made and steps required of applicants and/or clients [see Section 25.5-4-212(3), C.R.S. and 42 CFR 435.917].

What Problems Did the Audit Work Identify?

Overall, we found that the Department has taken a number of proactive steps since the passage of Senate Bill 17-121 to improve Medicaid client correspondence. Specifically, some of the Department’s efforts included identifying correspondence templates requiring improvements and immediately updating those templates that reach the most clients, convening and engaging with stakeholder groups such as the Member Experience Advisory Council, engaging a plain language expert to assist with creating new correspondence, developing a plain language guide to use in the development and

revision of future correspondence, and commissioning an independent study of Medicaid clients' correspondence-related inquiries and complaints involving 29 Colorado counties.

As a result, we found that the language in the Department's templates for the four primary correspondence types (i.e., Notice of Action, Verification Checklist, Income Letter, and Annual Renewal Letter) was reasonably understandable and consistent with the requirements of Senate Bill 17-121. For example, the correspondence used person-first, plain language; included the date of the correspondence and a client greeting; used the same and commonly used terms throughout; was translated into Spanish; conveyed the purpose of the correspondence; and included an explanation of the eligibility determinations made and descriptions of any necessary information or documents being requested from the applicants and/or clients.

Although the Department has made improvements in the correspondence that it sends to Medicaid applicants and clients, we found that there continue to be problems with some correspondence. Specifically, we reviewed a sample of 100 notices sent by the Department between October 1 and December 31, 2019, and found that 67 of the 100 notices (67 percent) had at least one problem with the accuracy, completeness, and/or understandability of the correspondence. The counts reported in the following sections reflect the total number of notices demonstrating each issue and may reflect duplicated counts across all sampled notices due to multiple errors within notices.

Accuracy and Completeness

Client notices contained inaccurate information or were missing information such as effective dates and contact information. Specifically, we found:

25 sampled notices provided inaccurate due dates, resulting in the clients' having fewer than the required minimum number of days allowed to provide information or take action about their eligibility or benefits.

For example:

- One notice dated December 19, 2019, was sent to a client requesting that they provide information about the value of their assets. The due date given to the client—September 27, 2011—had already passed by more than 8 years at the time the notice was generated. Additionally, according to the Department, this information was not necessary to obtain from the client, even if the date in the notice had been correct.

Exhibit 1: Screenshot of notice with due date that had passed at the time the notice was generated

Information to send	Due date for each program: send one copy by the earliest date listed
Proof of the current resale value of an asset you own, or the cash value of an account you have. See Notes or contact us for more information.	09/27/2011 for Medical Assistance

Source: Excerpt from a Verification Checklist dated December 19, 2019, and sent to a Medicaid client.

Due date in the past. This item should not have appeared in the notice.

- One notice dated November 20, 2019, was sent to a client informing them about their eligibility denial. The notice also informed the client of their right to appeal the denial and provided an appeal filing deadline of January 18, 2020, which was 1 day less than the required minimum allowance of 60 days to submit this type of information.

Exhibit 2: Screenshot of notice with inaccurate due date to file an appeal

To ask for an informal meeting for Health First Colorado (Medicaid)	
Deadline to request an informal meeting for Health First Colorado (Medicaid): January 18, 2020	To ask for an informal meeting (county conference), you can call your county human services office and request one. Or, send a letter to your county with your name, address, telephone number, case number, and the reason you disagree with the decision. Send the letter to: [REDACTED]
To appeal (ask for a formal hearing) for Health First Colorado (Medicaid)	
Deadline to appeal for Health First Colorado (Medicaid): January 18, 2020	You can ask for a formal hearing with a judge (also called a State Fair Hearing) in any of these ways: <ul style="list-style-type: none"> • Mail, fax, or bring a letter to the Office of Administrative Courts with: <ul style="list-style-type: none"> ◦ Your name ◦ Your signature (if mailing or faxing) ◦ Your mailing address ◦ Your daytime telephone number ◦ The reason for your appeal ◦ A copy of this notice. Be sure to keep a copy of the letter and this notice for your records. Office for Administrative Courts [REDACTED] <ul style="list-style-type: none"> • You can also request an appeal online at: [REDACTED] The Office of Administrative Courts will mail you the date, time and place for your hearing.

Incorrect appeals due date. Date should be 01/19/2020.

