



**Report to the  
Colorado General Assembly**

**Interim Study  
Committee on  
Communication  
Between the  
Department of Health  
Care Policy and  
Financing and  
Medicaid Clients**

*Prepared by*

*The Colorado Legislative Council  
Research Publication No. 676  
December 2016*

**Interim Study Committee on Communication  
Between the Department of Health Care  
Policy and Financing and Medicaid Clients**

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Senator Kevin Lundberg, Vice-Chair

Senator Larry Crowder  
Senator Linda Newell

Representative Jessie Danielson  
Representative Lois Landgraf

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***December 2016***

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December 2016

To Members of the Seventy-first General Assembly:

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

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

At its meeting on October 14, 2016, the Legislative Council reviewed the report of this committee. A motion to forward this report and the bills therein for consideration in the 2017 session was approved.

Sincerely,

/s/ Representative Dickey Lee Hullinghorst  
Chairman

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*This report is also available on line at:*

<https://www.colorado.gov/pacific/cga-legislativecouncil/2016-interim-study-committee-communication-between-hcpf-and-medicaid-clients>

## Committee Charge

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

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

## Committee Activities

The Interim Study Committee met four times during the 2016 legislative interim, on June 24, August 2, August 24, and September 29. The committee heard presentations from stakeholders including:

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

The following subsections discuss the issues considered by the committee.

### **Current Department Initiatives Related to Medicaid Client Correspondence**

At the June 24 and August 2 meetings, representatives from HCPF described ongoing initiatives related to Medicaid client correspondence. HCPF provided an overview of its points of contact with Medicaid clients, and described how HCPF receives feedback from clients regarding notices. HCPF explained that the office uses a joint noticing system for clients that receive public benefits other than Medicaid, and noted the advantages and limitations of the joint noticing system. A representative discussed federal requirements for eligibility and noticing for public benefit programs in Colorado. Bill D was recommended by the committee to guide HCPF's efforts to improve Medicaid correspondence. Bill D sets certain requirements on the form and content of correspondence to improve clients' understanding.

HCPF partnered with the Center for Health Literacy to study and make adjustments to the language used in notices to HCPF clients, and this project is nearing completion. The initial findings of the Center for Health Literacy were present at the June 24 meeting, and the final recommendations were presented at the August 2 meeting. The updated language for the notices is expected to be implemented in the spring of 2017. Representatives described the client feedback they have received on the revised notices, explaining that while clients feel their

comprehension of the notices has improved, the notices are too lengthy, and some clients are not familiar with medical and insurance-related terms. Based on the concerns raised about the information presented by the Center for Health Literacy, Bill D also requires HCPF to take steps to test correspondence with clients when making changes to client correspondence.

At the August 2 meeting, a representative of Connect for Health Colorado discussed its involvement in joint noticing with other state agencies and initiatives for improving client communications, including the use of social media to familiarize clients with health insurance terms.

### **Colorado Benefits Management System (CBMS)**

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CBMS is the statewide data system through which all food, cash, and medical assistance applications and eligibility determinations are processed. At the August 2 meeting, representatives from the Office of Information Technology explained how CBMS generates client notices regarding public benefits. A representative also provided background information on the evolution of CBMS and major changes and upgrades to the system in recent years, and discussed the accuracy of the data used in the client notices and how improvements to the CBMS system are initiated, prioritized, and financed. In response to the many issues witnesses presented regarding notices generated by CBMS, the committee recommended Bill C, which requires periodic performance audits by the Office of the State Auditor of the sufficiency of client correspondence about eligibility for Medicaid.

### **Client Perspectives on Medicaid Correspondence**

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Representatives from CCDC and CCLP testified at the August 24 meeting regarding their experiences with Medicaid correspondence. Public comment was also taken at each of the committee meetings. Medicaid clients provided an overview of the different types of communications they receive regarding Medicaid and other public benefits. Clients noted that there are issues with Medicaid letters beyond the comprehension of notices. These challenges include receiving notices with incorrect or missing information, receiving notices after a deadline, confusion between state and county agencies, and not receiving assistance or follow-up in a timely manner. Client representatives explained that information on the appeals process for Medicaid rulings is unclear and confusing. In addition, client representatives noted that the issues with Medicaid correspondence are magnified for the disability community, as disabled clients often rely on Medicaid for everyday care, and any disruption in care greatly impacts their lives. Clients also discussed confusion concerning continuation of benefits during an appeal.

