

Department of Health Care Policy & Financing

Medicaid Correspondence

Performance Audit
September 2023
2261P



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September 29, 2023

Members of the Legislative Audit Committee:

This report contains the results of a performance audit of the Department of Health Care Policy & Financing Medicaid Correspondence. The audit was conducted pursuant to Section 25.5-4-213(4), C.R.S., which requires the Office of the State Auditor to conduct a performance audit of Medicaid correspondence, and Section 2-7-204(5), C.R.S., which requires the State Auditor to annually conduct performance audits of one or more specific programs or services in at least two departments for purposes of the SMART Government Act. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy & Financing.

Kerri L. Hunter



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Report Highlights



Medicaid Correspondence

Department of Health Care Policy & Financing
Performance Audit • September 2023 • 2261P

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C O L O R A D O

Key Concern

The Department of Health Care Policy & Financing (Department) should improve its management of Medicaid correspondence. The Department does not have effective processes for identifying, updating, and implementing changes to Medicaid correspondence to ensure that correspondence is accurate, understandable, informative, and clear, as directed by statute.

Key Findings

- Our review of the four main types of correspondence in the Colorado Benefits Management System (CBMS), the main informational technology system that the Department uses for Medicaid correspondence, found problems involving the clarity, accuracy, and completeness of the letters. We found at least 1 problem in 72 of the 80 letters (90 percent) that we reviewed from CBMS. Medicaid members continue to receive letters with duplicated information, contradictory and confusing messages, unclear status and directions to members on next steps, and complicated sentences and word choice. We also found letters with non-compliant or inconsistent dates and letters with missing required elements and information.
- Previous work conducted by the Department's communications contractor in 2016 and our contractor in 2020 identified many of the same issues we continued to see in this audit. These problems persist because the Department has not fully implemented the previously recommended changes to its monitoring functions, work processes, guidance to workers, and system design.
- Medicaid correspondence sent by the Department's vendors who review prior authorization requests for Medicaid services did not meet standards for Medicaid correspondence, resulting in inaccurate and incomplete letters that do not align with plain language requirements and did not comply with rules giving members adequate time to appeal the decisions.
- The Department has not systematically reviewed vendor correspondence for compliance with applicable requirements. Additionally, the Department has not established or enforced consistent standards for vendors' Medicaid correspondence.
- The Department has not comprehensively identified all letters subject to the Medicaid correspondence improvement requirements. For the correspondence it has identified, the Department has made limited progress in reviewing, updating, and implementing changes to some correspondence.
- The Department has not assigned responsibilities and delegated authority to ensure that correspondence is compliant with requirements. Additionally, it does not have policies and procedures guiding the Medicaid correspondence identification, review, update, and implementation processes.

Background

- The Medicaid Correspondence Improvement Process Act (Act), codified in Section 25.5-4-212, C.R.S., defines Medicaid member correspondence, lists standards that correspondence must meet, and requires the Department to develop a process for ongoing correspondence improvement.
- The Department and its vendors send multiple types of letters from different information systems that are subject to these requirements. In January and February 2023, the Department sent more than 400,000 letters each month out of CBMS related to eligibility for Medicaid programs. Its vendors also sent more than 24,000 prior authorization approval and denial letters.
- Section 25.5-4-213(2), C.R.S., required the State Auditor to conduct performance audits of the Department's progress in implementing the Act in 2020 and 2023. This is the second of these required audits.

Recommendations Made

8

Responses

Agree: 8

Partially Agree: 0

Disagree: 0



Chapter 1

Overview

Colorado Medicaid

Medicaid is a federal-state program that provides health care coverage and services to eligible low-income individuals. Medicaid is administered federally by the Centers for Medicaid and Medicare Services (CMS) under Title XIX of the Federal Social Security Act, and within Colorado, by the Department of Health Care Policy & Financing (Department). The State's Medicaid program is named Health First Colorado.

In accordance with federal regulations [42 CFR, 435], Health First Colorado covers Medicaid benefits for the following low-income populations.

- Adults with an income at or below 133 percent of the federal poverty level.
- Children in families with a household income at or below 142 percent of the federal poverty level.
- Pregnant individuals with an income at or below 195 percent of the federal poverty level.
- Parents and caretaker relatives of a dependent child with a household income at or below 68 percent of the federal poverty level.
- Adults with an income between 133 percent and 260 percent of the federal poverty level are not eligible for full Medicaid, but are eligible for a limited family planning benefit for medical services related to reproductive health.

Individual applicants qualify for Medicaid benefits if they meet the established criteria in federal and state law; these criteria include the applicant's income, state residency, age, citizenship or immigration status, household composition, and pregnancy status. As of July 2023, the Department reported that there were about 1.7 million Coloradans enrolled in Medicaid. The Department refers to Medicaid recipients as members, and we use that term throughout this report for both Medicaid applicants and those enrolled in Medicaid.

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The Department uses the Colorado Benefits Management System (CBMS) as the statewide data system to process all Medicaid applications and determine an individual's Medicaid eligibility. The State contracts with a vendor to maintain CBMS. Applicants complete Medicaid applications online through the State's Program Eligibility and Application Kit (PEAK), and the applications are then transferred to CBMS. CBMS conducts automated, real-time verifications of applicants' identities, social security numbers, citizenship and immigration status, and income using electronic interfaces. If the applicant cannot use the PEAK website, county caseworkers collect applicant information and enter it directly into CBMS.

In addition, there are some Medicaid Long-Term Services and Support programs, overseen by the Department's Office of Community Living (OCL), that are only available to members that meet eligibility requirements based on needs assessments, such as services for intellectually and developmentally disabled individuals. The Department contracts with case management agencies who are responsible for conducting those needs assessments.

Some Medicaid benefits, such as surgeries, prescriptions, and physical therapy, are only covered by Medicaid if there is sufficient evidence that the service is medically necessary. For these benefits, the State requires the members' medical providers to request the service on the member's behalf in the form of a Prior Authorization Request (PAR). The Department contracts with nine vendors that review the required PARs to determine if the requested service should be approved or denied. The vendors send approval or denial letters to the provider and member with instructions on how to appeal a denial. Some of these vendors specialize in specific types of services such as dental or pharmacy, while others are regional organizations that manage member care on behalf of Medicaid.

Correspondence

In 2016, the General Assembly convened the Interim Study Committee on Communication Between the Department of Health Care Policy & Financing and Medicaid Clients (Interim Study Committee). The committee's purpose was to improve communication to individuals receiving Medicaid services by:

1. Evaluating the letters sent to members by the Department,
2. Assessing their frequency, and
3. Determining whether the Department could simplify the letters and clarify their content.

Shortly before the Interim Study Committee began its work, the Department contracted with health literacy and plain language consultants to review Medicaid correspondence. These consultants recommended areas for improvement to specific letters, as well as general best practices for all communication. Recommendations included limiting the number of messages to reduce information

overload, reducing the length of letters, streamlining and clarifying content, using formatting and visual cues to highlight key information, and conducting member testing after implementing changes to correspondence. The Department presented the consultants' recommendations during committee hearings. The Interim Study Committee also heard from other stakeholders directly, like the state and county departments of human services and advocacy groups representing Medicaid members. Ultimately, the Interim Study Committee's work resulted in Senate Bill 17-121, also known as the Medicaid Correspondence Improvement Process Act (Correspondence Improvement Act), which was codified in Section 25.5-4-212, C.R.S.

Health literacy and plain language recommendations included:

- Limit the number of messages to reduce information overload.
- Reduce the length of letters, streamline and clarify content.
- Use formatting and visual cues to highlight key information.
- Conduct member testing after implementing changes to correspondence.

In the Correspondence Improvement Act, the General Assembly declared that “accurate, understandable, timely, informative, and clear correspondence from the State Department is critical to the life and health of Medicaid recipients” [Section 25.5-4-212(1)(a)(I), C.R.S.] and that “unclear, confusing, and late correspondence from the State Department causes an increased workload for the state, counties administering the [M]edicaid program, and nonprofit advocacy groups assisting clients” [Section 25.5-4-212(1)(a)(II), C.R.S.]. Statute further states that the “Government should be a good steward of taxpayers’ money, ensuring that it is spent in the most cost-effective manner” [Section 25.5-4-212(1)(a)(III)] and that “...improving Medicaid [member] correspondence is critical to the health and safety of Medicaid [members] and will reduce unnecessary confusion...” [Section 25.5-4-212(1)(b), C.R.S.].

Statute defines member “correspondence” as any communication, the purpose of which 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;
- Or to request additional information that is relevant to determining an individual’s Medicaid eligibility or benefits” [Section 25.5-4-212(2), C.R.S.].

The Correspondence Improvement Act includes specific requirements to ensure that any Medicaid correspondence issued after January 1, 2018:

1. Is written using person-first, plain language;
2. Is written in a format that includes the date of the correspondence and a member greeting;
3. Is consistent, using the same terms throughout to the extent practicable including commonly used program names;
4. Is accurately translated into the second most commonly spoken language in the state, if a member indicates that this is the member's written language of preference, or as required by law;
5. Includes a statement translated into the top fifteen languages most commonly spoken by individuals in Colorado with limited English proficiency informing the applicant or member how to seek further assistance in understanding the content of the correspondence;
6. Clearly conveys the purpose of the correspondence, the action or actions being taken by the Department or its designated entity, if any, and the specific actions that the member must or may take in response to the correspondence;
7. Includes a specific description of any necessary information or documents requested from the applicant or member;
8. Includes contact information for member questions; and
9. Includes a specific and plain language explanation of the basis for denial, reduction, suspension, or termination of the benefit, if applicable.

We also use the term “letter” interchangeably with “correspondence” throughout this report to refer broadly to the written communication the Department sends Medicaid members to communicate about eligibility and about approvals and denials for benefits and services—which includes what the Department calls “notices.”

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Correspondence Systems

The Department generates correspondence out of the following systems:

Colorado Benefits Management System

The Department communicates most Medicaid eligibility determinations and requests information to determine eligibility through CBMS. The majority of correspondence generated by CBMS falls under one of four primary eligibility correspondence types: (1) notice of eligibility status, (2) request for information to determine eligibility, (3) request to verify self-reported income, and (4) an annual request to update any information the Department is using to determine eligibility. We have more details on the four main types of CBMS letters in Chapter 2.

CBMS is programmed to generate correspondence based on specific schedules and triggers. In some cases, multiple correspondence may be issued. For example, during the annual renewal period, Medicaid members may receive up to three types of correspondence: the Annual Renewal Letter, Verification Checklist, and Notice of Action. If there are income discrepancies, the member may also receive a fourth correspondence—the Income Letter. Each CBMS-generated correspondence contains information that is populated in two ways. First, standardized, or static, fields are generated using templates. The templates contain standard language, relevant to the nature and purpose of the correspondence. The second type of field is populated by CBMS and contains member-specific information through dynamic fields, which include information such as the effective date of the member's eligibility or case notes entered manually by a caseworker.

Under the Department's current structure, changes to CBMS correspondence are implemented through the Department's Eligibility Division.

Benefits Utilization System

The Department also sends Medicaid member correspondence outside of CBMS for Medicaid members who are eligible for long-term services and support benefits. Long-term services and support programs provide members assistance with daily living activities and include nursing facility care, adult daycare programs, home health aide services, personal care services, and supported employment. OCL must determine that a member is functionally eligible for each program and it oversees the long-term service and support programs to ensure members can remain in their homes and communities. OCL issues Notice of Action letters to members, which inform them of an approval or denial of their application regarding long-term service and support benefits, a disability determination, or a reduction or termination of benefits based on continual needs assessments. OCL has historically used its Benefits Utilization System (BUS), to issue member correspondence. In July 2023, OCL replaced BUS with a new case management system, called the Care and Case Management System.

Vendor Systems for Prior Authorization Requests

The Department contracts with nine vendors that issue approval and denial letters after reviewing a provider's request for services on behalf of a member. Each vendor has their own information system that issues correspondence. Some of these vendors also contract out the review of prior authorization requests and issuance of correspondence to subcontractor specialists.

Exhibit 1.1 shows the numbers of correspondence sent to members in January and February of 2023 from both the Department, through CBMS and BUS, and its vendors.

Exhibit 1.1
Medicaid Correspondence by Sender

Sender	January 2023	February 2023	Total Correspondence
CBMS	423,766	415,030	838,796
BUS	2,560	2,462	5,022
Prior Authorization Vendors	24,779	24,400	49,179
Total	451,105	441,892	892,997

Source: Office of the State Auditor analysis of correspondence data provided by the Department of Health Care Policy & Financing.

Sources of Feedback on Correspondence

Member Experience Advisory Council (MEAC)

This is a volunteer council made up of 18 Medicaid members or caregivers of Medicaid members who serve 2-year terms. When accepting new members, the Department seeks to represent a variety of geographic locations and Medicaid programs. MEAC members review Medicaid template letters and letters with generic member information created by the Department and then meet to discuss their impressions.

Plain Language Contractor

The Department contracts with a vendor that provides plain language correspondence reviews. The vendor produced reports in 2016 and 2020 for the Department on ways to improve some CBMS correspondence. The vendor assists the Department with testing correspondence with members, drafting correspondence, and providing recommendations on how to improve the understandability of correspondence.

County Correspondence Questionnaire

The Department works with 75 local organizations that determine Medicaid eligibility for members in their caseload. These include 64 county departments of human services and 11 medical assistance sites. The Department conducts a review of each organization's operations once every 3 years. Starting in Fiscal Year 2022, the Department requires the local organizations to fill out a questionnaire providing the Department with feedback on the clarity of the four major types of CBMS letters and common questions they receive from members related to Medicaid correspondence, in general, as part of this review.

Member Contact Center

The Department manages a call center that fields questions related to all aspects of Medicaid, including correspondence. If an agent in the call center determines that a call was primarily related to correspondence, they will label it with a "Correspondence" ticket type. Records of calls with this label can be retrieved and reviewed to identify common member questions regarding correspondence. The call center also conducts chat interactions with members through the PEAK website.

The MEAC, plain language vendor, and Member Contact Center are managed by the member experience section of the Department's Medicaid Operations Office.

Public Health Emergency

In January 2020, the U.S. Department of Health and Human Services declared a public health emergency (PHE) for the COVID-19 Pandemic. The U.S. Congress (Congress) passed legislation that ensured that anyone enrolled in Medicaid was guaranteed to keep their health coverage during the PHE, known as the "continuous coverage requirement." In the Consolidated Appropriations Act for 2023, Congress approved the end of continuous Medicaid coverage, effective March 31, 2023.

During the PHE, the Department continued conducting renewals normally, sending out a renewal letter to members annually, and asking for updated information on members' household and income. These renewals are staggered, with members receiving their renewal letter in the month that they first joined Medicaid. To meet the continuous coverage requirement during the PHE, the Department could not decrease or terminate members' benefits for any reason, including as a result of information they provided as part of their renewal.

Audit Purpose, Scope, and Methodology

Statute requires that the Office of the State Auditor conduct audits of Medicaid member correspondence in Calendar Years 2020 and 2023 [Section 25.5-4-213(2), C.R.S.]. The 2020 *Medicaid Client Correspondence* performance audit was completed by the Office of the State Auditor, under contract with Sjoberg Evashenk Consulting, LLC. Statute requires auditors to review correspondence generated from CBMS and correspondence generated outside of CBMS, which would include correspondence generated by OCL from the BUS and by the Department's prior authorization request vendors. Section 25.5-4-213(3), C.R.S., requires the performance audit to complete the following:

- A review of the accuracy of member correspondence at the time it is generated and whether member correspondence sufficiently satisfies the requirements of any state or federal law, rule, or regulation;
- A review of the Department's member correspondence testing process, including if it is conducted prior to implementing new or significantly revised letters, and the results of correspondence testing, including member comprehension of the intended purpose or purposes of the correspondence;
- A review of available customer service data regarding member confusion from Medicaid correspondence tracked by counties, the Department's call center, and from Connect for Health, the State's health benefit exchange; and
- A review of the accuracy of member income and household composition information that is communicated electronically, if applicable.

We also conducted this performance audit pursuant to Section 2-7-204(5), C.R.S., the State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act. Audit work was performed from January 2023 through August 2023. We appreciate the cooperation and assistance provided by the Department's management and staff during 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 our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The key objectives of the audit were to (1) determine if the Department's Medicaid correspondence is compliant with federal and state requirements including accuracy, completeness, plain language,

and sufficiency, and (2) determine the effectiveness of the Department's Medicaid correspondence monitoring process in ensuring correspondence is accurate, complete, and understandable.

To accomplish our audit objectives, we performed the following audit work:

- Reviewed relevant state and federal laws, program rules, Department policies, procedures, practices, guides, and contracts for requirements applicable to Medicaid correspondence.
- Interviewed staff regarding how the Department creates, defines, and monitors member correspondence, as well as how the Department tracks customer service data.
- Reviewed supporting data and documentation from the Department related to correspondence review and monitoring, including:
 - SMART Government Act presentations
 - The status report for the *2020 Medicaid Client Correspondence* performance audit
 - Vendor correspondence monitoring reports
 - PHE guidance.
- Evaluated the templates used by the Department and its vendors, and the correspondence sent by the Department and its vendors during January and February 2023.
- Analyzed Department data on letters sent in January and February 2023 for trends in volume and frequency of correspondence that it sent to members.
- Reviewed stakeholder feedback about correspondence collected by the Department including MEAC records from October 2020 to January 2023 and County Correspondence Questionnaires from October 2021 to June 2022.
- Evaluated customer service data for July to December 2022 that the Department categorized as correspondence-related.

We relied on three selection techniques to support our audit work as follows:

- **Random Samples.** In January and February 2023, the Department issued almost 840,000 letters from CBMS. We randomly selected a sample of 20 letters from each of the four main CBMS correspondence types—Notice of Action, Verification Checklist, Eligibility & Verification System Notice – Income Letter, and Redetermination, Recertification, and Reassessment Notice – Annual Renewal Letter—for a total sample size of 80 letters.
- **Volume-Based Selection.** We used a targeted, risk-based approach to select random Medicaid members based on the total volume of correspondence they received during the 2-month review

period—January and February 2023. For CBMS and two of the Department’s PAR vendors (the Pharmacy Benefits and Equipment and Specialized Service Benefits vendors), we totaled each family’s or member’s letters for the period to establish categories of volume based on each dataset’s distribution. For CBMS, we randomly selected from 6 categories – families who received 1 letter, families who received 2 letters, families who received between 3 and 5 letters, families who received 6 to 15 letters, families who received between 16 and 30 letters, and families who received 31 or more letters. For PAR vendors, there was less variation in terms of volume. For both vendors, members received between 1 and 5 letters, so we randomly selected 1 member from each category in that range. For each randomly selected family or member, we pulled all of their letters for the 2-month period to review. In some cases, we selected more than one CBMS family from a category due to extreme outliers in the volume of letters. This sampling design allowed us to look at a range of possible member experiences and aligned with risks identified in customer service data and member testing feedback. These risks included members receiving conflicting correspondence and being overwhelmed by the volume of letters and information communicated in each letter.