Source: Excerpt from a Notice of Action dated November 20, 2019, and sent to a Medicaid client. Office of Administrative Courts address, website, and other contact information has been redacted.

- One notice dated October 2, 2019, was sent to a client requesting that they provide a copy of their social security card or other proof of their social security number, as well as proof of identification and citizenship. For the social security card, the due date given to the client was October 17, 2019, which was 1 day less than the required minimum allowance of 10 days to submit this type of information. For the proof of identification and citizenship, the due date given to the client was January 1, 2020, which was 4 days less than the minimum allowance of 95 days to submit this type of information.

Exhibit 3: Screenshot of notice with inaccurate due dates for submitting additional information

Information to send	Due date for each program: send one copy by the earliest date listed
Proof of identification, (examples: passport, driver's license, identification card, school ID card, or U.S. military card). Notes for Medical Assistance:	01/01/2020 for Medical Assistance <i>Incorrect due date. Date should be 01/05/2020.</i>
Proof of income from your job (examples: paystubs or business profit and loss statement). Notes for Medical Assistance:	10/18/2019 for Medical Assistance
Copy of your social security card or other document from the Social Security Administration that shows your social security number. Notes for Medical Assistance:	10/17/2019 for Medical Assistance <i>Incorrect due date. Date should be 10/18/2019.</i>
Proof of U.S. citizenship, such as U.S. passport, birth certificate, or certificate of naturalization. Notes for Medical Assistance:	01/01/2020 for Medical Assistance <i>Incorrect due date. Date should be 01/05/2020.</i>

Source: Excerpt from a Verification Checklist dated October 2, 2019, and sent to a Medicaid client.

8 sampled notices provided incomplete or contradictory information about the clients' eligibility or benefits status.

For example:

- One notice dated October 8, 2019, was sent to a client and did not include the effective date of the client's benefits.

Exhibit 4: Screenshot of notice missing an effective date for benefits

✓ Health First Colorado (Colorado Medicaid). You will still get benefits. Your benefits continue on November 1, 2019.

✓ Payment of Medicare Part A &/or B Monthly Premiums and Co-Pays/Deductibles. You will still get benefits. Your benefits continue on . This benefit pays for your Medicare Part B premium, hospital deductibles and doctor co-pays.

Missing effective date.

Source: Excerpt from a Notice of Action dated October 8, 2019, and sent to a Medicaid client.

- One notice dated December 2, 2019, was sent to a client and provided two different effective dates for the client's Medicaid benefits. In this case, only the October 1, 2019, benefit start date should have been communicated to the client; the September 1, 2019, date was old information and should not have been included in the notice.

Exhibit 5: Screenshot of notice with contradictory effective dates for benefits

Health First Colorado (Colorado Medicaid). Your benefits start on September 1, 2019. You can go to Colorado.gov/PEAK or use the PEAKHealth app on your phone to print or view your card. Or, you can wait to receive a card in the mail.

Health First Colorado (Colorado Medicaid). Your benefits start on October 1, 2019. You can go to Colorado.gov/PEAK or use the PEAKHealth app on your phone to print or view your card. Or, you can wait to receive a card in the mail.

Contradictory benefit effective dates.

Source: Excerpt from a Notice of Action dated December 2, 2019, and sent to a Medicaid client.

- One notice dated November 16, 2019, was sent to a client and included language indicating that the client's Medicaid eligibility was both approved and denied. In this case, only the statement reflecting the client's disqualification as of November 30, 2019, should have been communicated to the client. The reference to the client's January 1, 2014, benefit effective date was outdated and should have not appeared in the notice.

Exhibit 6: Screenshot of notice with contradictory eligibility information

██████ qualifies for:

✓ Health First Colorado (Colorado Medicaid). Your benefits start on January 1, 2014. You can go to Colorado.gov/PEAK or use the PEAKHealth app on your phone to print or view your card. Or, you can wait to receive a card in the mail.

██████ does not qualify for:

✗ Health First Colorado (Colorado Medicaid). As of November 30, 2019, you don't qualify because you did not give us all the information we need to decide if you qualify for benefits.

Outdated notification of effective date.

Contradictory eligibility statements for the same client.

Source: Excerpt from a Notice of Action dated November 16, 2019, and sent to a Medicaid client. The client's name has been redacted.