In response to client feedback, the committee recommended Bill A, which clarifies issues surrounding continuation of benefits during an appeal. The committee also recommended Bill B, which addresses client concerns by creating a specific process during an appeal for an administrative law judge to assess the sufficiency of notice provided to a client.

### **Experiences of County Departments of Human Services With Noticing**

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At the August 2 meeting, representatives from various county departments of human services testified regarding their challenges with client correspondence. Difficulties include increasing workload for county staff, ensuring staff are properly trained, and insufficient county

administrative funding. County representatives discussed their data collection efforts on client correspondence, and noted that there have been various improvements to CBMS in recent years that have increased the efficiency of the Medicaid notices. Bill C requires the Office of the State Auditor to examine available county data in its audit of client correspondence.

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## Summary of Recommendations

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

### **Bill A — Technical Issues Filing Medicaid Appeals**

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

### **Bill B — Medicaid Appeal Review Legal Notice Requirements**

Bill B requires administrative law judges to review the legal sufficiency of Medicaid notices of action when a client appeals a termination or reduction in benefits (adverse action). The legal review of notices will take place at the start of an appeal. If the administrative law judge determines that the notice is not legally sufficient, he or she shall inform the client that the adverse action may be set aside. The client may then ask the administrative law judge to decide the case in his or her favor on the basis of the insufficient notice. Alternately, the client may waive his or her defense on the basis of insufficient notice and request that the appeal proceed to a hearing on the merits of the case. Administrative law judges must inform clients that the HCPF may issue a legally sufficient notice in the future and that the client may be required to repay any benefits received, as provided under current law, if the adverse action is upheld after the new notice is issued.

### **Bill C — Audits of Medicaid Client Correspondence**

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

### **Bill D — Improve Medicaid Client Correspondence**

Bill D requires HCPF to engage in an ongoing process to create, test, and improve Medicaid client communications. HCPF must ensure that communications with clients are accurate, readable, understandable, and consistent. Contact information for client questions, and, to the extent practicable, legal, privacy, and educational information, must be provided separately from

the main content of the correspondence. In all communications regarding denial, reduction, suspension, or termination of benefits, the following must be included:

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

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

### **Committee Letter A — Align Public Assistance Eligibility**

This letter requests that the federal government find ways to align eligibility for public assistance program to decrease confusion among clients who are applying for multiple programs.

## Resource Materials

Meeting summaries are prepared for each meeting of the committee and contain all handouts provided to the committee. The summaries of meetings and attachments are available at the Division of Archives, 1313 Sherman Street, Denver (303-866-2055). The listing below contains the dates of committee meetings and the topics discussed at those meetings. Meeting summaries and attachments are also available on the Legislative Council Staff website at:

<https://www.colorado.gov/pacific/cga-legislativecouncil/interim-committees>

### **Meeting Date and Topics Discussed**

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June 24, 2016

- ◆ Overview of client correspondence and legal and policy considerations
- ◆ Client perspectives on Medicaid letters and suggestions for improvements

August 2, 2016

- ◆ Presentation of the final report from the Center for Health Literacy
- ◆ Overview of joint noticing requirements and limitations
- ◆ County departments of human services experiences with noticing

August 24, 2016

- ◆ Presentation of legislative recommendations by the Colorado Center on Law and Policy and the Colorado Cross-Disability Coalition
- ◆ Presentation of legislative recommendations by the Department of Health Care Policy and Financing

September 29, 2016

- ◆ Committee bill drafts - discussion and vote

First Regular Session  
Seventy-first General Assembly  
STATE OF COLORADO

BILL A

LLS NO. 17-0159.01 Brita Darling x2241

HOUSE BILL

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HOUSE SPONSORSHIP

Danielson,

SENATE SPONSORSHIP

Crowder,

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House Committees

Senate Committees

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A BILL FOR AN ACT

101 CONCERNING TECHNICAL ISSUES RELATING TO THE FILING OF  
102 MEDICAID APPEALS.

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Bill Summary

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/billsummaries>.)*

**Interim Study Committee on Communication Between the Department of Health Care Policy and Financing (HCPF) and Medicaid Clients.** The bill clarifies that a medicaid recipient (recipient) who files an appeal does not need to make an affirmative request to continue medicaid benefits during the appeal. The bill requires the department of health care policy and financing (department) to send the

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
*Capital letters indicate new material to be added to existing statute.*  
*Dashes through the words indicate deletions from existing statute.*

recipient written confirmation of continuing benefits. For a recipient who chooses not to continue receiving benefits during the appeal process, the form and electronic filing process for appeals must include a check box or other method to opt out of continuing benefits.