- **Template-Based Selection.** For the Department’s other seven PAR vendors (one for dental benefits, and six for behavioral and physical health benefits), we selected at least one representative letter for each template type, for a total of 37 templates and letters. We used a targeted, risk-based approach to ensure we reviewed the different types of letters the vendors send Medicaid members. This approach allowed us to test letters sent to members to determine whether the dynamic fields operated correctly and produced text in line with readability goals.

The results of our random samples cannot be projected to the population. However, they are valid for confirming problems with letters. Along with the other audit work performed, the testing results provide sufficient, reliable evidence as the basis for our findings, conclusions, and recommendations.

As required by auditing standards, we planned our audit work to assess the effectiveness of those internal controls that were significant to our audit objectives. Details about the audit work supporting our findings and conclusions, including any deficiencies in internal control that were significant to our audit objectives, are described in the remainder of this report.

A draft of this report was reviewed by the Department. Obtaining the views of responsible officials is an important part of the Office of the State Auditor’s (OSA) commitment to ensuring that the report is accurate, complete, and objective. The OSA was solely responsible for determining whether and how to revise the report, if appropriate, based on the Department’s comments, as applicable. The written responses to the recommendations and the related implementation dates were the sole responsibility of the Department.

Chapter 2

Medicaid Correspondence

The Medicaid Client Correspondence Improvement Process Act (Correspondence Improvement Act) in state law defines Medicaid correspondence as any communication that approves or denies Medicaid eligibility or access to benefits, and any requests for information to determine eligibility [Section 25.5-4-212(2), C.R.S.]. Pursuant to state law, the Department of Health Care Policy & Financing (Department) must ensure that all Medicaid member correspondence created or revised after January 2018 meet the standards listed in the law [Section 25.5-4-212(3), C.R.S.]. Primarily, the standards require the Department to clearly communicate the letter’s purpose and the recipients’ next steps. Statute also requires the Department to ensure that both Colorado Benefits Management System (CBMS) and non-CBMS correspondence are compliant; to prioritize improvement to correspondence sent to smaller groups of vulnerable individuals if it has significant impact to their lives; and to develop a process for ongoing correspondence improvement [Section 25.5-4-212(6-8), C.R.S.]. The Department works with partners and vendors to send multiple types of correspondence subject to these statutory requirements.

Throughout these findings, we use the term “member” to align with the Department’s communication practices, and to refer to both Medicaid applicants and people already approved for the program and enrolled in Medicaid. We also use the term “letter” interchangeably with “correspondence” throughout our findings to refer broadly to the written communication the Department sends to its applicants and members to communicate about eligibility and about approvals and denials for benefits and services—which includes what the Department calls notices and letters.

Since Medicaid is funded jointly with state and federal dollars, the Department must comply with many federal requirements to obtain federal matching funds. For Medicaid member correspondence, the Department is responsible for communicating important health coverage information and requesting specific documents to determine eligibility pursuant to federal requirements. The Department will always have to apply rigorous communication best practices to ensure it both meets the federal requirements for what messages it needs to communicate and effectively communicates its message.

This chapter contains the results of our audit work from (1) examining the clarity of the Department’s correspondence against standards in state law and the Department’s member communication best practices and (2) reviewing the effectiveness of the Department’s management of correspondence improvement. We focused on the compliance and quality of Medicaid

correspondence and the Department's related management activities, including correspondence monitoring, quality assurance, and improvement processes. Specifically:

- **In Finding 1, we discuss Medicaid member correspondence compliance with the Correspondence Improvement Act.** This work builds on the 2020 *Medicaid Client Correspondence* performance audit work by testing the Department's reported progress addressing the compliance and quality problems of CBMS correspondence. The finding also expands on 2020 audit work by including a review of non-CBMS templates used by the Department's Office of Community Living's (OCL) Long Term Services and Supports programs. Both the CBMS and OCL letters in Finding 1 communicate information about member application status and eligibility for Medicaid programs.
- **In Finding 2, we discuss non-CBMS letter compliance with the Correspondence Improvement Act.** The letters in Finding 2 communicate approval or denial of Prior Authorization Requests (PARs) for members who are enrolled in Medicaid.
- **In Finding 3, we discuss the Department's effectiveness in implementing a correspondence improvement process to ensure that all Medicaid correspondence it created or revised after January 2018 meets statutory communication standards.** The Department is responsible for an ongoing improvement process that includes an assessment of compliance for both CBMS and non-CBMS letters, leverages member testing and stakeholder feedback to identify needed changes, and incorporates those changes in a timely manner.

The remainder of this chapter includes our findings and recommendations for improving Medicaid correspondence, member experiences, and the Department's management of correspondence.

Finding 1—Medicaid Eligibility Correspondence

The Department issues correspondence to individuals who apply for and use Medicaid for multiple program areas, from a variety of information systems, and in partnership with different entities who have varying levels of responsibility for that correspondence.

The Department works with 64 counties and 11 Medical Assistance sites that determine Medicaid eligibility and provide other customer service support directly to members. This finding relates to the two following program areas that communicate information related to Medicaid eligibility:

1. General Medicaid program eligibility, supported by county-level human services departments and state Medical Assistance sites. CBMS generates member correspondence about general Medicaid program eligibility status and the information needed to determine that eligibility.

2. Long Term Services and Supports program eligibility for people with disabilities and aging adults, supported by OCL. OCL and its partners previously used the Business Utilization System (BUS) to generate member correspondence about functional eligibility, approved services, changes to services, and waitlist status. In July 2023, OCL implemented a new system for this correspondence, the Care and Case Management System, or CCM.

CBMS generates four main correspondence or letter types that meet the statutory definition of “correspondence.” These include:

1. Notices of Action (Notices) to inform applicants and members of their current eligibility status.
2. Verification Checklists (Information Request Letters) to request additional or missing information needed to determine member eligibility.
3. Income Discrepancy letters (Income Discrepancy Letters) for members to confirm or correct electronically reported income from third parties.
4. Redetermination, Recertification, and Renewal forms (Renewal Letters) for members to annually certify household and income information used to determine eligibility.

CBMS generates letters for other assistance programs, such as for the Department of Human Service’s Supplemental Nutrition Assistance Program, or SNAP, and other types of Medicaid letters that do not meet the statutory definition of Medicaid member correspondence. For example, CBMS issues tax forms that members need to file taxes. These correspondence do not communicate approval or denial of eligibility, changes in access to benefits, or requests for information to determine eligibility, and therefore, are not considered Medicaid member correspondence. As a result, we did not include any of these letters in our analysis.

Exhibit 2.1 provides the number of letters and the number of people who received them during January and February 2023 for each of the four main types of CBMS correspondence that we included in our review.

Exhibit 2.1
CBMS Correspondence by Type
January and February 2023

CBMS Correspondence Type	January 2023	February 2023	Total Letters	Unique Households ¹	Unique Members ¹	Maximum Number of Letters Sent to a Single Household
Notices	175,440	173,641	349,081	282,507	618,896	16
Information Request Letters	41,508	39,893	81,401	74,266	74,279	8
Income Discrepancy Letters	154,087	155,652	309,739	144,616	189,715	42
Renewal Letters	52,731	45,844	98,575	95,559	95,559	4
Total CBMS	423,766	415,030	838,796	441,996	817,762	48

Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

¹ Some members and households received letters in multiple categories and, as such, are counted multiple times in the Unique Households and Unique Members columns. The totals for both of these columns are the actual number of unique households and members rather than the sum of the individual categories.

Exhibit 2.2 provides an overall count for the number of OCL letters sent and the number of members receiving them for the same time period. BUS uses the same basic template type for all letter purposes. While the data contained some description about these letters, the list format that it was provided in did not allow us to report on unique letters by type.

Exhibit 2.2
OCL Correspondence
January and February 2023

	January 2023	February 2023	Total Letters	Unique Members	Maximum Number of Letters Sent to One Member
OCL	2,560	2,462	5,022	4,758	5

Source: Office of the State Auditor analysis of BUS data provided by the Department of Health Care Policy & Financing.

What was the purpose of the audit work and what work was performed?

The purpose of the audit work was to determine how well Department-issued Medicaid correspondence demonstrates the principles of good communication—clarity, accuracy, and completeness—as outlined in statute [Section 25.5-4-212(1)(a)(I), C.R.S.]. We interviewed Department staff and reviewed customer service data, comments from the Department’s member

stakeholder group called the Member Experience Advisory Council (MEAC), Department monitoring processes, and previous reports evaluating correspondence. We used the information gathered to develop four testing approaches.

First, we selected a random sample of CBMS letters the Department sent to members. The Department provided lists of correspondence it sent to members in January and February 2023 for each of the four main CBMS correspondence types. Using these lists, we randomly selected 20 letters from each of the four main CBMS correspondence types to create samples totaling 80 letters. We tested each letter in these samples individually using the criteria we describe below. Additionally, an OSA staff member who is a native Spanish speaker reviewed the Spanish language version for one of each CBMS letter type in our random samples for general clarity and readability.

Second, we used a targeted, risk-based approach to select nine Medicaid member households as case studies in order to assess Medicaid members' experiences in relation to CBMS correspondence. We based the case study selection method on the total volume of CBMS correspondence that members received in the 2-month review period. We totaled each household's letters for the period to establish categories of volume based on the natural distribution of the dataset. We selected between one and three member households from each category for the CBMS case study to ensure full coverage of member experiences. For each member household selected, we reviewed all of the letters that they received from the Department during January and February 2023. We also researched other case records in CBMS for these households, like household composition information and caseworker comments, as available, to provide additional context for the correspondence.

Using these two different approaches for identifying which CBMS letters to review allowed us to more comprehensively test for risks. Specifically, the random sample approach allowed us to quantify errors in individual letters while the targeted, risk-based approach allowed us to describe member experiences more holistically in terms of frequency, volume, and consistent messaging. Each approach served a unique purpose so the testing design and results also varied. Because we designed random sample testing to identify any area where a letter did not comply with requirements, we present these results as counts and percentages. The case study testing design and results differ in their broader focus on assessing the clarity and consistency of the Department's overall messages to members. We considered aspects of compliance in this review primarily as they affected overall clarity and consistency of message but did not test each letter for every requirement. The results of this testing design support descriptive narratives of member experience.

Third, we used the CBMS correspondence lists the Department provided to develop aggregate data analyses based on the patterns we observed during our file reviews of both sample items and case studies. We used these data results to find the potential number of other letters that had been sent to members that were unclear, inaccurate, or incomplete in the full 2-month population of records. It is possible that some of these letters that appear to be errors are not. For example, a letter that might

appear to have a contradictory message in the data could actually have language explaining a denial for one month and an approval for the following month.

Fourth, we reviewed the OCL letter templates from BUS, which is the system that was in place during our review period, and the four letter templates that the Department has created for its new system, CCM, which was put into place in July 2023. We compared all of the letter templates against the statutory criteria for clarity, accuracy, and completeness.

While we primarily relied on the requirements outlined in statute for testing criteria, other requirements applied specifically to different types of letters, based on their sender and purpose. We discuss the requirements that vary for each letter type in the findings that follow.

Finally, we interviewed Department and vendor staff and requested supporting documentation as needed to confirm the errors we saw and to understand their underlying causes.

How were the results of the audit work measured?

The Department's mission is to "...improve health care equity, access, and outcomes for the people..." it serves. One of the Department's strategies towards this goal is improving communications so that members can better access and maintain their eligibility status and use their benefits.

Principles of Good Communication in Statute. In 2018, the General Assembly established its expectations for the Department to improve its communications with Medicaid members. Specifically, Colorado's Correspondence Improvement Act requires the Department to improve its communication to Medicaid members to ensure that they receive "accurate, understandable, timely, informative, and clear correspondence" [Section 25.5-4-212(1)(a)(I), C.R.S.]. It also requires the Department to have a process for the ongoing improvement of Medicaid correspondence [Section 25.5-4-212(6), C.R.S.]. The statute includes a list of provisions for Medicaid letters that can generally be categorized as principles of good communication, including clarity, accuracy, and completeness. Letters that are clear, accurate, and complete contribute to member understanding and help to reduce barriers to access Medicaid services.

The list of specific characteristics that Medicaid correspondence must demonstrate includes the use of plain language and consistent, common program names and terms. Correspondence must also clearly convey its purpose and include required content, as relevant. Additionally, the Department should provide an accurate translation of the correspondence in Spanish, Colorado's second most commonly spoken language, if the member expressed this preference [Section 25.5-4-212(3)(d), C.R.S.]

Some of the listed required content applies to all correspondence while others apply selectively based on the correspondence's purpose. Standard required content for all correspondence includes the date of the correspondence, a greeting to the member, and contact information if the member has questions. Correspondence must also include a statement translated into the 15 most commonly used languages in the State that tells a member how to seek additional language assistance if needed.

Content that may vary based on the purpose of the letter includes specific agency or member actions that have been or must be taken, a specific description of any necessary information or documents the member must submit in response, and a plain language explanation for any decision that negatively impacts the member [Section 25.5-4-212(3), C.R.S.].

Additional Definition of Clarity, Accuracy, and Completeness. We used other sources to provide additional criteria, including the Department's Member Communication Standards (Standards), and federal and state Medicaid regulations. These additional criteria were necessary because some of the characteristics required in state law overlap or are not explicitly defined. For example, clear purpose and common and consistent program names and terms are components of plain language. Additionally, the Department's Standards have several other principles and strategies not defined in the state law that address aspects of plain language and clarity, like organization, visual cues, and format. Other concepts outlined in statutory intent, like accuracy and completeness of notice, also require additional definition and criteria by which to judge the correspondence.

- **Sources Used for Clarity.** The Department adopted its Standards in February 2022 as guidance for all member communication. To better define clarity, we used both the characteristics discussed in statute, like clear purpose and common, consistent names and terms, as well as other elements of plain language included in the Department's Standards. The Standards address practices such as stating the purpose first, keeping sentences and paragraphs simple and short, organizing the document with descriptive headings and page numbers, placing subject and verbs close together, avoiding unnecessary words and noun phrases, and using active voice, personal pronouns, visual cues, formats, graphics, tables, and lists. We also referred to the Department's memos on how caseworkers should implement these principles in their notes that are included in some of the letters.
- **Sources Used for Accuracy and Completeness.** For accuracy and completeness, we referred to Medicaid program regulations from the Code of Federal Regulations (C.F.R.), the Colorado Code of Regulations (C.C.R.), Volume 8, and the Department's operational memos. These regulations and Department guidance provide varying levels of detail for required content in letters and timeframes that apply to different letters based on their purpose. The timeframes are either for advance notice of department decisions that impact members negatively or deadlines for members' response to those decisions or to department requests for more information. While there were several sections applicable to correspondence, Exhibit 2.3 lists the regulations most relevant to our testing exceptions.

Exhibit 2.3**Supplemental Criteria for Medicaid Correspondence**

Criteria Source	Attribute	Description
42 C.F.R. 435.917 (b)	Required content of Notice of Action	Federal law outlines required content for Notices related to the eligibility decision, basis, and date; applicant's responsibility to report changes; coverage and benefits; premiums and cost amounts; right to appeal; how to receive additional information; and notice of adverse actions.
42 C.F.R. 435.956 (b.2.i-ii) and 10 C.C.R. 2505-10 8.100.3 G, item 3 a and 8.100.3.H, item 9	Time to respond to Department requests for citizenship	For eligibility notice regarding immigration or citizenship status, the window to provide a response starts 5 days after the date on the Notice and is 90 days long. State rule indicates the same 90-day timeframe but appears to conflict with federal guidance by stating the period begins on the same date as the Notice for both immigration and citizenship or identity. Department staff said they apply the federal rule in practice but did not implement a rule change to the C.C.R. to align state and federal criteria.
42 C.F.R. 435.952 (c.2.iii), 10 C.C.R. 2505-10 8.100.4.C, item 2, and Department Operational Memo to County departments	Time to respond to Department requests for income	Federal law requires time for applicants and members to provide income information. States can amend this time with federal approval. The Department has determined that reducing the time to respond for income information from 90 calendar days to 30 calendar days will benefit applicants and members in submitting income information more timely.
10 C.C.R. 2505-10.8.057.3F	Time to appeal eligibility determination	If an applicant or member disagrees with an eligibility decision, they may dispute the decision within 60 calendar days of the eligibility determination date listed on the Notice.
10 C.C.R. 2505-10 8.519.22.A	Time to Appeal Long Term Service and Support Denial	Case management agencies must provide a Notice to the member within 11 business days of an adverse decision regarding their appeal rights.
Department Guidance, Verification Checklist Best Practices	Format of caseworker notes	Notes should use sentence case and punctuation, not include repetitive information, and use correct spelling and the member's preferred language.

Source: Office of the State Auditor analysis of federal, state, and Department of Health Care Policy & Financing rules and regulations.

Principles of Good Management in the Green Book. The Office of the State Controller (OSC) requires state agencies, including the Department, to follow the *Standards for Internal Control in the Federal Government* (Green Book), published by the U.S. Government Accountability Office. These standards provide criteria for designing, implementing, and operating effective internal controls for an entity to achieve its mission, goals, objectives, and legal compliance. Internal controls are any activity or process management has in place to help ensure that programs operate as intended. Internal controls may include activities like program monitoring or staff training, documents like policies and procedures, or work process and information system design features like supervisory review or required fields and formats for data entry.

Under Green Book Principle 7, management should identify and respond to risks related to achieving their defined objectives. Green Book Principle 13 requires management to use quality information to achieve its objectives. The Green Book defines quality information as “...appropriate, current, complete, accurate, accessible, and provided on a timely basis.” The Department should also establish and operate monitoring activities. Consistent with statute’s ongoing process improvement requirement for correspondence [Section 25.5-4-212(6), C.R.S.], Green Book Principle 16 requires the Department to ensure that, “Ongoing monitoring is built into the entity’s operations, performed continually, and responsive to change.” Finally, the Department should identify and improve internal controls that are deficient [Green Book, Principle 17].

What problems did the audit work identify?

Overall, our review of the Department’s four main types of CBMS correspondence found problems involving clarity, accuracy, and completeness. We found at least 1 of these errors in 72 of the 80 letters (90 percent) we reviewed through our random samples of CBMS letters. We also observed the same issues in each of the 9 CBMS case studies we reviewed, which included an additional 147 letters, and in each of the 4 new OCL templates in CCM that we reviewed.

The sections below group similar errors that we identified through each of our four testing methods by their impact on the principles of good communication outlined in statute [Section 25.5-4-212(3), C.R.S.] – correspondence with unclear purpose and guidance (clarity), with inaccurate information (accuracy), or with incomplete information (completeness). Specifically:

- **Unclear Purpose and Guidance.** We found six types of problems in the CBMS letters and member experiences reviewed. These six categories include: (1) letters with duplicated information, (2) contradictory messages in the same letter, (3) families who received multiple and confusing messages letter-to-letter, (4) letters that did not directly state eligibility status, (5) letters with unclear direction to members, and (6) letters that used complicated sentences and word choices with undefined terms.