- One notice dated December 4, 2019, was sent to a client and included information stating that their benefits would start on February 1, 2014. However, 12 days prior, the

client had already been sent a notice dated November 22, 2019, indicating that their benefits would continue on January 1, 2020. The December 4, 2019, notice containing information about a February 1, 2014, benefit effective date was for a prior eligibility period and should not have been sent to the client.

Exhibit 7: Screenshots of two separate notices sent to the same client with contradictory eligibility information

Client Notice Dated December 4, 2019

✓ Payment of Medicare Part A &/or B Monthly Premiums. **Your benefits start on February 1, 2014.** This benefit pays for your Medicare Part B premium. You can go to Colorado.gov/PEAK or use the *PEAKHealth* app on your phone to print or view your card. Or, you can wait to receive a card in the mail.

Effective date for a prior eligibility period.

Contradictory benefit effective dates.

Client Notice Dated November 22, 2019

✓ Payment of Medicare Part A &/or B Monthly Premiums. You will still get benefits. **Your benefits continue on January 1, 2020.** This benefit pays for your Medicare Part B premium.

Source: Excerpts from Notices of Action dated November 22, 2019, and December 4, 2019, and sent to the same Medicaid client.

8 sampled notices included incomplete or outdated employment and income information.

For example:

- One notice dated November 3, 2019, was sent to a client for whom the Department was unable to verify income for two periods of time: wages for the quarter April through June 2019, and wages for the quarter July through September 2019. However, the notification sent to the client for review and verification only included income information for the first period—about \$7,900 in wages. The notice did not include income information for the second period—about \$9,700 in wages. This more current and up-to-date income information was available in CBMS as of July 1, 2019.

Exhibit 8: Screenshot of notice with incomplete income amounts

Employed: Yes
Employer: [REDACTED]
Income type: WAGE - CDLE
Amount: \$7836.90
How often: Quarterly

Quarterly wages for April through June 2019. Notice did not include more recent quarterly wages of \$9,700 for July through September 2019.

Source: Excerpt from Annual Renewal Letter dated November 3, 2019, and sent to a Medicaid client. Employer information has been redacted.

- One notice dated October 2, 2019, was sent to a client and included income information for a one-time wage of \$2,400 the client earned in November 2015. However, the notice did not include the client's bi-weekly wages of \$150. This more current income information was available in CBMS in 2018.

Exhibit 9: Screenshot of notice with incomplete income amounts

Employed: Yes
 Employer: [REDACTED]
 Income type: Wages, Salaries and Tips
 Amount: \$2400.00
 How often: One Time Only

Notice should also have included current bi-weekly wages of \$150.

Source: Excerpt from Annual Renewal Letter dated October 2, 2019, and sent to a Medicaid client. Employer information has been redacted.

40 sampled notices included incomplete contact information for the clients' county eligibility site.

Specifically:

- 40 sampled notices were missing the county's fax number and/or phone number, despite the notice stating that clients could fax requested documentation or call the county about the renewal of their health benefits.

Exhibit 10: Screenshot of notice with missing fax and phone numbers

■ Go to Colorado.gov/PEAK. Log in to your account. Click on "Redetermination/Recertification." If you do not have an account, you can create one at any time. Follow the instructions on Colorado.gov/PEAK to create an account.
 ■ Complete the "Renewal Form" included with this letter. Mail, fax, or bring the Renewal Form to:
 PARK County
 [REDACTED]
 Fax:
 ■ Call PARK County at / State Relay: 711 and tell them you are calling about renewal of your health benefits.

Fax number is missing.

Phone number is missing.

QUESTIONS } Visit CO.gov/HCPF/Letters-FAQs or call Page 1

Source: Excerpt from an Annual Renewal Letter dated October 3, 2019, and sent to a Medicaid client. Park County address has been redacted.

Understandability

During our review of the Department's standard templates and sampled notices for understandability, we adopted a client-centered perspective and identified the following examples where the content or structure of the notices may have made it difficult for clients to understand the correspondence:

- One notice dated October 20, 2019, was sent to the client in Spanish, which was the client's preferred language. However, this Spanish-translation notice contained manual-typed notes from a caseworker in English. This same caseworker note was repeated four different times in the notice.