- **Inaccurate Information.** We found three types of accuracy problems in the CBMS letters, member experiences, and OCL templates we reviewed. These three categories include: (1) non-compliant dates for listed deadlines, (2) inconsistent response timeframes listed for the same type of information requests and (3) Spanish-language translations that were unclear due to tone and word choice.
- **Incomplete Information.** We found two types of completeness problems in the CBMS letters, member experiences, and OCL templates reviewed. These two categories include: (1) notices that were missing information on the reasons for the denial or the member status and (2) letters and OCL templates that were missing the required or recommended elements.

We discuss the issues we identified in more detail in the following sections.

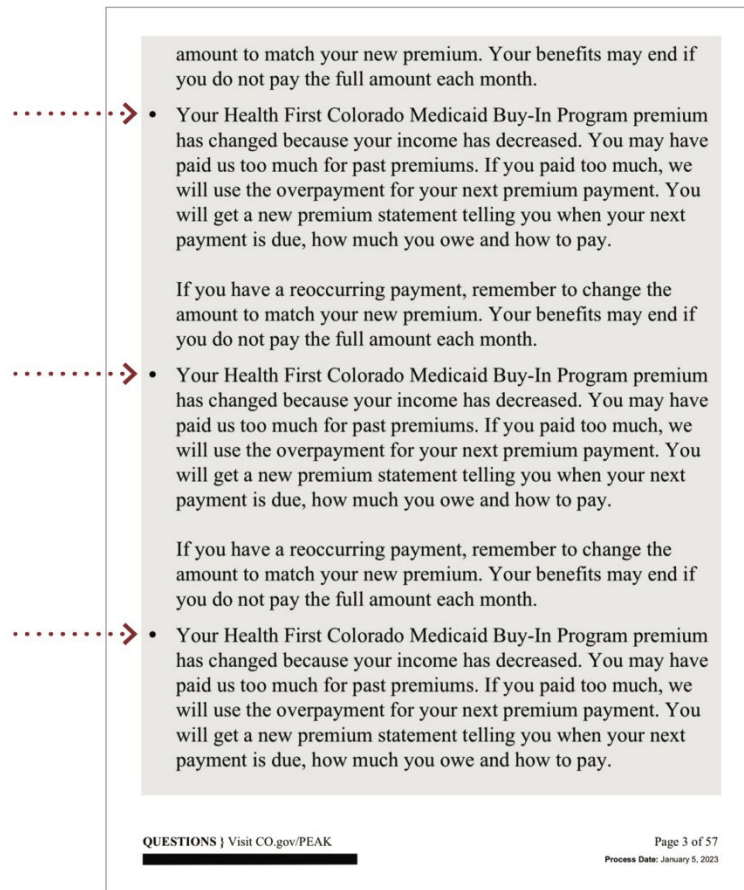
Unclear Purpose and Guidance

We found instances of letters and member experiences in which the purpose of the correspondence and the Department's guidance to members on their responsibilities and options were both unclear and confusing. These issues involved duplicate information; letters with contradictory, confusing, or indirectly- rather than directly-stated messages about eligibility; unclear direction about next steps; as well as complicated sentence structure and word choice with undefined terms.

- **Duplicate Information.** In our case study and random sample testing, we found examples of members receiving Notices with duplicated information, duplicate Notices, duplicate Income Discrepancy Letters, and Information Request Letters with repeated sections and requests for income, citizenship, and asset information. Sometimes this occurred letter-to-letter and sometimes it occurred within the same letter, as we outline in the following bullets:
 - **Repetitive Messages in the Same Notice.** We found letters in which approval and denial messages were repeated for the same member in the same letter. Of the 20 Notices in our sample, we found repeated messages in 2 letters (10 percent). We also found letters repeating messages in 4 out of the 9 case studies (44 percent) we reviewed. Our case study found examples ranging from 2 repeated messages per member up to 63 repeated messages per member, per Notice. Exhibit 2.4 includes a one-page excerpt from a 57-page Notice that repeated the same message 63 times for each of the 2 household members.

Exhibit 2.4

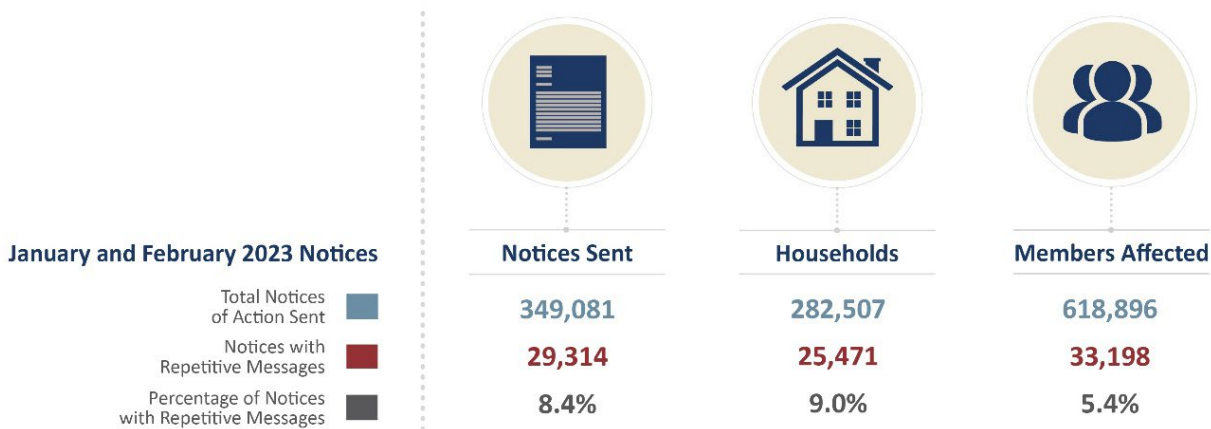
Screenshot of Notice with Repetitive Messages



Source: Excerpt from a CBMS Notice of Action dated January 5, 2023, and sent to a Medicaid member.

To get a sense of how prevalent the issue of repeating messages in the same letter could be outside of our sample, we analyzed the Department's data on Notices sent to members in January and February 2023 for duplicate messages sent to the same member in the same Notice. We found a little more than 29,000, or 8 percent of Notices, included repeated messages, including one Notice that had 128 repetitive messages. Exhibit 2.5 provides additional details on the number of letters, households, and members for which the Department's CBMS records listed a repeated message in the same Notice for a member in the 2 months we reviewed.

Exhibit 2.5
Notices of Action with Repetitive Messages



Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

- **Repetitive Sections and Requests in Information Request Letters.** Information Request Letters also included duplicate sections and requests in the same letters to members. In our random sample, we found 8 of the 20 sample letters (40 percent) included different types of repetitive information, including one with more than one type of repetition. Five letters included repeating deadline and note sections, while two included the same request for information twice in the letter. Two of the requests also involved the caseworker adding a note that repeated instructions already in the letter. Exhibit 2.6 provides an example from one of these Information Request Letters with duplicate caseworker notes and deadlines and a blank note section.

Exhibit 2.6

Screenshot of an Information Request Letter with Duplicate and Blank Sections

Information needed for [REDACTED]

Information to send	Due date for each program: send one copy by the earliest date listed
Proof of income from [REDACTED], which could be paystubs, employer statement, or other proof from your employer.	01/20/2023 for Medical Assistance
Information to Send: Provide the requested document(s) for 12/2022 for Medical Assistance.	01/20/2023 for Medical Assistance
Blank → Notes for Medical Assistance:	01/20/2023 for Medical Assistance
Notes for Medical Assistance: You may submit your documents via Colorado PEAK website, fax. 719-444-5139, by mail or in person. Thank you.	01/15/2023 for SNAP
Notes for Medical Assistance: You may submit your documents via Colorado PEAK website, fax. 719-444-5139, by mail or in person. Thank you.	01/15/2023 for SNAP
Notes for Medical Assistance: You may submit your documents via Colorado PEAK website, fax. 719-444-5139, by mail or in person. Thank you.	01/15/2023 for SNAP

Repeated Date → (points to 01/20/2023 for Medical Assistance)

Repeated Date → (points to 01/15/2023 for SNAP)

Repeated Message ← (points to the duplicate Notes for Medical Assistance sections)

Source: Excerpt from a CBMS Information Request dated January 4, 2023, and sent to a Medicaid member.

- **Duplicate Notices.** In 1 of the 9 case studies, we found examples of unique Notices mailed within a few days of each other that duplicated the same messages. Specifically, the family received a Notice on January 28, 2023 that was an exact duplicate of one the family received on January 25, 2023. The same thing happened again to this family with a set of duplicate Notices sent on February 24, 2023 and February 28, 2023.
- **Duplicate Income Discrepancy Letters.** In 3 out of the 9 case studies we reviewed (33 percent), we found examples of duplicate Income Discrepancy Letters, typically sent a few days apart, with requests for families to update their income information. Exhibit 2.7 provides information about these 3 families' experiences. For example, Family 1 received a total of 48 letters from CBMS over this 2-month period. This included 8 sets of individual requests to each family member to update income information; 4 of the 8 sets were exact duplicates. In total, this family received over 460 pages in CBMS letters during these 2 months.

Exhibit 2.7**Case Study Summary of Duplicative Income Discrepancy Letters
January and February 2023**

Family	Total Number of Requests for Family to Update Income	Duplicate Requests	Percent Duplicate Requests	Total CBMS Letters Received	Total Pages of CBMS Letters Received
Family 1	8	4	50%	48	460
Family 2	10	6	60%	40	208
Family 3	9	7	78%	26	238

Source: Office of the State Auditor analysis of CBMS correspondence records

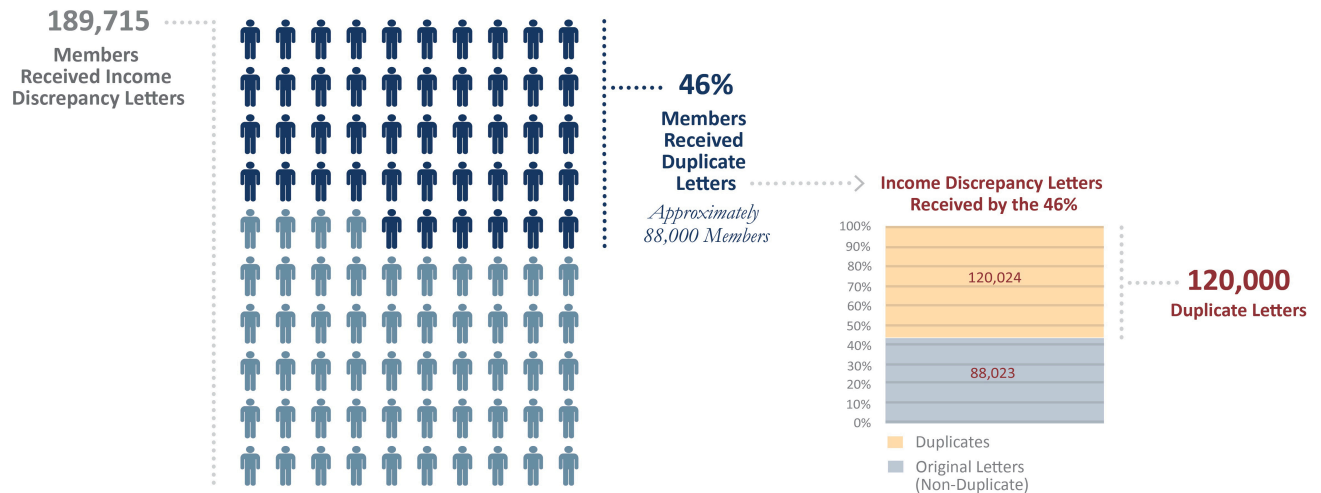
To understand how widespread this issue of duplicate Income Discrepancy Letters may be in the 2-month population, we analyzed the Department's CBMS data for these letters to identify members who received more than one of these requests and the timing between those requests. We found that of the 189,715 members who got an Income Discrepancy Letter in January or February 2023, about 88,000 (46 percent) received multiple requests to update their income information during this 2-month period.

After sending the initial requests, the Department sent an additional 120,000 repeat Income Discrepancy Letters to these 88,000 members. In terms of the timing between these requests, the Department sent almost 2,000 of these 120,000 repeated letters (2 percent) to members on the same day that it sent that same member another Income Discrepancy Letter. Almost 30,000 letters (25 percent of 120,000 letters) were sent to members on the same day or within a week of another request. One member received 35 separate requests in the 2 months that we tested. Exhibit 2.8 shows the number of Medicaid members who received duplicate Income Discrepancy Letters and the number of duplicate letters they received.

Exhibit 2.8

Duplicate Income Discrepancy Letters

January and February 2023

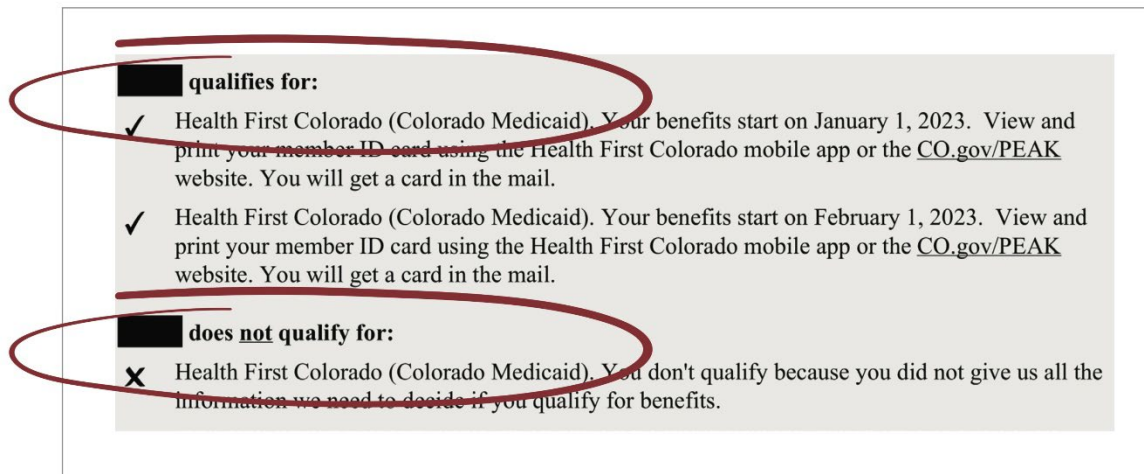


Source: Office of the State Auditor analysis of CBMS correspondence records.

- **Contradictory Messages in Same Letter.**
 - **Approval and Denial Messages in Same Letter.** We found Notices that informed a member that they were eligible for benefits, but then immediately followed the approval message with a denial message for the same benefits. Department staff referred to these messages as “love/hate letters.” We found 2 out of 20 sampled Notices (10 percent) and 2 out of 9 case studies (22 percent) with Notices that communicated contradictory eligibility status. Exhibit 2.9 provides an example of a Notice Letter with contradicting approval and denial messages to the same member. Further, the two approval messages provided different starting dates.

Exhibit 2.9

Screenshot #1 of Notice with Contradictory Messages

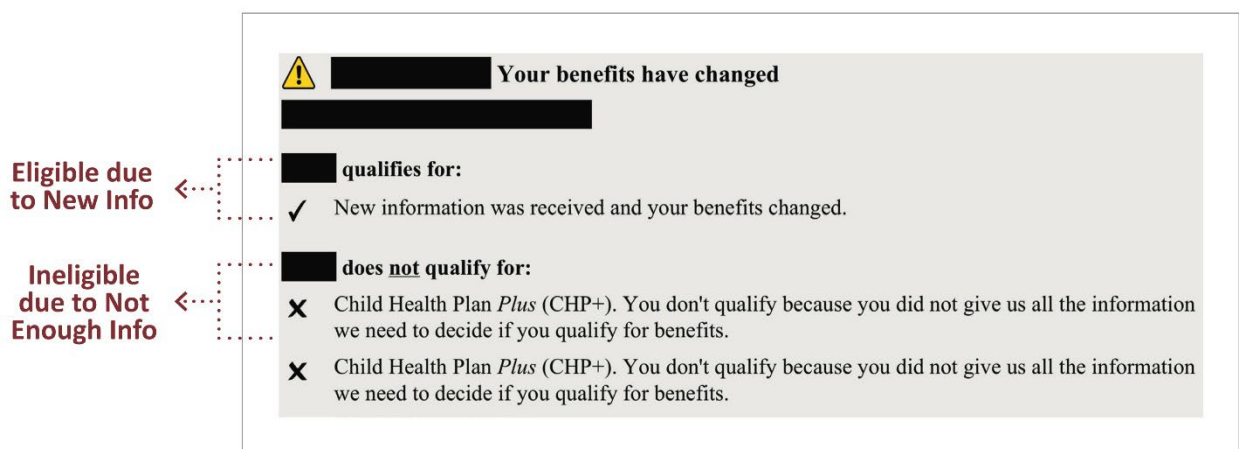


Source: Excerpt from a CBMS Notice of Action dated January 2, 2023, and sent to a Medicaid member.

- **Conflicting Messages about Member Information and Status.** In another case study, we found an additional example of status messages used together that appeared to conflict. The first message states that the member qualifies because “New information was received and your benefits changed,” even though it does not state what they qualify for, followed by a second message that states “You don’t qualify because you did not give us all the information we need to decide if you qualify for benefits.” Exhibit 2.10 provides an example of the Notice with these messages to the same member.

Exhibit 2.10

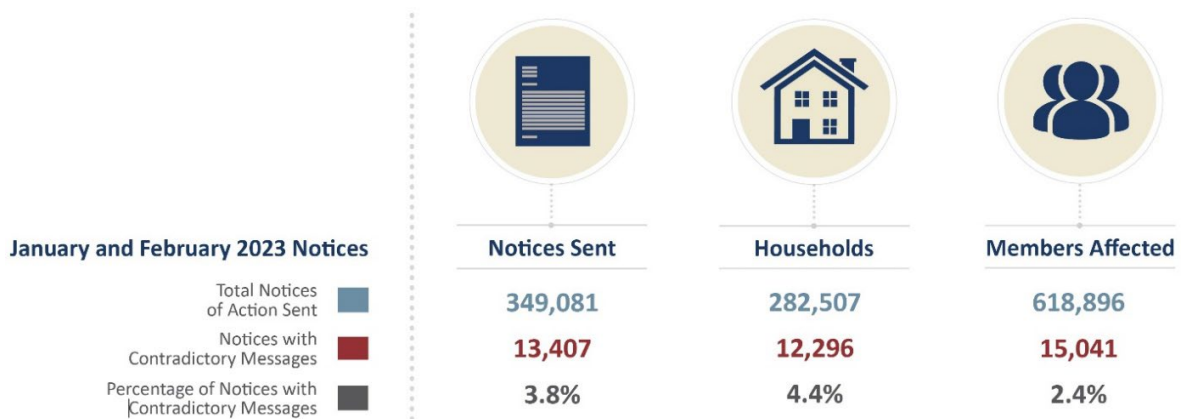
Screenshot #2 of Notice with Contradictory Messages



Source: Excerpt from a CBMS Notice of Action dated January 9, 2023, and sent to a Medicaid member.

To measure the extent of Notices at risk for contradictory messages, we analyzed CBMS records for Notices the Department sent in January and February that included both an approval and a denial message to the same member in the same Notice. We identified more than 15,000 additional members who might have received a contradictory message. We randomly reviewed six of the Notices identified through our analysis and found that three included details to help explain the contradiction, such as dates listed for the denial and approval messages. However, only one of the three included phrasing and dates that clearly communicated that the messages applied to two mutually exclusive timeframes. Exhibit 2.11 provides context for how many letters, households, and members may have been affected by contradictory messages.

Exhibit 2.11 Notices with Contradictory Messaging



Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

- Multiple and Confusing Messages Letter-to-Letter.** For families who received multiple letters during the 2-month review period, we often found it difficult to follow what the Department was trying to communicate. For example, in one of our case studies, a family received 12 Notices, an Information Request Letter, and a Renewal Letter in January and February 2023, totaling 185 pages of correspondence. The family received a letter every few days in January and every 2 weeks in February 2023. The letters went back and forth every few days in terms of whether family members qualified for a benefit or did not, often listing ambiguous or incomplete denial reasons. For example, some Notices stated a member was denied on the basis of not providing enough information but never specified what information was missing. In other Notices, a member was told they were denied but the Notice did not include the program for which the member was denied or the justification for denial.

For this case, when a family member did qualify, the start dates for coverage swapped between September and February 2022 without explanation. The letters listed each member's status

differently, sometimes repeating information from previous letters and sometimes listing them as no change. The letters also sometimes omitted family members from one letter to the next, which made it difficult to trace each member’s eligibility and what had or had not changed throughout the 2-month span. Because of these issues, we also reviewed this family’s March correspondence to see if their statuses were ever clearly communicated and found a contradictory message in one of the last records on file. The letter stated that one household member was both eligible and ineligible for Medicaid.

Considering this family’s pattern of receiving confusing correspondence, other families with a higher volume and frequency of correspondence may also be at risk for a similarly confusing experience. Using the Department’s CBMS records of letters sent in January and February 2023, we identified the distribution of total CBMS letters per family, shown in Exhibit 2.12.

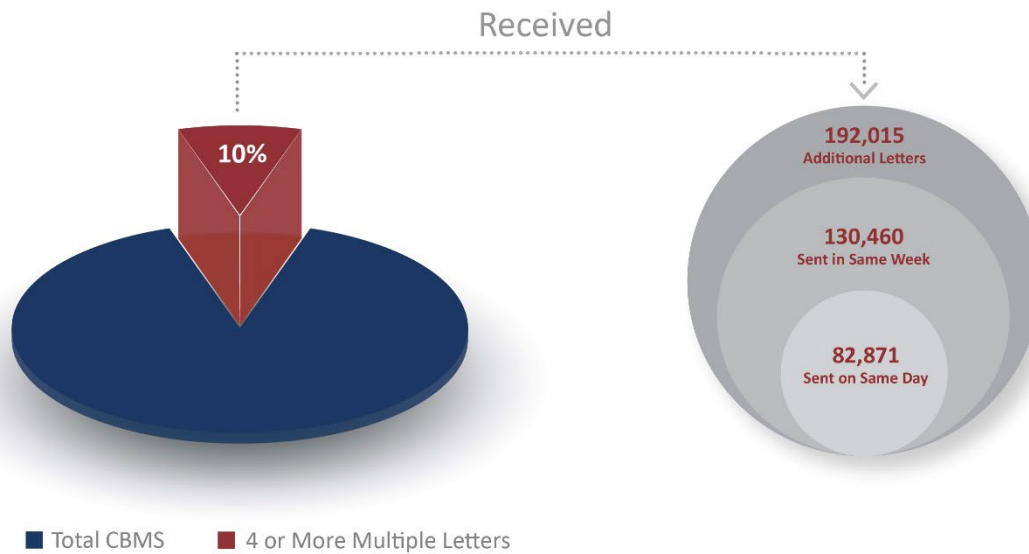
Exhibit 2.12
Number of CBMS Letters per Family
January and February 2023

Letters Received	Households	Percent
1	234,104	53%
2 to 3	163,255	37%
4 to 5	31,713	7%
6 to 10	11,595	3%
11 or more	1,329	<1%
Total	441,996	100%

Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

While there are legitimate reasons for families to receive one to three letters, households or families who received four or more CBMS correspondence during the 2 months may be at risk of receiving similar types of confusing messages. We looked at the timing between the letters for the families who received four or more CBMS letters. A little more than 44,600 families (10 percent of all families receiving CBMS letters) received four or more letters. As shown in Exhibit 2.13, after their first letter, the Department sent these families 192,000 additional letters, with almost 83,000 letters (10 percent of all CBMS letters sent) sent to families on the same day as another letter. Including the same day letters, almost 130,500 letters (16 percent of all CBMS letters sent) were sent within the same week as another letter.

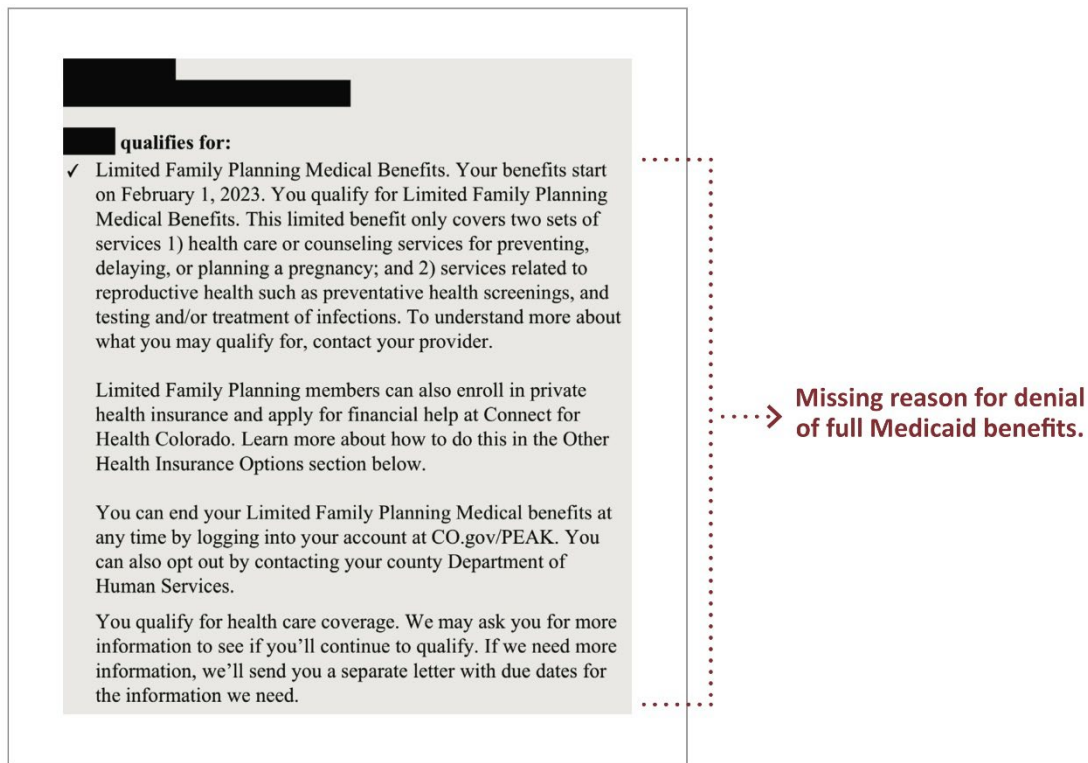
Exhibit 2.13
Families who received Four or More CBMS Letters
January and February 2023



Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

- Eligibility Status Not Directly Stated for One Program.** The qualification message for limited benefits under Medicaid’s Family Planning Program also lacked clarity. In some cases, an individual may not meet eligibility requirements for full Medicaid benefits but may be eligible for limited reproductive and family planning services. We found two examples of letters with these messages, one in our case studies and one in the random samples. While the message in this letter states the member is eligible for limited benefits, it does not directly and clearly state that the member did not qualify for full Medicaid benefits or why they did not qualify. Exhibit 2.14 provides an example of this type of message sent to members.

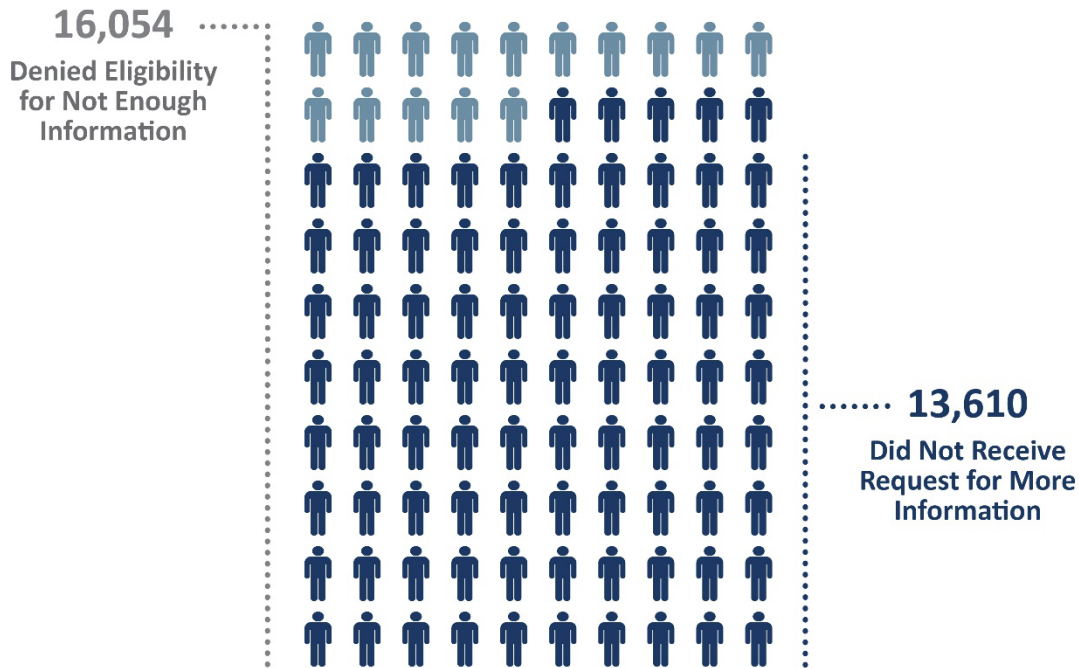
Exhibit 2.14
Screenshot of Notice with Status Not Directly Stated



Source: Excerpt from a CBMS Notice of Action dated February 18, 2023, and sent to a Medicaid member.

- **Unclear Direction to Members.** Some letters did not provide clear and consistent direction to members on their required next steps or responsibilities. For example:
 - **No Description for Missing Information.** One of the standard denial messages we saw stated, "You don't qualify because you did not give us all the information we need to decide if you qualify for benefits." In the 17 Notices we reviewed that used this language, we did not find any explanation of the missing information. We found three examples of Notices—two in our case studies and one in the random sample—that referenced the Department's Information Request Letter and instructed the member to provide all of the information requested in that letter. However, our file review found only one family who received a Notice with these messages and also received an Information Request Letter. The Information Request Letter addressed some of the family members with missing information although the Notice had listed other family members as well with the same message. As shown in Exhibit 2.15, using the data that the Department provided, we found a little more than 16,000 people who were denied benefits because they had not provided all requested information during the 2 months we reviewed. Of these, more than 13,600 (85 percent) did not receive an Information Request Letter during the same time frame to specify what information they were missing.

Exhibit 2.15
Members Denied Eligibility for Not Enough Information
January and February 2023



Source: Office of the State Auditor analysis of CBMS data provided by the Department of Health Care Policy & Financing.

- **Missing Instructions for Contact and Reason.** Another standard denial message states, “You don’t qualify because we can’t reach you.” However, the message does not go on to include instructions for who, specifically, the member should contact and how or what information the program needed to address the qualification message. General contact information is included in other sections of the Notice but the message does not direct the member to it.
- **Member Responsibility and Next Steps Unclear.** Another standard message about the Medicaid Buy-in Program requires members to infer next steps rather than clearly stating them. The message states “You may have to pay a monthly premium for this program.” Buried in the third line of the next paragraph is a reference to a second letter the member may receive that will presumably tell them whether they owe money for monthly premiums and how much. However, the reference does not clearly state whether the member will receive a second letter or not. Exhibit 2.16 provides an example of this unclear guidance.

Exhibit 2.16

Screenshot of Notice with Unclear Guidance

The screenshot shows a notice with a yellow warning icon and the title "Your benefits have changed". The text is as follows:

██████████

██████████ for:

- ✓ Health First Colorado Medicaid Buy-In. Your benefits start on November 1, 2014. You may have to pay a monthly premium for this program.

You can make your monthly premium payments online through www.Colorado.gov/PEAK, or by mailing a check or money order to the address listed on the monthly premium letter. Premiums can also be paid in person at 655 Bannock Street, 1st floor, Denver, Colorado 80204. If you do not want to receive Medical Assistance benefits or pay a premium, contact your county eligibility worker to opt-out or use www.Colorado.gov/PEAK Report My Changes to end your Health First Colorado Buy-In program benefits. View and print your member ID card using the Health First Colorado mobile app or the CO.gov/PEAK website. You will get a card in the mail.

Two red annotations with arrows point to specific parts of the text:

- "Implies Financial Obligation" points to the circled text: "You may have to pay a monthly premium for this program."
- "Vague Reference to a Second Letter" points to the circled text: "on the monthly premium letter."

Source: Excerpt from a CBMS Notice of Action dated January 5, 2023, and sent to a Medicaid member.

- **Confusing Date Formats.** The Information Request Letters may also provide confusing guidance on due dates for requested information. All of the Information Request Letters that we looked at used a format for the date, MM/DD/YYYY, that communities from other countries may find confusing. Many other countries use a different format that switches the placement for days and months, DD/MM/YYYY. The Department's Standards recommend spelling out the month to avoid confusion, Month, DD, YYYY. Additionally, the "Information to Send" section sometimes lists two dates with instructions to send by the earliest date listed. While one appears to be the due date, it is not always the earliest date listed in the section, which could cause confusion.
- **Instructions Not Clearly Identified.** All of the Income Discrepancy Letters we reviewed used inconsistent formatting for instructions to members on how to fill out the form. Because one set of instructions is not bolded like the rest, a member may miss that the text includes guidance. The red box in Exhibit 2.17 illustrates the section of the letter that is not formatted consistently.

Exhibit 2.17

Screenshot of Income Discrepancy Letter with Inconsistent Format

About My Income Form
Please check **all** boxes that apply to you. Use the space at the end of this form if you need to tell us more. Changes to your income and household could change what programs you qualify for.

☐ I no longer work at a job listed under Income Information.
Employer name: _____ **My last day was:** _____

☐ My hours at my job(s) changed.

☐ My income at my job(s) changed. **Use the space at the end of this form to explain, and give us proof of your current income, such as a letter from your employer or a pay stub.**

☐ I have a new job. Please give us proof of your income from your new job, such as a letter from your employer or a pay stub. If you have more than one new job, use the space at the end of this form to tell us. This doesn't include self-employment. <----- **Instructions Not Bold**

Employer name: _____
Monthly total income (before taxes): _____
Pay Period (for example: daily, biweekly, monthly): _____

☐ Some or all of the income information listed above is wrong. **Use the space at the end of this form to explain, and give us proof of your current income, such as a letter from your employer or a pay stub.**

Source: Excerpt from a CBMS Income Discrepancy Letter dated February 3, 2023, and sent to a Medicaid member.

- **Unclear Instructions.** The Renewal Letters instruct members to report “shelter expenses” but none of the forms we looked at defined the term. It is unclear what costs members should include in this category and report.
- **Complicated Sentences and Word Choices with Undefined Terms.** All Renewal Letters are based on a template with two legal sections that use technical jargon, prohibited terms, and long, complex sentences that are difficult to understand. For example, a section on member rights and responsibilities uses terms like “capitation payments” without a definition. Additionally, Exhibit 2.18 provides an excerpt with long and complicated sentences from a section on authorizing a representative. Each sentence exceeds the Standards’ recommended word count of less than 20 words per sentence, uses multi-syllable and technical terms without definition, and includes multiple ideas and clauses that could be broken up and simplified as short sentences.

Exhibit 2.18

Screenshot of Renewal Letter Legal Section

Source: Excerpt from a CBMS Renewal Letter dated January 14, 2023, and sent to a Medicaid member.

Inaccurate Information

In addition to letters with unclear purpose and guidance, we also found letters that used incorrect or inconsistent deadlines for when the member responses were due. In some cases, the dates listed represent non-compliance with a program rule. In others, the dates listed resulted in longer timeframes for response for some families and shorter timeframes for others. The specific issues we identified are discussed in the following sections.

- **Noncompliant Deadlines.** Some of the Notices and Income Discrepancy Letters we reviewed, as well as the OCL template, contained deadlines for responses that did not comply with the State’s Medicaid program rules. Program rules set the minimum number of days provided for each member to file an appeal or to respond to the Department’s information requests. These response periods vary based on the type of Medicaid program and information requested. First, 9 of the 20 Notices (45 percent) in our random sample listed a 59-day timeframe for appeal processes instead of a 60-day timeframe listed in the Medicaid program rules for general eligibility. We also observed the same issue for the Notices in 7 of the 9 case studies we reviewed (78 percent). Further, one of the Income Discrepancy Letters in our random sample listed a 29-day response period instead of the 30-day period listed in program rules for updating income information. Additionally, we found that the OCL templates include an error in the logic used to auto-populate response dates. Specifically, the logic uses the wrong date field in the letter, giving members 10 fewer days—60 days—to respond compared to the 70-day response period provided in the Long Term Services and Supports program rules.
- **Inconsistent Treatment of Members.** From a fairness perspective, we identified two issues with the listed response periods. While these response periods comply with program rules, they provide some members with more time than others to respond for the same type of information. First, half of the Income Discrepancy Letters in our random sample (10 out of 20,

or 50 percent) listed a 31-day response period; almost half of the other letters in our sample listed the required 30 days. We observed similar patterns in the Income Discrepancy Letters for all 3 of the 9 case studies we performed (33 percent) that included these requests. Second, the Information Request Letters in the random sample included a range of response periods for similar information. Income-related request response periods ranged from 14 to 16 days, cash and asset confirmation request response periods ranged from 14 to 16 days, and requests to verify other insurance coverage had response periods ranging from 13 to 18 days. The Department could not provide program rules that list a response period specific to the Information Request Letters. Additionally, we found that different types of letters provided different response periods for the same type of information. For example, Information Request Letters in our sample included response periods for providing income information ranging from 14 to 16 days, while the Income Discrepancy Letters in our sample required a 30-day response period for income information.