Exhibit 11: Screenshot of Spanish-translation notice with caseworker's notes to client in English

Información que debe enviar	Fecha de vencimiento para cada programa: Envíe una copia antes de la fecha de vencimiento más próxima indicada.
Comprobante de ingresos de su trabajo (ejemplos: talones de cheques de su salario o estado de pérdidas y ganancias de negocio).	10/21/2018 para Medical Assistance 09/17/2018 para Medical Assistance 08/16/2018 para Medical Assistance 07/29/2018 para Medical Assistance
Notas para Medical Assistance: If you reported having job income, we require proof of that income. This can include, but is not limited to, check stubs, employer statements, or IRS Tax Records.	
Notas para Medical Assistance: If you reported having job income, we require proof of that income. This can include, but is not limited to, check stubs, employer statements, or IRS Tax Records.	
Notas para Medical Assistance: If you reported having job income, we require proof of that income. This can include, but is not limited to, check stubs, employer statements, or IRS Tax Records.	
Notas para Medical Assistance: If you reported having job income, we require proof of that income. This can include, but is not limited to, check stubs, employer statements, or IRS Tax Records.	

Repeated instructions to Spanish-speaking client in English.

Source: Excerpt from a Verification Checklist dated October 20, 2019, and sent to a Medicaid client.

- One notice dated December 19, 2019, was sent to a client with manual-typed instructions from a caseworker. The caseworker's notes contained some grammatical errors and were written in all-caps, which is generally interpreted to imply yelling or shouting. These manual-typed user notes are where we found increased frequency of unclear or grammatically incorrect language in the correspondence being sent to Medicaid clients.

Exhibit 12: Screenshot of notice with caseworker's notes to client

Information to send	Due date for each program: send one copy by the earliest date listed
<p>Notes for Food Assistance: WE NEED A SIGNATURE ON THE REDETERMINATION BEFORE WE CAN PROCESS YOUR CASE. PLEASE SIGN THE FRONT PAGE OF THE REDETERMINATION AND RETURN TO OFFICE, THANK YOU.</p>	<p>12/30/2019 for Food Assistance</p>
<p>Proof of the current resale value of an asset you own, or the cash value of an account you have. See Notes or contact us for more information.</p>	<p>09/27/2011 for Medical Assistance</p>
<p>Notes for Medical Assistance: SOMEONE FROM [REDACTED] WILL BE CALLING YOU TO DO AN ASSESSMENT PLEASE MAKE CONTACT WITH THEM WHEN THEY CALL YOU (THIS IS THERE) PHONE NUMBER [REDACTED]</p>	

Use of all-caps can imply yelling or shouting.

Grammatical errors.

Source: Excerpt from a Verification Checklist dated December 19, 2019, and sent to a Medicaid client. The contact name and phone number has been redacted.

- One client was sent a notice dated October 30, 2019, that requested the client provide documentation for seven items. However, two of the requests in the notice appear duplicative, which may have made it difficult for the client to understand whether different or multiple types of documentation were needed. For example, the client may be confused about whether two copies of the same vehicle registration are needed or whether a second vehicle registration document is required and how it differs from the first document. According to the Department, these are not duplicate requests; the items relate to different data points entered in CBMS, each requiring verification. Nonetheless, we maintain that from a client-centered perspective, as presented, these items reasonably appear to be duplicative, thereby lowering the notice's understandability for the client.

Exhibit 13: Screenshot of notice showing requests for information that appear duplicative

Information to send	Due date for each program: send one copy by the earliest date listed
Proof of the current resale value of an asset you own, or the cash value of an account you have. See Notes or contact us for more information. Notes for Medical Assistance:	11/14/2019 for Medical Assistance
Your Medicare ID number (also called the Medicare claim number or Medicare Beneficiary Identifier). Notes for Medical Assistance:	11/14/2019 for Medical Assistance
Proof of cash or an asset that can easily be changed to cash (examples: bank account statements, investment accounts, income tax refund, statement declaring how much cash savings you have). Notes for Medical Assistance:	11/14/2019 for Medical Assistance
Proof of cash or an asset that can easily be changed to cash. (examples: bank account statements, investment accounts, income tax refund, statement declaring how much cash savings you have). If it is jointly owned, the proof must show all owners. Notes for Medical Assistance:	11/14/2019 for Medical Assistance
Proof of money you get from something besides a job (examples: Social Security, pension, severance pay, or unemployment). Notes for Medical Assistance:	11/14/2019 for Medical Assistance
A copy of your vehicle registration or statement about the value of the vehicle. Notes for Medical Assistance:	11/14/2019 for Medical Assistance
A copy of your vehicle registration or statement about the value of the vehicle. If the vehicle is jointly owned, send proof of all owners and what percent of the item(s) is owned by each. Notes for Medical Assistance:	11/14/2019 for Medical Assistance

Requests appear duplicative.

Requests appear duplicative.

Source: Excerpt from a Verification Checklist dated October 30, 2019, and sent to a Medicaid client.

- The Department’s standard template for the Income Letter does not clearly separate the contents of the notice’s introduction section (i.e., purpose) from the contents of the client action section. The template appropriately opens with a clear purpose statement for the correspondence, but then immediately includes instructions for the client to provide certain information by a due date. These same client instructions and due date are included later in the template—more appropriately in a “What you need to do” section—using somewhat different language. By providing redundant information or instructions with small variations in two sections of the correspondence, the Department is increasing the opportunity for confusion and the likelihood that a client will call for clarification.

Exhibit 14: Screenshot of commingled purpose and client instructions

Dear [Case Name]:

Purpose → We are writing to let you know that the income you most recently gave us does not match what we have in our records. **Please read this letter to make sure we have the correct information about your income so we can make a decision about the health benefits the people in your household qualify for.**

Client instructions →

- **If the information we have is wrong or you have a change to report, send us the information on the About My Income Form at the end of this letter by [IEVS Due Date].**
- **If the information is correct and you do not have any changes on the About My Income Form to report, you do not have to send any information.**

Your income

Our records for [Individual Name]'s total income for the three-month period from [Quarter Begin Date] to [Quarter End Date] from his/her employer(s) show:

<u>Employer Name</u>	<u>Total amount from [Quarter Begin Date] to [Quarter End Date]</u>
[Employer Business Name]	[Gross Income]

Note: If you do not recognize the employer name, ask your employer if they do business under a different name.

What you need to do by [IEVS Due Date]

Purpose → **Sometimes the income information we have is wrong or out-of-date. If the income information above is wrong or you have a change to report, send us the About My Income Form by [IEVS Due Date] so we can make a decision about the health benefits for the people in your household.**

Client instructions → **If this income amount is correct and you have no changes to report, you do not need to send us the About My Income Form.** This may mean you make too much money to qualify for Health First Colorado (Colorado's Medicaid Program) or Child Health Plan *Plus* (CHP+). This letter is not changing

Source: Excerpt from the Department's Income Letter template for Medicaid clients.

- We found that three of the standard notices (Income Letter, Verification Checklist, or Annual Renewal Letter) that the Department uses to request information from Medicaid applicants and clients may ask for similar types of information, such as documentation to support income or resources, at different times, using different language, and with different due dates. Each standard notice has a different purpose and verification timeframe, and sending separate notices is necessary to comply with various federal and state requirements. However, given the objectives of this performance audit, we must recognize that receiving multiple notices, especially if they contain apparently duplicative or conflicting information, is confusing and difficult to understand from the client's perspective.

Why Did These Problems Occur and Why Do They Matter?

Client correspondence is a key component of the Medicaid eligibility and enrollment process. Notices are critical to ensuring that Medicaid clients can understand and use their benefits, comply with applicable requirements, and take appropriate action when needed. As the General Assembly stated in Senate Bill 17-121, “improving [M]edicaid client correspondence is critical to the health and safety of...clients and will reduce unnecessary confusion....”

Improving Medicaid client correspondence is a process of *ongoing quality improvement* taking place in a complex environment of federal and state requirements and requiring internal coordination across multiple divisions and functions, and external coordination with stakeholders, counties, system programmers, contractors, and other state agencies. Recognizing that its efforts to improve Medicaid client correspondence were generally siloed within and led by different divisions, in the fall of 2019, the Department designated two key positions within its Communications and Government Relations Division to lead this quality improvement process moving forward.

With a new process improvement owner and defined roles, responsibilities, and authority of key individuals in place, the Department needs to focus its efforts in two key areas to help ensure that continued improvements to Medicaid client correspondence are made. These two areas of focus are consistent with principles found in several management frameworks used in the public and private sectors—Project Management Institute, Total Quality Management (LEAN/Six Sigma), and the U.S. Government Accountability Office’s *Standards for Internal Control in the Federal Government* (Green Book).