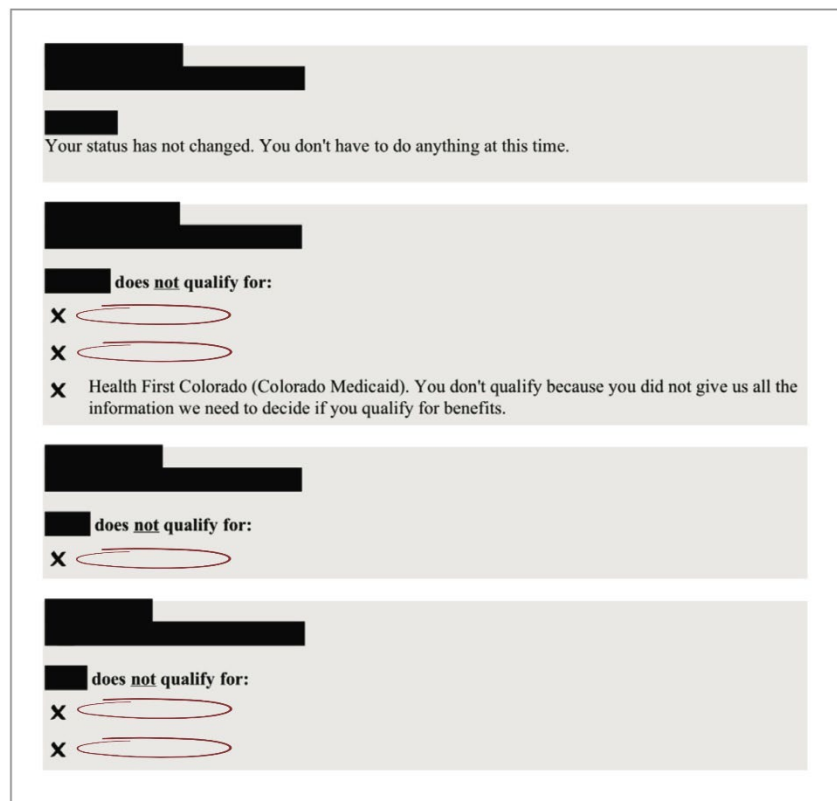
- **Inaccurate Translation.** In our Spanish-language review, we found plain language issues in the standard template language in the Notices. Specifically, the translation of household used a confusing Spanish term. Pages one and three of the letter used the word “nucleo”—technically meaning “core”—in place of the word for household. Additionally, instructions for updating member contact and other required information by phone or through the Department’s online app used inconsistent tone and wording. The list of instructions for reporting changes to member information used confusing and potentially incorrect translations of “and” and “or,” and the reporting instructions also inappropriately capitalized the translation for “sources.”

Incomplete Information

We found letters that appeared to be missing information—either an element required by state law, an element recommended in Department guidance, or relevant case information.

- **Notices Missing Denial Rationale and Status.** The Department did not comply with statute regarding the required content that varies based on the letter’s purpose. Specifically, Section 25.5-4-212, C.R.S., requires Medicaid correspondence to include the reasons for any decision that negatively impacts a member, like a denial. Some Notices in one of the case studies included incomplete reasons for denial. Additionally, for 3 of the 9 case studies (33 percent), the Notices omitted relevant case information, like the status of all household members, in some letters. Exhibit 2.19 provides an example of a Notice with incomplete program denial reasons – there are 5 blank entries—shown as X—for what program the members were denied from and why they were denied.

Exhibit 2.19
Screenshot of Notice with Blank Denial Messages



Source: Excerpt from a CBMS Notice of Action dated January 28, 2023, and sent to a Medicaid member.

- **Missing Required and Recommended Elements.** None of the 20 Renewal Letters in our random sample included a member greeting or a language assistance statement, as required by statute [Section 25.5-4-212(3)(b), C.R.S.] for all Medicaid correspondence. The 4 new OCL letter templates did not include all statutory requirements or follow the recommendations in the Department's Standards on visual cues, such as a greeting with the member name or page numbers.

Why did these problems occur?

Previous work conducted by the Department's communications contractor in 2016 and our contractor in 2020 identified many of the same issues we continued to see in this audit. These problems persist because the Department has not fully implemented the previously recommended changes to its monitoring functions, work processes, guidance to workers, and system design.

Lack of Monitoring for Department Correspondence. The Department has not developed a systematic and complete monitoring function for correspondence that includes:

- 1) A risk-based approach to testing actual letters sent to members,
- 2) Proactively identifying and addressing gaps in work processes that result in errors, and
- 3) Stakeholder and member feedback.

The Department currently performs reviews of some aspects of CBMS correspondence, such as running system checks for blank fields in CBMS-generated letters and one staff spot-checking a few CBMS letters each quarter. Although there is value in each as part of a more comprehensive monitoring approach, neither of the review activities in place are likely to address the problems we found. For example, the Department runs system checks for blank fields in CBMS that populate contact and other standard content in the letters. This strategy does not address the quality or accuracy of the information in the fields or fields that vary based on the purpose of the letter. The fields that vary include the most important information in the letters and present the most risk of inaccurate and confusing content as workers must apply their judgment individually to these fields. We also found the most errors in terms of clarity within these fields.

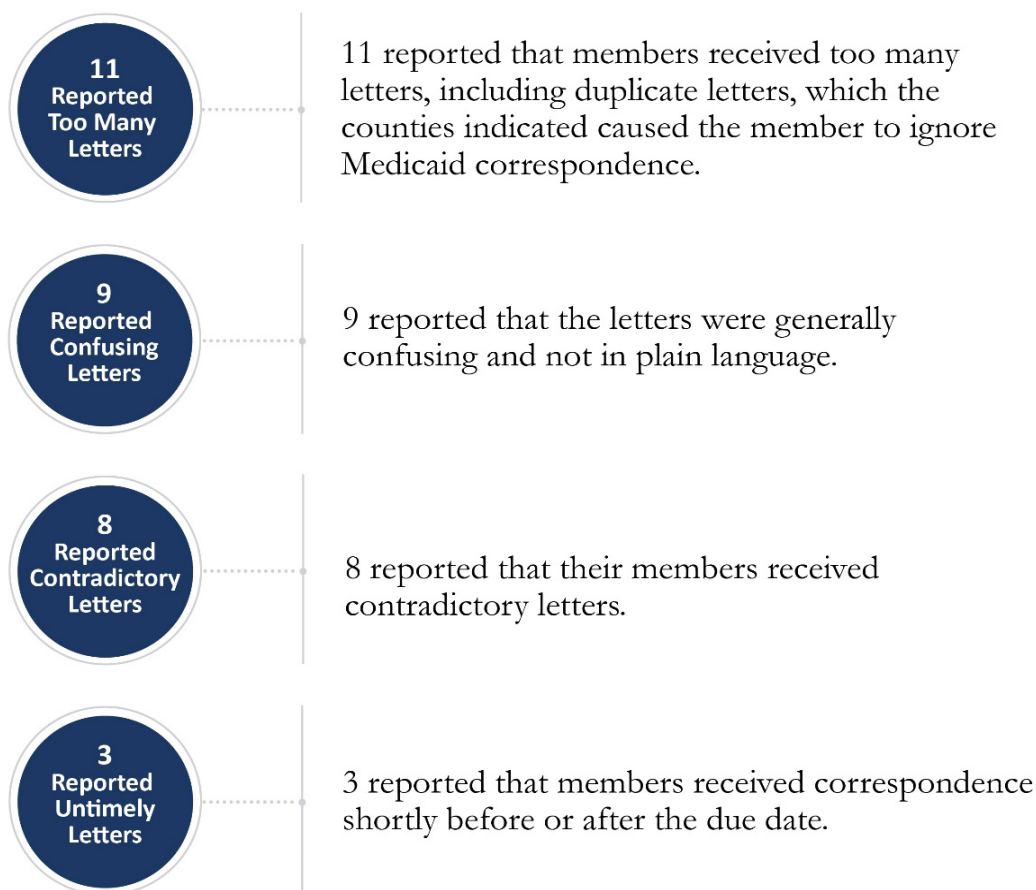
Another current Department monitoring activity involves one staff member who periodically spot checks a file with the letters created for a specific day each quarter. However, the Department described an unstructured and informal process in terms of the actual number of letters the staff member reviews in the sample and the specific aspects the staff member evaluates in each letter. Further, neither approach assesses correspondence from a holistic, member experience perspective to identify issues like duplicates or multiple and confusing messages. In our 2020 audit, we recommended that the Department expand its routine monitoring activities to include the systematic testing of correspondence actually sent to Medicaid clients to ensure that it identifies issues in a timely manner. The Department has not yet implemented a systematic review process of letters sent to members.

Statute assigns the Department responsibility for the ongoing improvement of Medicaid correspondence [Section 25.5-4-212(6), C.R.S.]. Consistent with that responsibility, according to the Green Book [Principles 16 and 17], the Department should have a monitoring process for the safeguards it has in place to ensure it meets program objectives. When these safeguards are not working as intended, the Department should take timely action to correct them. An efficient monitoring activity should also incorporate other good management principles, like identifying and responding to risks that jeopardize program success [Green Book, Principle 7] and supporting decisions with program data tied to its success and risks [Green Book, Principle 13]. The Department should continue to build on its current monitoring approach by systematically assessing and responding to correspondence risks.

In addition, the Department collects feedback regarding correspondence from counties and Medical Assistance sites through its management evaluations of these entities that determine Medicaid eligibility on the Department's behalf; however, the Department does not review the feedback to help monitor correspondence. The Department said that county feedback was previously shared with a Department staff member in a member correspondence position, but because of staff

turnover it does not know how that information was used. We reviewed the 24 questionnaires the Department collected from counties and Medical Assistance sites between October 2021 and June 2022 and saw that the counties and sites reported many of the same issues that we identified during the audit. Exhibit 2.20 summarizes correspondence issues from the 24 counties.

Exhibit 2.20
Problems with Correspondence from Eligibility Entities



Overreliance on Workers' Self-review and System Design Issue Interaction. In terms of quality control for correspondence, the Department relies primarily on the workers who enter information in the system to review their own work with some system logic programmed to connect CBMS templates and workflow processes. These two components are at play to varying degrees for each type of CBMS correspondence. People, such as county caseworkers and eligibility technicians as well as the members themselves, enter data about the cases that trigger CBMS to start automated processes that result in letters to members. Some letters involve more worker action and review, while others are mostly automated through the system. However, the Department has not fully identified how actions by people and the system's workflow design interact to create the issues we saw.

Based on the department staff descriptions, we identified some process weaknesses involving both people and system design that, if addressed, would help improve the quality of CBMS correspondence. For example, each day, CBMS consolidates any change on a case across all of the programs that use CBMS to create a single Notice for a household. According to the Department, caseworkers should review the generated correspondence and authorize it for mailing. However, if the caseworker has not authorized the correspondence or flagged it specifically as not being ready to send by 6 pm each day, CBMS will send it without the authorization in an afterhours batch process.

The combined effect of the Department's work process design, both for workers and CBMS, allows letters to be sent that have not undergone a quality control review. In addition to clarifying review responsibilities for workers, the Department could also re-design CBMS' ability to override caseworker authorization. This redesign could involve removing the override function all together or introducing an additional check that prompts the caseworker or a supervisor to review any unauthorized correspondence in the queue.

Some of the errors we saw in other CBMS letters also result from the interplay between human action and system design. For example, the Income Discrepancy Letters typically run in batches each month. However, a system error linked this Income Discrepancy notification process to the eligibility check process. As a result, if either a caseworker making changes to a case or the system's batch process causes an eligibility check to run, the system generates multiple, duplicate Income Discrepancy Letters to run outside of the regularly scheduled monthly process.

Additionally, while workers have more control over customizing notes to members in Information Request Letters, the system selects response deadlines, resulting in the inconsistent dates we saw for the same type of information. Based on the Department's response, it is not clear what program rule the CBMS logic uses to calculate these deadlines. Again, for each of these processes, caseworkers are largely responsible for reviewing the quality of their own work and the system allows letters to be sent without ensuring this review occurs.

Gaps in Worker Training and Guidance. If the Department relies primarily on caseworkers reviewing their own work, training and guidance become crucial to ensuring the quality of correspondence. According to the Department, it provides statewide training that addresses some general caseworker review responsibilities and counties and sites may provide more in-depth training to their caseworkers. However, the Department does not provide training or written guidance for workers that clearly establishes what it expects good correspondence to look like. While Department training and guidance sometimes references correspondence in relation to other topics, the training and guidance to workers does not include specific information on their role and responsibilities in creating and reviewing correspondence that is clear, accurate, and complete.

Further, according to the Department, county- and site-level training varies in terms of duration and extent. However, the Department could not provide additional details on what each county and site provides in terms of training or written guidance. Based on the prevalence and severity of errors that

we found, there appear to be gaps in caseworkers' understanding. Because the Department is ultimately responsible for ensuring compliance with Medicaid requirements and State rules, the Department should have a process in place to address training gaps.

Flaws in System Design. According to the Department, system workflow design primarily accounts for some of the other errors we saw. In addition to selecting the Information Request Letter response deadlines, CBMS auto-populates all of the other letter date fields. Deadlines appear to be built off a system-generated date rather than the letter date. As a result, when the afterhours batching process occurs, deadlines are a day off. In 2020, we made a recommendation that the Department make necessary CBMS programming changes to address date fields. While the Department agreed to the 2020 recommendation, this problem is still occurring and this design issue continues to impact the quality of Medicaid correspondence. Additionally, the Department says that the CBMS design prevents caseworkers from editing or consolidating standard messages used in Notices, which results in contradictory and repeated messages.

The Department's Responsibility for Ongoing Improvement of Correspondence. The Department was not able to provide an explanation for all of the problems we found in testing although it reports that it continues to work with its vendor to identify why the issues happened. Additionally, based on the timing of our audit, we were not able to test the correspondence from the Department's new OCL system that the Department implemented in July 2023. Finally, some of the problems we identified were previously known to the Department through other audit work. Given these partial explanations and unaddressed problems, the Department should continue to search for, investigate, and correct problems with correspondence outside of the audit process.

Addressing the four internal control areas we identified will help the Department meet its responsibility for improving Medicaid correspondence, starting with a more robust approach to monitoring. Specifically, using a risk-based monitoring approach that identifies unexpected and unusual trends in the correspondence sent from all systems and why these occur would allow the Department to better focus its limited resources on the changes to other internal controls, like work processes, training and guidance, and system design, that will have the greatest benefit for members.

Why do these problems matter?

According to the Department, Medicaid members report that they struggle to understand correspondence and often receive duplicate, contradictory messages. Our review of the county and Medical Assistance Site questionnaires that the Department collected, as detailed above, identified several comments that support our conclusions about how these errors impact members and caseworkers. Unclear, inaccurate, and incomplete correspondence can create frustration and confusion for Medicaid members and ultimately lead to barriers to accessing health care, wasted resources, and potential legal issues for the Department.

First, duplication within and between letters, along with letters with unclear messages, create unnecessary stress and frustration by making it difficult for a family to understand what the Department is trying to communicate. According to county and site responses to the Department questionnaire, one response stated, “Members voice frustration and confusion when the same letter depicts opposite information regarding the same program.” As we found in our case study, it may also be difficult for members to understand what the Department’s final decision is related to their eligibility. With multiple letters, members and case managers may also struggle to apply the right timeframes for other processes triggered by the letter date. With each new letter, a new timeframe starts for response deadlines and appeal processes. According to one county response, “The amount of correspondence customers receive is something that is often brought up, since they get so much they are not sure which one is the final result.” Another noted, “...we have a hard time making sense out of correspondence and explaining it to the member.”

Overwhelming a reader with repetitive text may make them less likely to pay attention to other information in the letter in addition to damaging the credibility of the sender and the message. It can also result in a member ignoring important correspondence from the Department, like Renewal Letters. If a member fails to respond when the Department needs renewal information, they will lose access to healthcare. One county’s response stated, “Some customers do not enjoy getting monthly or semi-monthly notices. They get to the point that they do not even look at the correspondence there and they do not see their renewals.” Another response noted, “...[Members] are not opening letters received because they say it’s just junk mail.”

In addition, printing and mailing costs may be wasted on ineffective communication attempts that also result in indirect costs, diverting program resources to customer help and appeal functions instead of healthcare services for members. A comment from another response stated, “In my experience, this only serves to confuse the member and increase the volume of correspondence-related questions.”

Finally, the compliance and fairness issues for response timeframes and language assistance not only works against the Department’s mission to improve equity in healthcare, it also opens the program up to legal liability. Federal funding relies to some extent on the State’s compliance with federal rules. Additionally, the difference of a day, a few days, or even 2 weeks may seem insignificant, but the result is unequal treatment for some families when requesting the same type of information. Treating some families differently than others may increase appeals and other legal actions against the program by members who did not receive extra time for responses. This fairness issue applies as well to the non-English speakers whose access to services may have been limited by the Department’s omission of language assistance resources and translation services.

Recommendation 1

The Department of Health Care Policy & Financing (Department) should improve Medicaid correspondence by:

- A. Developing and implementing risk-based monitoring activities of correspondence actually sent to Medicaid members, including establishing a frequency to ensure timely identification of issues, and a process by which correspondence will be modified to address the issues and then implemented timely. This should include a proactive process to identify and address the causes of any errors the Department finds.
- B. Using information about the Medicaid correspondence sampled as a part of this audit:
 - i. To make the necessary programming changes to the Colorado Benefits Management System (CBMS). This should include addressing issues with the case worker authorization and system override for mailing correspondence and the system logic and design for populating appeal and response date fields, and allowing case workers to edit standard messages for clarity and accuracy.
 - ii. To inform, develop, and provide guidance and training to all case workers as appropriate. This should include clearly establishing the Department's expectation for what good correspondence should include and communicating worker roles and responsibilities in creating that correspondence.

Response

Department of Health Care Policy & Financing

- A. Agree

Implementation Date: July 2026

The Department agrees to develop and implement risk-based monitoring activities of correspondence actually sent to Medicaid members, including establishing a frequency to ensure timely identification of issues, and a process by which correspondence will be modified to address the issues and then implemented timely. This will include a proactive process to identify and address the causes of any errors the Department finds.

The Department does not currently have the resources to fully implement this recommendation. Implementing this recommendation will require additional dedicated funding for a new centralized team and a content management system that will create an independent correspondence environment to ensure the audit recommendations are implemented as prescribed.

B. (i.) Agree

Implementation Date: July 2026

The Department agrees to develop and implement risk-based monitoring activities of correspondence actually sent to Medicaid members, including establishing a frequency to ensure timely identification of issues, and a process by which correspondence will be modified to address the issues and then implemented timely. This will include a proactive process to identify and address the causes of any errors the Department finds and use information about the sampled Medicaid correspondence audit. The Department will also make the necessary programming changes to the CBMS.

The Department does not currently have the resources to fully implement this recommendation. Implementing this recommendation will require additional dedicated funding to implement the changes into the system(s), for a new centralized team, and a content management system that will create an independent correspondence environment to ensure the audit recommendations are implemented as prescribed.