- **Define the full scope of work and set a review schedule.** Although the Department took steps subsequent to the enactment of Senate Bill 17-121 to update templates for those correspondence types that reach the most clients, as of June 2020, the Department had not yet identified the population of all templates that are being used to generate client correspondence, nor had it completed its review of these templates to determine whether and what revisions are needed.
- **Expand routine monitoring activities and provide results back to the process improvement team.** The Department’s monitoring activities to date have been focused primarily on correspondence templates and do not currently include systematic testing of notices that are actually sent to Medicaid clients, similar to the approach used in this audit. Monitoring activities that focus on templates containing standard boilerplate language are important for ensuring qualities such as the use of plain language, inclusion of all required elements, and overall understandability. However, the contents of Medicaid correspondence, especially correspondence that is generated through CBMS, are also driven by dynamic fields that populate the standard templates with client- or case-specific information (e.g., effective dates, due dates, household and income information, caseworker notes). The content driven by dynamic

fields can only be effectively assessed and evaluated through systematic testing of actual client notices. In fact, most of the problems with client correspondence that we identified and discussed in this report were related to dynamic fields and not the templates themselves. Monitoring activities also must occur frequently enough (e.g., monthly or quarterly) to ensure that issues are identified and corrected in a timely manner. Because the results of client correspondence testing could drive CBMS programming changes, further template revisions, and/or changes to guidance and training for caseworkers, it is critical that the results of routine client correspondence testing be communicated back to the improvement process ownership team for evaluation, prioritization, and implementation of appropriate remedies.

Without defining the full scope of work, including having a set schedule for the systematic review and update of all templates, the Department is limited in its ability to make sufficient progress in its Medicaid client correspondence improvement efforts. Without routine monitoring activities that include systematic testing of actual client correspondence and communication of the results back to the improvement process ownership team, the Department is limited in its ability to identify and, most importantly, remedy problems with the accuracy, completeness, and understandability of the correspondence being sent to Medicaid clients.

Throughout our audit, we communicated and provided the Department with the details of our sample test work. As part of this process, the Department performed its own research into the underlying causes of the problems we identified through our review of the sampled notices. In addition to making the overall process improvements discussed previously, the Department should use this detailed information about the sampled notices to make more targeted changes and address the issues identified in this audit.

- **CBMS Programming Changes.** Most of the problems we identified in the sampled notices occurred at the time the correspondence was generated and appear to be the result of computer system or interface issues. For example:
 - Notices with incomplete phone and fax numbers for county eligibility sites occurred because county-specific profiles in CBMS were not complete with respect to contact information, resulting in blanks being inserted into the client notices when they were generated by CBMS.
 - Inaccuracies in the due dates for some notices occurred due to the timing of batch processes in CBMS. The Department explained that the system functionality for client correspondence may result in notices providing clients one day less to respond to information and documentation requests. At 6:00 p.m. each day, CBMS processes all correspondence requests for that day. Any client correspondence requests created after 6:00 p.m. are processed on the following day. The Department's explanation for why we observed problematic due dates on some notices is reasonable; however, this

explanation does not resolve the underlying problem that some correspondence being sent to clients affords them less than the minimum required allowable response times.

- Inaccuracies in the due dates for other notices occurred because CBMS coding had not properly implemented a mandate within the Code of Federal Regulations that affords individuals a reasonable opportunity period of 95 days to provide certain information—individuals have 90 days from the date the individual receives the notice to submit required documentation, and regulations state that the date of receipt is considered to be 5 days after the date of the notice.
- Incomplete or outdated employment and income information in some notices occurred because CBMS coding did not ensure that information was being pulled from relevant data fields when generating client notices.
- Incomplete and contradictory eligibility and benefits status information in some notices occurred because CBMS coding did not ensure that prior eligibility determinations and previously communicated effective dates were suppressed (i.e., kept inactive) when issuing new client notices.
- **Caseworker Guidance and Training.** The problems we identified with several sampled notices were not the result of system issues, but rather were the result of caseworkers' manual-typed instructions and directions that were included in the notices. Also, in at least one sampled notice, CBMS pulled outdated income information into the notice because the caseworker did not manually clear the outdated information from CBMS before the notice was processed. The information that county caseworkers input into CBMS and the activities they perform in the system are no less important for achieving clear and understandable communications with Medicaid applicants and clients. Thus, some of the sampled notices from this audit can help the Department inform guidance and training for caseworkers in support of its goal to improve the understandability and clarity of client correspondence.

Recommendation No. 1:

The Department of Health Care Policy and Financing should continue to strengthen its ongoing Medicaid client correspondence improvement efforts by:

- a. Identifying the population of all templates that are used to generate Medicaid client correspondence and developing a system for the prioritization, review, and update of these templates.