(ii.) Agree

Implementation Date: July 2026

The Department agrees to inform, develop, and provide guidance and training to all case workers as appropriate. This will include clearly establishing the Department's expectation for what good correspondence should include and communicating worker roles and responsibilities in creating that correspondence.

Finding 2—Vendor Prior Authorization Correspondence

The Department requires medical providers to get approval before providing some Medicaid Benefits such as certain specific medications, medical equipment, dental procedures, physical therapy, and intensive behavioral health services. The Department contracts with multiple vendors to approve or deny requests for these Medicaid benefits on the Department's behalf. Medical providers send PARs to a Department vendor on the member's behalf. The Department's vendors then determine if the provider-requested services are medically necessary and communicate their approval or denial decision to both the member and the medical provider. We identified nine PAR vendors that send approval and denial correspondence on the Department's behalf, including separate vendors for:

- Pharmacy Benefits (*one vendor*)
- Equipment and Specialized Service Benefits (e.g., wheelchairs, physical therapy) (*one vendor*)
- Dental Benefits (*one vendor*)
- Behavioral Health Benefits (Regional Accountable Entities) (*five vendors*)
- Combined Behavioral and Physical Health Benefits (Managed Care Organizations) (*two vendors*)

The Department contracts with six vendors in total that coordinate care and review PARs for Behavioral Health and Managed Care benefits. Every Medicaid member is assigned to a Regional Accountable Entity, but in certain regions members can instead opt into a Managed Care Organization that helps coordinate both the member's physical and behavioral health care. The Department contracts with one vendor that only provides managed care. One vendor operates as a Regional Accountable Entity and also offers a managed care option for members; this vendor is listed in both counts above. In this finding, we refer to these vendors collectively as Coordinated Care vendors. We will refer to the remaining three vendors by their bulleted title throughout this finding.

All nine PAR vendors generate and send correspondence to Medicaid members using their own information technology (IT) systems rather than CBMS. Exhibit 2.21 summarizes the total number of correspondence, or letters, that PAR vendors sent to Medicaid members in January and February 2023.

Exhibit 2.21

PAR Vendor Correspondence January and February 2023

PAR Vendor Correspondence	January 2023	February 2023	Total Letters
Pharmacy Vendor	3,154	3,199	6,353
Equipment and Specialized Service Vendor	2,520	2,599	5,119
Dental Vendor	7,844	8,285	16,129
Coordinated Care Vendors	11,261	10,317	21,578
Total	24,779	24,400	49,179

Source: Office of the State Auditor analysis of data provided by Department vendors.

What was the purpose of the audit work and what work was performed?

The purpose of our audit work was to determine if the correspondence that the nine PAR vendors sent to Medicaid members in January and February 2023 met statutory and other requirements and to assess the Department's process for reviewing and monitoring the correspondence its vendors send.

We reviewed statutes, federal laws, and Department rules and policies to understand requirements and best practices for Medicaid correspondence. In addition, for each PAR vendor, we reviewed the letter templates they use to communicate approvals and denials to Medicaid members and selected samples of letters sent to members in January and February 2023. For the Pharmacy vendor and the Equipment and Specialized Service vendor, we selected households to test by stratifying the list of households by the number of letters they received from the vendor into five strata. We then randomly selected one household from each stratum for both vendors for a total of ten households. For the other seven vendors, we selected at least one representative letter for each template type. For each vendor, we reviewed their letter templates as well as actual letters sent to members, as shown in Exhibit 2.22.

Exhibit 2.22
PAR Vendor Samples

PAR Vendor	Templates Reviewed	Letters Reviewed
Pharmacy Vendor	1	15
Equipment and Specialized Service Vendor	13	16
Dental Vendor	3	6
Coordinated Care Vendors	14	14
Total	31	51

Source: Office of the State Auditor: sample size per vendor.

Finally, we interviewed the Department staff who monitor the nine vendor contracts. No single division at the Department monitors the activities of these vendors; instead, contract monitors for each vendor are located in separate Department divisions.

How were the results of the audit work measured?

Medicaid member correspondence must comply with federal and state laws, Department rules and policies, and vendor contracts, and should align with the Department's member communication best practices.

Statute

The legislative intent for the Correspondence Improvement Act is to ensure that member correspondence is accurate, understandable, timely, informative, and clear [Section 25.5-4-212(1)(a)(I), C.R.S.]. When a vendor sends correspondence on the Department's behalf, the correspondence is subject to the same statutory requirements as correspondence sent directly by the Department. Medicaid correspondence must comply with the following requirements outlined in statute:

- **Purpose and Guidance.** Statute requires that correspondence clearly conveys a purpose, including the actions being taken by the entity and any actions the member may or must take [Section 25.5-4-212(3)(f), C.R.S.]. Statute also requires that correspondence include a specific and plain language explanation of the basis for the denial of benefits [Section 25.5-4-212(3)(i), C.R.S.].
- **Clear Instructions in Multiple Languages.** Statute requires that correspondence include translation statements in the top 15 languages in the State on how to seek further assistance to better understand the content of correspondence [Section 25.5-4-212(3)(e), C.R.S.]. The Department establishes a list of the top 15 languages in the State that should be included in the correspondence.
- **Consistent Terminology.** Statute requires that correspondence use consistent naming conventions as practicable, and commonly used program names [Section 25.5-4-212(3)(c), C.R.S.].
- **Plain Language.** Statute requires correspondence to be written in plain language [Section 25.5-4-212(3)(a), C.R.S.]. Federal law defines plain language as "...writing that is clear, concise, well-organized and follows other best practices appropriate to the subject or field and intended audience" [Public Law 111-274, Section 3, 3]. The Department developed plain language best practices in its Member Communication Standards (Standards). The Standards explain that plain language lowers barriers to comprehension and increases readability and include the following as plain language tools:
 - **Common Vocabulary.** Plain language means information is told in the clearest way possible, using common, everyday words. Further, legal, technical, and bureaucratic language should be avoided, or explained if the terms are necessary.

- **Brief, One-Topic Paragraphs.** Correspondence should not include unnecessary wording that can make the correspondence longer and paragraphs should be kept short and focused on a single-subject.
- **Active Voice.** Active voice promotes conversational messaging that attributes each action. Active voice is also smooth, clear, and easy to understand.
- **Simple Sentences.** Simple sentences use plain language, have an active voice, have a friendly tone, use familiar words, and are often fewer than 20 words.
- **Friendly Tone.** Readers respond more positively to a friendly, respectful, and encouraging tone.

Department Rule

PAR vendors are required to include information on members' rights to appeal the vendors' decisions, including deadlines for filing appeals, in Medicaid correspondence. Department rules set the amount of time members have to appeal a PAR denial. Rule 10 CCR 2505-10, 8.209 lays out the Medicaid grievance and appeal process that applies to the Coordinated Care and Dental vendors. Members have 60-days to file an appeal with the vendor in response to a benefit denial and 120-days to file an appeal through the Office of Administrative Courts. The Dental vendor has internal policies that reflect these requirements.

Anti-Discrimination Laws and Policies

Department policies, and federal and state civil rights laws prohibit discrimination against individuals who receive Medicaid benefits. The Department's nondiscrimination policy states that the Department and its vendors do not exclude, deny benefits to, or otherwise discriminate against any individual 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. The Department requires PAR vendors to include a statement in their correspondence that the Department and its vendors do not discriminate against individuals on the basis of any of the characteristics included on this list and provide contact information for members to file a discrimination complaint. The contact information should direct members to the Department or the federal Office of Civil Rights within the U.S. Department of Health and Human Services.

Department Guidance

The Department created its Standards to help ensure that the Department's and its vendors' communication with members is always easy to read, understand, and use. The Standards include the following best practices:

- **Purpose First and Key Messages.** The Standards emphasize that the letter’s purpose is the most important message, and should go first.
- **Form.** The Standards suggest that letter writers limit the number of messages in a letter to one main message and a few supporting messages because, “the sheer length can intimidate readers. They may conclude based on the number of pages alone that reading the correspondence will be too hard or too time consuming.”
- **Easy-to-Follow Organization and Visual Cues.** The Standards recommend organizing the information in correspondence to make it possible for readers to grasp what they need to know and do, such as adding in titles that tell the reader right away what the communication is and using headings that help readers scan and find messages. Correspondence should also spell out all acronyms upon first use. Lastly, the Standards suggest that information be separated by logical line and white space breaks that help with visual appeal, readability, and flow of information.
- **Date Formatting.** Medicaid member letters often include important due dates and deadlines. To avoid confusion, the Department’s Standards recommend writing out the date so all readers—including members whose country of origin is not the United States—will not confuse the day and month in abbreviated dates.

Contracts

The Coordinated Care vendor contracts require that vendors:

- Use member notices developed by the Department
- Ensure that correspondence is member-tested
- Follow standards in the Department’s Brand Standards. The Department’s Brand Standards guide its vendors in how to use the Department’s logo and how to refer to Health First Colorado, Colorado’s Medicaid program.

The Department drafted a denial letter template for the Coordinated Care vendors that, according to Department staff, was last updated and provided to the vendors in January 2022. The denial letter template includes a title, alternative language statements, and detailed information regarding the service: request date, requester, and reasoning for the denial or approval of service. The denial letter template also has the Coordinated Care vendor’s contact information and appeal deadline dates before the signature line. The Department has not developed similar types of denial letter templates for its other vendors or approval letter templates for any of its vendors.

What problems did the audit work identify?

Overall, we found that Medicaid correspondence sent by the Department's PAR vendors did not meet standards for Medicaid correspondence in the following areas: statute, Department rules, Department policies and communication best practices in guidance, and vendor contracts. We provide details on which templates and letters did not meet the standards in the following sections.

Statutory Requirement Issues

First, we found that some PAR vendor letters did not meet statutory requirements regarding accuracy; the completeness in the notice's information; the required translation statements; the use of consistent and common terms; or the Department's plain language standards including using active voice, simple sentences, and a friendly tone. Specifically, we found:

Inaccurate Legal Language. The Department's Coordinated Care denial letter template has an inaccurate legal citation. The template references the Children and Youth Mental Health Treatment Act, but provides an inaccurate citation to Section 27-64-104, C.R.S., which is the Crisis Hotline Cash Fund.

Incomplete Letters. We identified letters sent by the Department's Equipment and Specialized Services vendor and Coordinated Care vendors that did not include complete information required by statute. Specifically:

- **Equipment and Specialized Services vendor.** We found 3 of the 16 letters (19 percent) we reviewed that were sent by the Department's Equipment and Specialized Services vendor had blank fields, as follows:
 - One denial letter had blank fields for the service requested, the reason for denial, and the legal criteria used to evaluate the request, as shown in Exhibit 2.23.

Exhibit 2.23

Screenshot of a Denial Letter with Blank Fields

Your benefit or service request was denied for a technical reason

Dear Member,

You are receiving this letter because we denied your health care provider's request for the following benefit or service: <-----

We denied your request for a technical reason.

Why we denied your request
Your health care provider made a request for this service. Medical professionals reviewed this request on behalf of Health First Colorado. A clinical team that includes nurses and doctors determines whether requested services are medically necessary according to established criteria and guidelines.

The medical professionals who reviewed your request were not able to make a determination about whether your request was medically necessary because <-----

We denied your request for not meeting the Health First Colorado criteria as described in <-----

If the request for services is for a member 20 years of age or younger, the request was also evaluated for medical necessity under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations at 10 C.C.R. 2505-10, Section 8.280.4.E.

-----> **Blank Fields**

Source: Excerpt from an Equipment and Specialized Services PAR letter dated February 2, 2023 and sent to a Medicaid member.

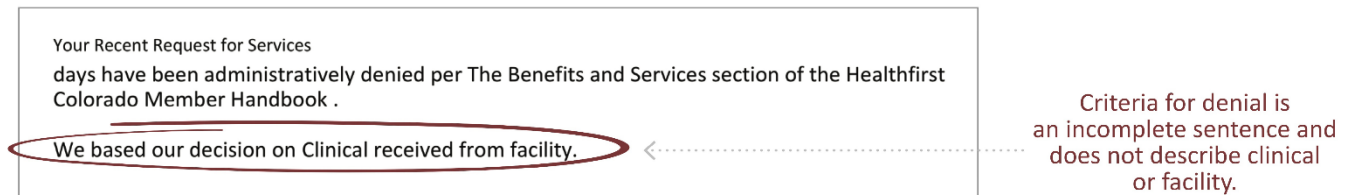
The vendor sent a second letter to the member on the same day with these sections filled out.

- One reconsideration letter upholding a denial had blank sections for the service requested and the date of the previous denial letter.
- One letter approved the remaining services in a request that was partially approved a day earlier. However, the letter included blank sections with language suggesting, incorrectly, that some services were still denied.
- **Coordinated Care Vendors.** We found that 10 of the 14 letters (71 percent) we reviewed that were sent by one of the Coordinated Care vendors were missing information needed to understand the purpose of the letter and the reason for denial, or missing instructions for the member's next steps. Some letters had more than one of these problems. Specifically:

- Five letters did not include enough information to align the decision with the request—two letters were missing the service and request date, two were missing the request date, and one was missing the name of the requesting provider. In addition, three of these letters did not include the basis for the denial, as shown in Exhibit 2.24.

Exhibit 2.24

Screenshot of Denial Letter excluding Basis for Denial



Source: Excerpt from a Coordinated Care vendor denial letter dated February 17, 2023 sent to a Medicaid member.

- Four letters did not include required information on the next steps the clients could take. For example, one letter was missing instructions indicating that the member should talk to their provider, two letters were missing instructions that the member could contact the vendor for alternative care options, and one letter did not have either of these next steps.
- The Department’s Coordinated Care denial letter template and all eight Coordinated Care denial letters that we reviewed were missing instructions for some of the actions the members could take if they disagreed with the vendor’s denial of the PAR. For example, as shown in Exhibit 2.25, the template states that the member has the right to ask for an appeal hearing with the Office of Administrative Courts, or to continue their benefits during an appeal, but does not provide instructions on how the member should make these requests. In the template, the Department refers to the appeal hearing as a “State Fair Hearing.” For example, the template states that the member has the right to ask for a State Fair Hearing with the Office of Administrative Courts, or to continue their benefits during an appeal, but does not explain key terms like “State Fair Hearing” or include instructions on what information, if any, the member should include with their request, as shown in Exhibit 2.25.

Exhibit 2.25

Screenshot of Denial Template without Appeal Instructions

HOW TO ASK FOR A STATE FAIR HEARING

If you do not agree with the decision << MANAGED CARE PLAN NAME OR REGIONAL ORGANIZATION>> made about your appeal, you have the right to ask for a State fair hearing.

1. To ask for a State fair hearing, you must file an appeal with << MANAGED CARE PLAN NAME OR REGIONAL ORGANIZATION>> first and receive a decision that you do not agree with.
2. You can request a State fair hearing up to **120 calendar days** after receiving an appeal decision that you do not agree with.
3. To request a State fair hearing, please write, call, or fax:
Office of Administrative Courts
1525 Sherman Street, 4th Floor
Denver, CO 80203
Phone: 303-866-2000
State Relay 711 for callers with speech or hearing disabilities
Fax: 303-866-5909

Does not include instructions on what information the member needs to include, if any, in their request.

TO CONTINUE RECEIVING YOUR BENEFITS AND SERVICES DURING THE APPEAL, QUICK APPEAL OR STATE FAIR HEARING PROCESS, YOU MUST:

Ask << MANAGED CARE PLAN NAME OR REGIONAL ORGANIZATION NAME >> to continue your benefits and services. Even if you file an appeal or request a State fair hearing, you must make a separate request for your benefits and services continue, if you want them to continue during the appeal or State fair hearing process.

- o During an Appeal or Quick Appeal: You must ask to continue your benefits and services within **ten calendar days** of the date on this letter or on or before the date your services are to be reduced, whichever is later.
- o During a State fair hearing: You must ask to continue your services within **ten calendar days** of receiving the notice that our appeal decision is not in your favor, that is we decided that our original decision to deny the services is correct.

Does not include instructions on what information the member must submit, such as the member's name or the services that need to be continued or how to submit information in order to ask for continued benefits in a separate request.

Source: Excerpt from the Department of Health Care Policy & Financing's Coordinated Care vendor denial letter template.

- o One Coordinated Care vendor letter started with an incomplete sentence, as shown in Exhibit 2.26.

Exhibit 2.26

Screenshot of Denial Letter Beginning with Incomplete Sentence

Dear [REDACTED]

[REDACTED] is your Health First Colorado (Colorado's Medicaid Program).
Every Health First Colorado member belongs to a health plan or regional organization.

Incomplete Sentence

Source: Excerpt from behavioral health denial letter sent by a Coordinated Care vendor dated December 15, 2022.

The sentence should read, “[Regional Accountable Entity] is your Health First Colorado (Colorado’s Medicaid Program) regional organization.” This omission makes it difficult to understand what role the vendor plays in the member’s care.

Missing Translations. We found that the Department’s Coordinated Care, Pharmacy, and Dental vendors did not include statements in the top 15 languages commonly spoken by individuals in Colorado with limited English proficiency, as required by statute.

- The Department’s Coordinated Care vendor letters we reviewed did not include all of the required translation statements—9 of the 14 letters (64 percent) did not include any of the required translation statements and 4 letters (29 percent) included translation statements for only some of the 15 required languages.
- The Department’s Pharmacy vendor’s letters only included translation statements in Spanish and Vietnamese, the top 2 required languages, but did not include statements in the remaining 13 required languages.
- The Department’s Dental vendor’s letters did not include translation statements in one of the 15 required languages.

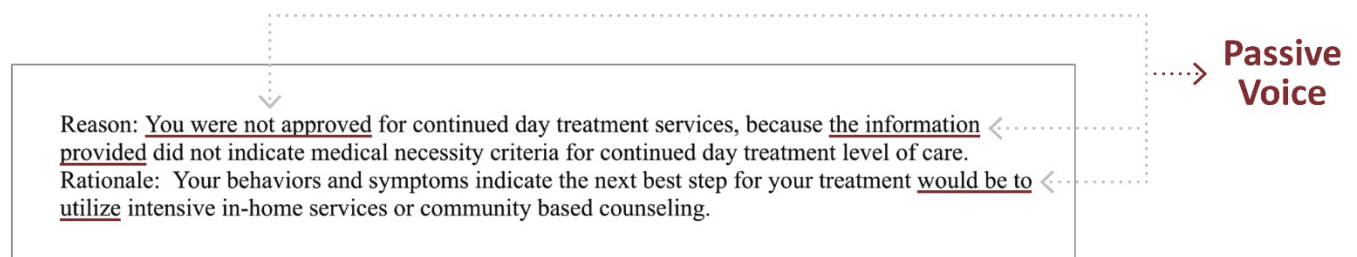
Inconsistent Terminology. Statute requires the Department to use consistent terms and commonly used program names. All but one of the PAR vendors included at least some terminology in their letters that the Department discourages in its Standards. These included using the terms “Medicaid Number” and “Member ID” to describe the same identifier in a letter and using the terms “Regional Accountable Entity,” “RAE,” or “health plan” rather than the recommended term “regional organization.”

Plain Language Techniques. Statute requires the Department to write letters in plain language. We found instances where PAR vendor letters did not follow the Department’s plain language guidance to use active voice, avoid legal jargon, and use simple sentences and a friendly tone.

- **Passive Voice.** We found that 5 of the 14 letters (36 percent) we reviewed that were sent by Coordinated Care vendors did not use active voice for the basis of their denials or approvals, as recommended in the Department’s Standards, and as shown in Exhibit 2.27.

Exhibit 2.27

Screenshot of Denial Letter with Reason for Denial in Passive Voice



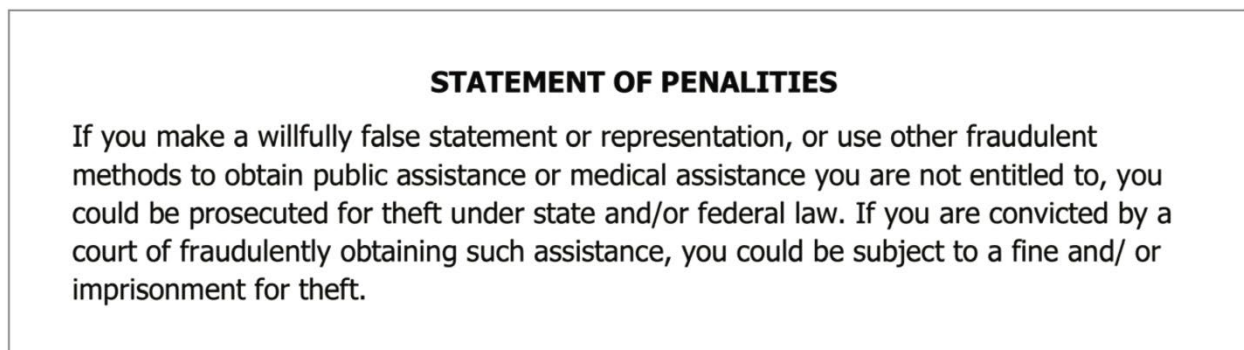
Source: Excerpt from a behavioral health denial letter sent by a Coordinated Care vendor dated January 10, 2023.

Passive voice makes it confusing for the reader to determine who did what, and in this case, who denied treatment and who did not provide the necessary information. We also identified sentences written in passive voice in templates and dynamic text created by the Department's Dental and Pharmacy vendors.

- **Unfriendly Legal Language.** The Department does not require PAR vendors to include legal disclaimers in addition to the nondiscrimination statement. However, we found two vendors that included an additional legal statement in their letters related to penalties. Letters sent by the Department's Dental and Pharmacy vendors included a "Statement of Penalties" section that did not appear in other Department correspondence and informed the reader they may be fined or imprisoned if they commit Medicaid fraud, as shown in Exhibit 2.28. This section also included complex legal language and did not strike a friendly tone, contrary to guidance provided in the Department's Standards.

Exhibit 2.28

Screenshot of Complex Legal Language from Denial Letter



Source: Excerpt from Pharmacy Vendor Denial Letter Template.

- **Unclear Legal Language.** Letters sent by the Department's Pharmacy and Dental vendors also included a "Continuing Benefits" section that made it unclear whether the member or the State pays for continuing services during an appeal, as shown in Exhibit 2.29.

Exhibit 2.29

Screenshot of Unclear Legal Language from Denial Letter

The screenshot shows a section titled "Continued Benefits" from a denial letter template. The text states: "To continue receiving the denied services listed on the notice, you must file your request for a hearing in writing no later than 60 calendar days after the date on the front of this notice. You may continue receiving services while you are waiting for a decision on your appeal. If you lose your appeal, you must pay back the cost of the services you received during the appeal. If you win your appeal, the State will pay your provider for the service(s) you received during your appeal process. Your provider is responsible for reimbursing you for the amount you paid them during your appeal." Two red annotations with arrows point to underlined phrases. The first annotation, "Implies the member pays for services during appeal.", points to "you must pay back the cost of the services you received during the appeal." The second annotation, "Implies the State pays for services during appeal.", points to "Your provider is responsible for reimbursing you for the amount you paid them".

Continued Benefits

To continue receiving the denied services listed on the notice, you must file your request for a hearing in writing no later than 60 calendar days after the date on the front of this notice. You may continue receiving services while you are waiting for a decision on your appeal. If you lose your appeal, you must pay back the cost of the services you received during the appeal. If you win your appeal, the State will pay your provider for the service(s) you received during your appeal process. Your provider is responsible for reimbursing you for the amount you paid them during your appeal.

Implies the member pays for services during appeal.

Implies the State pays for services during appeal.

Source: Excerpt from Pharmacy Vendor Denial Letter Template.

Department Rule Compliance Issues

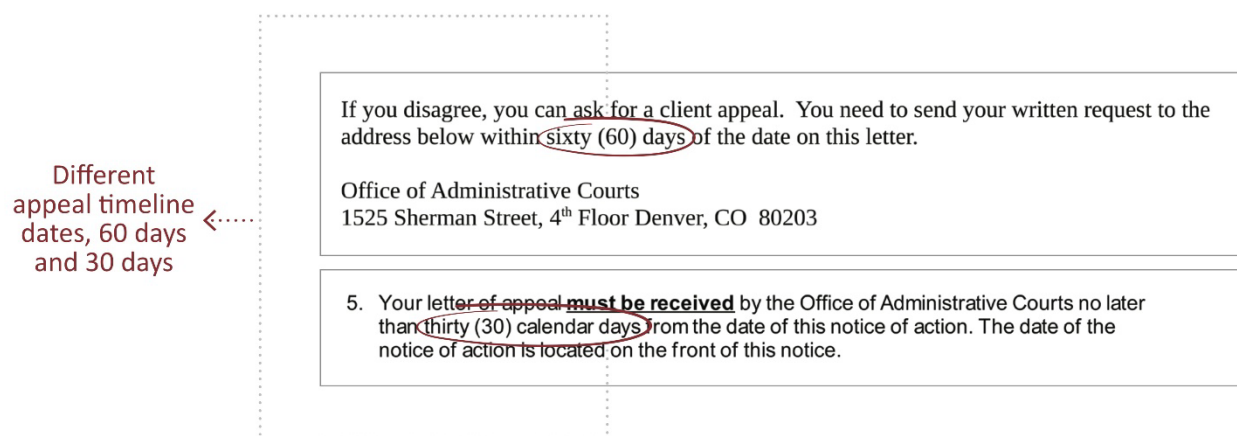
Second, we found that some PAR vendor letters did not follow Department rules about providing Medicaid members with 60 days to appeal a denial.

Inaccurate Appeal Dates. We found that all of the templates and letters that we reviewed from the Department's Dental vendor included inaccurate appeal dates. The PAR denial template used by the Dental vendor includes a section describing an internal appeals process through the vendor, which incorrectly gives the member 10 days to file an internal appeal rather than the legally required 60 days [Section 8.209.4.B, 10 CCR 2505-10].

In addition, we found that the Dental vendor's reconsideration letters sent to members included contradictory dates that are not consistent with Department rule. This letter communicated the Dental vendor's decision on an internal appeal, and included a section describing the process for the member to appeal the internal appeal decision through the Office of Administrative Courts. Both of the reconsideration letters that we reviewed from this vendor included contradictory dates. Specifically, the body of the letter informed the member that they had 60 days to file an appeal, while the attached appeals sheet informed the member that they had 30 days to file an appeal, as shown in Exhibit 2.30. Neither of these time periods are consistent with the 120-day time period required by Department rule [Section 8.209.4.N, 10 CCR 2505-10].

Exhibit 2.30

Screenshots of Contradictory Appeal Dates in Same Letter



Source: Excerpts from a Dental Reconsideration Letter dated January 9, 2023 and sent to a Medicaid member.

Department Policy Issues

Third, we found that some letters included language that did not comply with the Department's nondiscrimination policy. Specifically, we found that 8 of the 14 (57 percent) Coordinated Care vendor letters that we reviewed did not include a nondiscrimination notice, as required by the Department. In addition, we found that the civil rights notice included in the Department's Dental vendor letter template does not describe protected classes consistent with Department policy. These letters include both a "discrimination" and a "nondiscrimination" section. The "nondiscrimination" section lists race, color, national origin, age, disability, and sex as protected classes and the "discrimination" section repeats these classes and adds religion as a protected class. However, Department policy states that the Department does not discriminate based on any of the following: race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. Therefore, the protected classes listed in the Dental vendor's letter template are not consistent with the protected classes listed in Department policy. In addition, the Dental vendor's letter directs members with civil rights complaints to submit their complaint to the vendor rather than to the Department, as required.

Departmental Guidance Issues

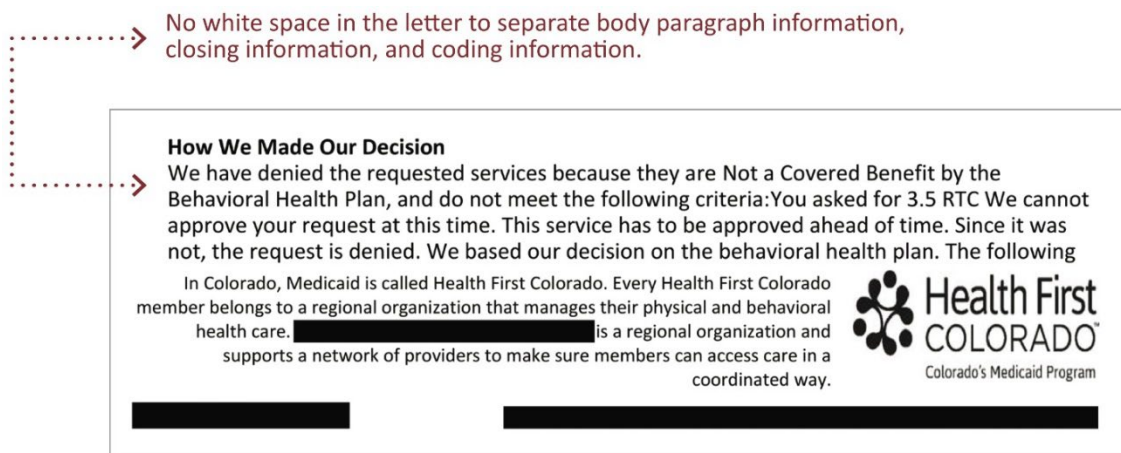
Fourth, we found that some letters provided to Medicaid members did not follow the Department's guidance to ensure the letters are easy to understand.

Organization and Visual Cues. In general, we found that the Pharmacy, Equipment and Specialized Services, and Dental vendors' templates and letters were easy to follow. For the Coordinated Care vendor letters, we identified instances where they did not follow certain readability and formatting requirements. Specifically:

- **Purpose First.** None of the 14 Coordinated Care letters we reviewed included the letter’s purpose as the first sentence, as recommended by Standards. Instead, we found that the sentence stating the letter’s purpose (i.e., to state the vendor’s decision on whether requested services had been approved or denied) was the third to seventh sentence in all of the letters.
- **Key Messages.** One Coordinated Care vendor’s denial letter did not include language stating that the member had 60 days to appeal the denial in the body of the letter; instead, it was listed later in the appeal instructions on page 11 out of 26. The Department’s Standards indicate that this information should be at the beginning of the communication because it is considered key information.
- **Length.** The eight Coordinated Care vendors’ denial letters include member appeal rights. However, the instructions that they provide to members on how to appeal a decision are 7 pages long. By contrast, the same required information was communicated on 1 page in the other Department denial letter templates.
- **Headers.** The 14 Coordinated Care vendor letters that we reviewed had disjointed information between the headers and the subsequent paragraphs after the headers. For example, member’s right to appeal statements were under the “Call Us with Questions” section and information on how the Coordinated Care vendor can help the member coordinate care was under the “How We Made Our Decision” header.
- **Blank Space.** Two of the 14 Coordinated Care vendor letters (14 percent) that we reviewed did not separate the header and footer from the body of the letter. This makes it difficult to distinguish sections of the letters and reduces the readability of the letters. Exhibit 2.31 shows an example of a letter where this occurred.

Exhibit 2.31

Closing of Coordinated Care Letters



Source: Excerpt from a Coordinated Care vendor letter dated February 17, 2023 and sent to a Medicaid member.

- **Date Formatting.** All of the letters that we reviewed that were sent by the Department’s Pharmacy and Dental vendors were written in American numeric format, contrary to the guidance provided in the Department’s Standards. The Department’s Standards recommend that any dates included in a letter be written out fully. For example, dates should be written as, “October 1, 2023” rather than in an American numeric format, such as, “10/1/2023” because countries outside of the United States use a different date format, and Medicaid members who are not familiar with the American format may read it incorrectly. For example, the numeric date above could be read as the 10th of January rather than the 1st of October. Writing the date out fully eliminates this ambiguity.

Vendor Contract Issues

Finally, we found that some of the Coordinated Care vendor letters that we reviewed did not comply with the vendor contract requirements. Specifically:

- **Department Template.** We found that none of the 8 Coordinated Care vendor denial letters that we reviewed copied the entire Department template, as required; instead the letters used only parts of the Department template.
- **Member Testing.** We found that none of the Coordinated Care vendors tested letters with members. As such, none of the 14 letters in our analysis were member-tested as required by vendor contracts.
- **Health First Colorado Logo.** We found that 9 of the 14 letters (64 percent) we reviewed did not include the Health First Colorado logo, as recommended by the Department’s Brand Standards.

Why did these problems occur?

The Department does not monitor its vendors and has not systematically reviewed vendor correspondence to ensure that the vendors comply with correspondence requirements. We interviewed the Department’s contract monitors for all nine of the PAR vendors. As of July 2023, the contract monitoring staff reported to us that they had not reviewed any Medicaid correspondence that is generated outside of CBMS for compliance with statute, or any other guidance or requirements, with one exception. According to the Department, in 2023, its Equipment and Specialized Service vendor made extensive use of department processes to rewrite its correspondence in response to negative media attention it received for denying private duty nursing services for some Medicaid members from November 2021 through May 2023. When the Department reviewed the letter, it found that members felt the wording was harsh and at times, confusing. Department staff later reported that they told the vendor to not include complex medical terminology in the hand-typed sections of the letters. This was the only instance we identified where

a PAR vendor and Department staff had reviewed a letter to assess its compliance with applicable requirements.

Department staff told us that the legal language threatening a penalty for fraud was inserted into the Dental and Pharmacy vendors' letters as the result of an Attorney General's Office review of the letters 6 years ago, prior to the enactment of Senate Bill 17-121, and the letters have not been modified to address the new requirements. The Department's Pharmacy vendor is using the same denial template that was first implemented in 2017, with a single change made in 2018 to correct a grammatical error. Similarly, the Department's Dental vendor templates were drafted prior to the enactment of Senate Bill 17-121, effective January 2018, and the vendor has not made any changes to the template to address the statutory requirements related to correspondence included in the bill.

The Department drafted the Coordinated Care vendor letter template in 2017, but the template was not drafted using statutory requirements or best practices in the Department's Standards. The Department requires Coordinated Care vendors to use letters that are tested with members. The Department tested a few sentences from its denial template with members to meet this requirement, but did not test the full letter with members. The Coordinated Care vendor operations, including member letters, are evaluated by a third party but the review does not include testing letters for compliance with Senate Bill 17-121 requirements, the Department's Standards, or all contract provisions. Further, the Dental, Pharmacy, and Equipment and Specialized Services contract monitors reported that they do not review or test vendor letters for compliance with requirements or have a third party review vendor letters for compliance with statutory requirements or Department Standards.

Moreover, none of the Department's contract monitors for these PAR vendors have a process to collect and review a risk-based sample of the vendor letters on an ongoing basis to ensure the letters are accurate, complete, understandable, and compliant with all applicable standards.

The Department's contracts include inconsistent language regarding correspondence.

Contracts for the Department's PAR vendors include a general requirement that the vendor follow applicable laws. However, the contracts do not include any language regarding the Correspondence Improvement Act, Section 25.5-4-212, C.R.S., which is the statute requiring that correspondence are written in person-first language, have a client greeting, and clearly convey the purpose of the letter. Further, the Pharmacy and Equipment and Specialized Services contracts do not include provisions requiring the contractors to ensure that their correspondence meet the plain language and formatting requirements under state and federal requirements. The other seven PAR vendor contracts include language directing vendors to write correspondence using language that is easily understandable, is in an easy-to-follow format, includes the reason for the letter, and explains how the member can request an appeal.

The Department has not established and enforced a consistent set of communication standards or best practices for PAR correspondence created and sent by its vendors. While

the Department has written a set of communication standards, it does not require vendors to comply with them. In addition, although the Department's Brand Standards state that, "Consistent usage [of the Brand Standards] over time strengthens the State brand," the Department did not implement its own standards and guidance when creating templates in collaboration with its vendors or in the denial template it provided to its Coordinated Care vendors. Further, the Department collects data from members as part of its Member Experience Advisory Council, or MEAC, made up of Medicaid members who volunteer to review letters for understandability and give feedback to the Department based on their review; however, the Department does not require vendors to make changes in response to this feedback. For example, during member testing, MEAC members reported that the Department-created Coordinated Care denial letter is "...not a WARM letter. It's very cut to the bone and all "black and white" and "There is a stoic beat to it." The Department received the feedback on the denial letter in October 2021, but has not addressed members' concerns by implementing any changes to the letter in the last nearly 2 years.

Why does this problem matter?

When the Department does not test, review, and monitor correspondence sent by its vendors, there is a risk that Medicaid members will receive incomplete, inaccurate, confusing, and fragmented letters. This creates unnecessary barriers to healthcare and is not respectful to members who must then review the letters and discern what actions they need to take and how the outcome of decisions will affect their physical and financial well-being.

Confusing and inaccurate correspondence also increases the likelihood that a member will call someone, such as the Department's call center, the counties, or advocacy groups for help, placing an unnecessary burden on these organizations. The new employee training manual for the Department's call center lists "Educate members about correspondence sent by Health First Colorado and our partners" among the 10 main tasks call center agents are expected to perform. The Department has reached out to 24 counties and eligibility sites for feedback on correspondence quality and all of them indicated that members come to them with questions about correspondence—one county stated that "Questions, concerns, and complaints regarding correspondence have remained the same and constant for many years." The Department has also collected information from members indicating that members do not understand the purpose or benefit of the Coordinated Care vendors. For example, a member reported to the Department, that they wished they would have known, "What a RAE is and how much help they offer to find in-network providers, since providers listed might not actually accept Medicaid." The PAR vendor letters can also provide an opportunity for the Department and the vendors to educate Medicaid members about how the vendors can help connect them to care they need, which is the objective of the Department's Coordinated Care approach.