- b. Expanding routine monitoring activities to include the systematic testing of correspondence actually sent to Medicaid clients, including establishing a frequency to ensure the identification of issues in a timely manner, and providing results back to the process improvement ownership team for evaluation, prioritization, and implementation of appropriate remedies.

Department of Health Care Policy and Financing Response:

- a. Agree. Implementation Date: July 2021.

Work to support this recommendation is already underway, in several forms. The Department has created a correspondence and member facing communication tracking spreadsheet. This spreadsheet is an evolving inventory for CBMS member correspondence, as well as correspondence sent out from all other systems to members directly from the Department. We will continue to grow the inventory to include correspondence sent to members by our contractors. Data captured includes the name and file for each correspondence being sent, date of creation or revision and identity of any revisions to these documents (if applicable), the system or contractor responsible for sending them out.

The Department has also conducted, through a third-party vendor, key informant interviews with members, county and agency partners to help identify issues in the correspondences, document development and revision process. These interviews gave us insights that will inform our processes, both internal and external, and our prioritization work. This same vendor is also contracted to provide support to our existing Department staff by reviewing correspondence, suggesting prioritization and completing revisions to fully implement this recommendation by July 2021.

- b. Agree. Implementation Date: July 2021.

The Department currently leverages our Member Experience Advisory Committees, through virtual meetings and virtual surveys and focus groups to test language used in correspondence before it is input into systems. This is our mechanism to test correspondence that is newly developed and correspondence that is substantively changed with our members to ensure correspondence is understandable and in plain language. The Department will work with our vendors to expand monitoring activities and proactively test correspondence with members.

The Department agrees with this recommendation and will develop and implement a plan by July 2021 that will expand current work to include correspondence actually sent to members. The plan will include establishing a frequency for timely identification of issues, providing results back to the

process improvement ownership team for evaluation, prioritization and implementation of remedies in a timely manner.

Recommendation No. 2:

The Department of Health Care Policy and Financing should use information about the sampled client notices reviewed as part of this audit to:

- a. Make necessary programming changes to the Colorado Benefits Management System (CBMS).
- b. Inform guidance and training for county caseworkers, as appropriate.

Department of Health Care Policy and Financing Response:

- a. Agree. Implementation Date: July 2021.

The Department has thoroughly researched the situation for each of the sampled client notices discussed in the audit and determined that remedies for 40 of the notices (49%) are related to CBMS changes. The Department had previously identified issues related to eight of the notices, which were corrected. For the one notice that was sent requesting old verifications and seven notices that did not have all the employer records, these were corrected through programming changes made in October and December 2019 during the audit's sample testing period. The auditors' work identified nine additional issues that were also corrected. For one notice that was sent requesting verification with a past due date, seven notices where the system was sending out multiple notices, and one notice where correspondence was missing a begin date, these were all corrected in February, May, and August 2020. Therefore, 42.5% of the sampled notices where CBMS programming was the underlying cause were completed before this report will be issued.

For the remaining 23 sampled client notices (57.5%) where the remedy requires CBMS changes (six notices that were sent 90 days prior to the due date and seventeen notices related to client correspondence created after 6:00 PM that were processed the following day), the Department agrees to research the original system design and federally required policies and then make appropriate regulation and programming changes by July 2021.

- b. Agree. Implementation Date: July 2021.

The Department has thoroughly researched the situation for each of the sampled client notices discussed in the audit and determined that remedies for 40 of the notices (49%) were due to County Security Administrators not including eligibility caseworkers' contact information, such as a fax number or

telephone number, within CBMS so it could be properly populated in the correspondence. The Department is working with County Security Administrators to ensure all fields are completed when setting up a county eligibility caseworker's user profile in CBMS. The Department will also research the feasibility and implementation of a CBMS change to populate the information from a different source by July 2021.

Problems with two client notices (2%) were related to the county caseworker's manual typed notes and entries into CBMS. The Department agrees to provide these issues to the CBMS training team to revise their current curriculum. Currently, the Department's CBMS training team uses a webinar to instruct workers on correspondence etiquette and plain language writing. The training includes information on user note character limit, instruction on checking for grammatical errors, advises against the use of acronyms, the use of plain language, and a desk aid of "using plain language for User Notes". The Department will work with our county partners and update trainings to county caseworkers by July 2021.