Recommendation 2

The Department of Health Care Policy & Financing (Department) should ensure that Medicaid members receive accurate, complete, and useful correspondence from its Prior Authorization Request (PAR) vendors by:

- A. Developing and implementing policies and procedures to identify, review, and modify correspondence sent by its vendors for compliance with statutes, federal and state rules, Department standards and guidance, and contracts. This strategy should include requiring contract monitors to review vendor correspondence on an ongoing basis and whenever substantive changes are made to correspondence, communications standards, or Medicaid programs.
- B. Amending current PAR vendor contracts to include language requiring the vendors to comply with specific requirements (statutory, federal and state rules, and Department standards and guidance) related to Medicaid correspondence that the vendors send to Medicaid members and include this language in all PAR vendor contracts in the future.
- C. Establishing and enforcing a consistent set of communication standards for all correspondence created and sent by the Department's PAR vendors.

Response

Department of Health Care Policy & Financing

- A. Agree

Implementation Date: November 2025

The Department agrees to develop and implement policies and procedures to identify, review, and modify correspondence sent by its vendors for compliance with statutes, federal and state rules, Department standards and guidance, and contracts. This strategy will include requiring contract monitors to review vendor correspondence on an on-going basis and whenever substantive changes are made to correspondence, communications standards, or Medicaid programs. Due to the various vendors involved, various RFP's occurring, stakeholder engagement efforts, internal Department reviews and training needed this will be completed by November, 2025.

- B. Agree

Implementation Date: November 2025

The Department will amend current PAR vendor contracts to include language requiring the vendors to comply with specific requirements (statutory, federal and state rules, and Department

standards and guidance) related to Medicaid correspondence that the vendors send to Medicaid members and include this language in all PAR vendor contracts in the future. Due to the various vendors involved, various RFP's occurring, stakeholder engagement efforts, internal Department reviews and training needed this will be completed by November 2025.

C. Agree

Implementation Date: November 2025

The Department will establish and enforce a consistent set of communication standards for all correspondence created and sent by the Department's PAR vendors. Due to the various vendors involved, various RFP's occurring, stakeholder engagement efforts, internal Department reviews and training needed this will be completed by November 2025.

Finding 3—Medicaid Correspondence Management

As discussed in the two previous findings, the Department has the responsibility to ensure that the correspondence it sends Medicaid members are easy to read and understandable. As part of the Correspondence Improvement Act, the General Assembly declared that, "Accurate, understandable, timely, informative, and clear correspondence from the state department is critical to the life and health of [M]edicaid recipients, and in some cases is a matter of life and death for our most vulnerable populations" [Section 25.5-4-212(1)(a)(I), C.R.S.].

The Department sends multiple types of correspondence to Medicaid applicants and members each month related to items such as eligibility determinations and prior authorization for services decisions. In January and February 2023, the Department sent more than 800,000 eligibility letters out of CBMS to Medicaid applicants and member and about 5,000 letters out of BUS to the members in its Long-Term Services and Supports program related to eligibility for its programs and services, and its vendors sent more than 49,000 prior authorization approval and denial letters.

What was the purpose of the audit work, what work was performed, and how were the results of the audit work measured?

Section 25.5-4-212(3), C.R.S., enacted by Senate Bill 17-121, requires the Department to ensure that all Medicaid member correspondence revised or created after January 1, 2018 meet a list of communication standards outlined in the law. The purpose of our audit work was to evaluate the effectiveness of the Department's processes for: (1) identifying letters that meet the statutory definition of Medicaid member correspondence and are subject to statutory requirements; (2) reviewing and updating any correspondence that does not meet statutory requirements; and (3) implementing the revised correspondence, as applicable, timely.

As part of the OSA’s audit work, we interviewed Department staff; reviewed Department policies, procedures, guidance, and standards; reviewed the Department’s status report for our 2020 *Medicaid Client Correspondence* performance audit; listened to stakeholder interviews conducted by the Department that discussed their concerns about the understandability of Medicaid correspondence and how it could be improved; and reviewed the Department’s vendor contracts that include requirements to draft, send, and monitor correspondence. When conducting our audit work, we applied the following provisions:

The Department should identify Medicaid correspondence that is subject to statutory requirements. Statute defines Medicaid member correspondence as, “...any communication, the purpose of which is to provide an approval, denial, termination, or change to an individual’s eligibility; to provide notice of the approval, denial, reduction, suspension, or termination of a Medicaid benefit; or to request additional information that is relevant to determining an individual’s Medicaid eligibility or benefits. [Medicaid member correspondence] does not include communications regarding the State Department’s review of trusts or review of documents or records relating to trusts” [Section 25.5-4-212(2), C.R.S.]. In our 2020 *Medicaid Client Correspondence* performance audit, we recommended that the Department, “...should continue to strengthen its ongoing Medicaid [member] correspondence improvement efforts by: identifying the population of all templates that are used to generate Medicaid [member] correspondence...”.

The Department should have a system for reviewing and updating the templates for all correspondence subject to statutory requirements. Statute requires the Department to “develop a process to review and consider feedback from stakeholders including [member] advocates and counties prior to implementing significant changes to correspondence.” Statute also outlines that the Department’s reviews should ensure that letters that may go to fewer people, but that have significant impact, be prioritized for revision [Section 25.5-4-212(6), C.R.S.].

Our 2020 *Medicaid Client Correspondence* performance audit recommended that the Department develop a system for the review and updating of all correspondence to ensure compliance with the communication standards outlined in the bill. In addition, in February 2022, the Department created its *Member Communications Standards* (Standards) to help ensure that the Department’s and its vendors’ communication with members is always easy to read, understand, and use. The Standards state that the Department’s Communications team should be involved in the planning for correspondence to provide expertise on plain language, a requirement of the Medicaid correspondence statute. The Department’s informal review process includes engaging the Department’s Communications team, taking the steps to review correspondence for compliance with state law, and obtaining feedback from Medicaid members on drafts.

The Department should implement the changes that it makes to correspondence consistently and in a timely manner. Section 24-17-102(1), C.R.S., requires each state agency to institute and maintain a system of internal controls and in 2016, the OSC directed all state agencies to begin following the *Standards for Internal Control in the Federal Government* (Green Book), published

by the U.S. Government Accountability Office. The Green Book outlines under Principle 1, *Adherence to Standards of Conduct*, that management should address, "...deviations from expected standards of conduct timely and consistently" [Green Book, Principle 1.10].

What problems did the audit work identify?

Throughout the audit, as we discussed in our Medicaid Eligibility Correspondence and Vendor PAR Correspondence Findings, we found that the Department does not have effective processes for identifying, updating, and implementing changes to Medicaid correspondence to ensure that correspondence is accurate, understandable, informative, and clear, as directed by statute. In addition, we found that the Department has not fully implemented all of the recommendations from our 2020 *Medicaid Client Correspondence* performance audit. Specifically, we found problems in each of the areas we reviewed, as discussed below:

As of July 2023, the Department had not identified all Medicaid member correspondence subject to statutory requirements. After our 2020 audit, the Department reviewed CBMS correspondence and identified 143 CBMS letter templates that could potentially be subject to Senate Bill 17-121 requirements because they communicate approval or denial for Medicaid or a Medicaid benefit. Upon further review, the Department determined that 80 of the letters were obsolete and were no longer needed, so the Department removed them from the system. In addition, the Department created four new letter templates to be issued from CBMS. Therefore, the Department reported that it had identified 63 CBMS letter templates that needed to meet Senate Bill 17-121 requirements. However, the Department has not reviewed all of the letter templates that are sent to Medicaid members outside of CBMS for other programs within the Department to determine if these letters meet the statutory definition of Medicaid correspondence and, therefore, need to comply with Senate Bill 17-121.

At the start of our audit, we requested all of the letters that the Department identified as letters that should comply with the Correspondence Improvement Act. The Department reported that it did not have a comprehensive or updated inventory of letters and provided a partial list. At the time, Department staff did not have a consensus on what letters should comply with the standards in the state law. Through Department staff interviews, we learned that the Department contracts with vendors that send approval and denial letters for Medicaid benefits that require prior authorizations. According to the Department, these correspondence *do* fall under the statutory definition of Medicaid correspondence and, therefore, should comply with all of the Senate Bill 17-121 requirements. We discuss our testing of these vendor letters in our Prior Authorization Correspondence Finding. Additionally, during the audit staff told us about other letters that the Department sends to Medicaid members that fit the statutory definition of Medicaid correspondence that the Department had not previously identified as "Medicaid member correspondence." For example, OCL sends a Hospital Back-Up letter to Medicaid members when it reduces their hospital benefits. However, when we interviewed OCL staff in January 2023, they said

that they do not send any correspondence other than long-term service eligibility notifications and they did not mention the Hospital Back-Up letter. Subsequently, the Department's Communication staff provided us the OCL Hospital Back-Up letter as an example of incorporating plain writing and member feedback. We confirmed with Department staff outside of OCL that the letter is a member correspondence and should comply with the law. Similarly, the Department's non-emergent transportation vendor sends denial letters to members for some transportation benefit requests, but in our interview with program staff they said these letters were rare and did not know if they were member correspondence, as defined in statute. Later, Department communication staff said that the letters should comply with the Correspondence Improvement Act. In addition, county eligibility sites sometimes send Medicaid members correspondence outside of CBMS. The Department has a policy that these letters should be reviewed by the Department to ensure timeliness and accuracy, but they are not reviewed for compliance with Senate Bill 17-121 requirements. Because the Department has not evaluated all letters that it sends to Medicaid members throughout all of its programs to determine if they are subject to Senate Bill 17-121 requirements, there is a possibility that there are additional letters that we did not review during our audit that fit the statutory definition of Medicaid member correspondence and, therefore, need to be identified and reviewed for compliance with Senate Bill 17-121.

The Department has not reviewed and updated some correspondence for compliance with statute, or implemented the changes that have been made to some correspondence.

Specifically, we found:

- **No Review, Update, or Implementation.** The Department's Pharmacy, Dental, and Coordinated Care PAR vendors send approval and denial letters to members, but the letters have not gone through the Department's Communication team review process, and the MEAC has not reviewed them or provided feedback on them. The Department's Coordinated Care PAR vendors have 14 templates, the Dental vendor has 3 templates, and the Pharmacy vendor has 1 template, none of which have been reviewed for compliance with Senate Bill 17-121 or the Department's Standards.
- **Reviewed and Updated but Not Implemented.** After our 2020 audit, the Department prioritized its review of and updates to CBMS letters that go out to the most members. The Department hired a communications expert to revise the 63 CBMS Medicaid correspondence templates that it had identified based on statutory requirements and the MEAC recommendations. However, the Department had not implemented any of those changes as of July 2023; that is, the Department was not sending out the revised letters to Medicaid members. The Department reports that it will implement the changes to the 63 templates in summer and fall of 2024. It said that it had to prioritize the renewal process at the end of the public health emergency for the first year of the renewal cycle and then could turn back to the letter template improvements. Additionally, according to the Department, the OCL implemented four letter templates that were drafted according to statutory requirements and the Department's Standards and that have been reviewed by the MEAC, when it implemented its new system, CCM that

replaced the BUS in July 2023. The Department had not reviewed or updated any of prior OCL letters to be compliant with statute as of the time of our audit.

The Department's Equipment and Specialized Service Benefit PAR vendor had about 13 letter templates at the time of our testing that were drafted in accordance with statutory requirements and the Department's Standards, all of which have been implemented.

The Department did not obtain stakeholder and county feedback on significant changes to some correspondence. In 2022 and 2023, the Department implemented three new Medicaid letters, but did not get stakeholder or county feedback on them, as required by statute. The letters included: a new Notice of Action letter that was sent to all members who were no longer eligible for Medicaid as of the end date of the public health emergency; an updated Renewal Letter, changed to make it work with computer character recognition software to reduce manual entry; and a letter requesting updated immigration documents in order to determine the applicants' eligibility.

Why did these problems occur?

Overall, the problems identified by this performance audit signify the need for improved Department management over Medicaid correspondence. We found that the problems occurred because the Department has not implemented an effective structure or processes to ensure that it reviews correspondence as a whole—regardless of what system or what entity develops and sends the correspondence—nor has it ensured that correspondence changes are implemented timely so that all Medicaid correspondence is compliant with federal and state requirements. Specifically:

- **The Department has not established a centralized structure with assigned responsibilities and delegated authority to ensure that correspondence is compliant with requirements.** Department staff have responsibilities for different parts of the Medicaid program. Some are responsible for overseeing vendors who send correspondence and some run various programs that send correspondence, both in and out of CBMS. However, the Department has not assigned an individual or group of individuals who are responsible for identifying member correspondence that is subject to Senate Bill 17-121 requirements; ensuring that it is reviewed by Department staff for compliance with statute and Department guidance, and by the MEAC; or ensuring that changes to correspondence are implemented timely. Further, the Department has not assigned anyone the responsibility and authority to conduct ongoing monitoring of correspondence to ensure continued compliance, as correspondence must change with updated program requirements. In addition, the Department does not maintain complete or updated lists of what letters it has reviewed and revised based on feedback from its Communication team and the MEAC. Therefore, the Department does not have a comprehensive, centralized list of which letters have gone through the various reviews, what changes should be made, or which updated letters are ready to be implemented. Without a centralized oversight function, the Department has not made significant progress in identifying,

updating, and implementing changed correspondence so that all correspondence is compliant with the requirements.

- **The Department does not have policies and procedures guiding the Medicaid correspondence identification, review, update, and implementation processes.** Specifically, the Department does not have policies and procedures that guide (1) the identification of correspondence subject to Senate Bill 17-121; (2) which staff members at the Department have the responsibility to review and update correspondence; and (3) what steps staff who oversee the different Medicaid programs need to take to implement changed correspondence once it has been updated.

Why do these problems matter?

When the Department does not have effective processes to review Medicaid correspondence to determine if it is subject to the requirements established in Senate Bill 17-121, update correspondence that does not comply with these requirements, and then implement the updated correspondence, Medicaid members continue to receive unclear, contradictory, and inaccurate correspondence, contrary to the legislature’s intent when it enacted the bill. For example, in the three new CBMS letters that the Department implemented in 2022 and 2023, there are problems with the effective date, the letter length, and the plain language. Specifically,

- The new Notice of Action had conflicting dates. The last day of the public health emergency was May 11, 2023, but the letter states that as of May 31, 2023, the member does not qualify for the limited coverage that ended on the last day of the public health emergency. It is unclear if the benefits ended on May 11 or 31.
- In 2022, the Department updated the Medicaid renewal packet so that a computer could read the forms using character recognition technology and reduce manual entry. Prior to the update, the renewal packet was 15 pages long; the updated renewal packets that we reviewed in our samples ranged from 19 pages to 48 pages. These redesigned packets were sent to all members beginning in February 2022, though the pilot program was only conducted at four counties and ended in February 2023 without the Department adopting the technology. The Department’s Standards explain the problems with long letters and note that, “sheer length can intimidate readers. They may conclude based on the number of pages alone that reading the correspondence will be too hard or too time consuming.” Six counties have provided the Department with member feedback that the length and complexity of the packet is discouraging members from reading and completing it.
- The Department’s immigration document request letter that it started using in February 2023 does not have language assistance statements or contact information for member questions as required by Senate Bill 17-121. The letter also does not implement the Department’s

communication best practices regarding using headers and logos to guide the reader, reduce confusion, and promote an appropriate member response.

As a result of the continued issues with correspondence, some Medicaid members report that they do not trust the Department and these issues with the correspondence may make members less likely to use their benefits, as we noted in our previous findings.

In addition, when the Department does not implement correspondence changes timely, it can result in additional work for staff. In the Correspondence Improvement Act, the General Assembly stated, “unclear, confusing, and late correspondence from the state department causes an increased workload for the state, counties administering the [M]edicaid program and nonprofit advocacy groups assisting [members]” [Section 25.5-4-212(1)(a)(II), C.R.S.]. Further, the Department’s communications vendor drafted the CBMS templates to comply with plain language standards in late 2020, but these revised templates were never implemented. According to Department staff, all of the templates will need to be re-reviewed since program requirements have changed since the vendor updated them.

Unclear messages in the correspondence can also result in increased calls to the Department’s call center with member questions. Department staff categorize calls from members based on the main subject of the members’ questions. Between July 2022 and December 2022, call center technicians categorized about 1,000 calls as correspondence-related. We reviewed those call tickets and found that about 300 (30 percent) of the calls were regarding a Department CBMS letter related to the end of the COVID-19 public health emergency. It informed members that their benefits were set to end when the public health emergency expired and that the member should check online for the date their benefits would end. The Department did not test the letter with members and stakeholders before it mailed it out to all Medicaid members in Colorado who were not currently imprisoned, including members who would still be eligible for Medicaid after the end of the public health emergency. The Department made no changes to the letter in response to calls from confused members or negative feedback from counties over the 3 years it was in use, from May of 2020 to the end of the public health emergency in May 2023.

Finally, because the Department does not have effective processes for ensuring that Medicaid correspondence complies with Senate Bill 17-121 requirements, the Department is not able to provide complete and accurate information to legislators when reporting on its implementation efforts. Annually, the Department must report specifically on its progress in improving Medicaid correspondence during its State Measurement for Accountable, Responsive, and Transparent (SMART) Government Act presentations [Section 25.5-4-212(8), C.R.S.]. In 2023, during its SMART Act presentation, the Department reported that it had an error rate of 0.002 percent in its Medicaid correspondence. However, the Department reported during the audit that the error rate only applies to the percent of blank fields in CBMS correspondence, meaning that only two tenths of 1 percent of its CBMS correspondence that go out to Medicaid members contain blank fields. This error rate does not account for the Department’s compliance with federal or state standards,

the accuracy of the correspondence, the frequency of the correspondence, or for any aspects of correspondence produced outside of CBMS.

Recommendation 3

The Department of Health Care Policy & Financing (Department) should continue to strengthen its ongoing Medicaid member correspondence improvement efforts to help ensure that the correspondence complies with state and federal requirements and Department guidance by:

- A. Establishing and implementing a centralized structure with assigned responsibility and delegated authority for identifying, reviewing, updating, and implementing changes to Medicaid member correspondence across the Department and by its vendors that includes key staff with authority to guide the Department's actions.
- B. Developing and implementing policies and procedures for how correspondence should be identified, reviewed, updated, and implemented, including timeliness guidelines for implementing changes.

Response

Department of Health Care Policy & Financing

- A. Agree

Implementation Date: July 2026

The Department agrees to establish and implement a centralized structure with assigned responsibility and delegated authority for identifying, reviewing, updating, and implementing changes to Medicaid member correspondence across the Department and by its vendors that includes key staff with authority to guide the Department's actions.

The Department can take interim steps towards this recommendation but does not currently have the resources to fully implement this recommendation. Implementing this recommendation will require additional dedicated funding for a new centralized team and a content management system that will create an independent correspondence environment to ensure the audit recommendations are implemented as prescribed.

- B. Agree

Implementation Date: July 2026

The Department agrees to develop and implement policies and procedures for how correspondence will be identified, reviewed, updated, and implemented, including timeliness guidelines for implementing changes.





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