The bill requires the form and electronic filing process for appeals to include a check box or other method to request an accommodation to file the appeal or to participate in the hearing and to request the county or service delivery agency dispute resolution process.

Additionally, the electronic appeals filing website must allow the applicant or recipient to attach the number of documents sufficient to support the appeal along with the appeal form.

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

2 **SECTION 1.** In Colorado Revised Statutes, 25.5-4-207, **amend**  
3 (1)(a)(II) and (1)(a)(III) as follows:

4 **25.5-4-207. Appeals - rules.** (1) (a) (II) (A) The applicant or  
5 recipient has sixty days after the date of the notice to file an appeal. If the  
6 recipient files an appeal prior to the effective date of the intended action,  
7 existing medical assistance benefits must automatically continue  
8 unchanged WITHOUT THE NECESSITY OF AN AFFIRMATIVE REQUEST BY THE  
9 RECIPIENT until the appeal process is completed, unless the recipient  
10 requests in writing that medical assistance benefits not continue during  
11 the appeal process; except that, to the extent authorized by federal law,  
12 the state department rules may permit existing medical assistance benefits  
13 to continue until the appeal process is completed even if the recipient's  
14 appeal is filed after the effective date of the intended action. THE STATE  
15 DEPARTMENT SHALL PROVIDE THE RECIPIENT WITH WRITTEN  
16 CONFIRMATION OF HIS OR HER CONTINUING BENEFITS PENDING APPEAL.

17 (B) The state department shall promulgate rules consistent with  
18 federal law that prescribe the circumstances under which the county or  
19 designated service agency may continue benefits if an appeal is filed after

1 the effective date of the intended action. At a minimum, the rules must  
2 allow for continuing benefits when the recipient's health or safety is  
3 impacted, the recipient was not able to timely respond due to the  
4 recipient's disability or employment, the recipient's caregiver was  
5 unavailable due to the caregiver's health or employment, or the recipient  
6 did not receive the county's or designated service agency's notice prior to  
7 the effective date of the intended action.

8 (C) THE FORM AND ELECTRONIC FILING PROCESS FOR APPEALS  
9 MUST INCLUDE A CHECK BOX OR OTHER METHOD FOR A RECIPIENT WHO  
10 CHOOSES TO DO SO TO MAKE A WRITTEN REQUEST THAT HIS OR HER  
11 MEDICAL ASSISTANCE BENEFITS NOT CONTINUE DURING THE APPEAL  
12 PROCESS.

13 (D) THE FORM AND ELECTRONIC FILING PROCESS FOR APPEALS  
14 MUST INCLUDE A CHECK BOX OR OTHER METHOD FOR AN APPLICANT OR  
15 RECIPIENT TO MAKE A REQUEST FOR AN ACCOMMODATION IN ORDER TO  
16 SUBMIT THE APPEAL OR TO PARTICIPATE IN THE HEARING. IF AN APPLICANT  
17 OR RECIPIENT REQUESTS A REASONABLE ACCOMMODATION, THE  
18 REASONABLE ACCOMMODATION SHALL BE PROVIDED.

19 (E) THE ELECTRONIC APPEALS WEBSITE MUST ALLOW AN  
20 APPLICANT OR RECIPIENT TO ATTACH THE NUMBER OF DOCUMENTS  
21 SUFFICIENT TO SUPPORT HIS OR HER APPLICATION FOR APPEAL ALONG WITH  
22 THE APPEAL FORM.

23 (III) Either prior to appeal or as part of the filing of an appeal, the  
24 applicant or recipient may request the dispute resolution process  
25 described in ~~paragraph (b) of this subsection (1)~~ SUBSECTION (1)(b) OF  
26 THIS SECTION through the county department or service delivery agency.  
27 THE FORM AND ELECTRONIC FILING PROCESS FOR APPEALS MUST INCLUDE

1 A CHECK BOX OR OTHER METHOD TO REQUEST THE DISPUTE RESOLUTION  
2 PROCESS DESCRIBED IN SUBSECTION (1)(b) OF THIS SECTION.

3 **SECTION 2. Safety clause.** The general assembly hereby finds,  
4 determines, and declares that this act is necessary for the immediate  
5 preservation of the public peace, health, and safety.

First Regular Session  
Seventy-first General Assembly  
STATE OF COLORADO

**BILL B**

LLS NO. 17-0160.01 Brita Darling x2241

**HOUSE BILL**

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**HOUSE SPONSORSHIP**

**Danielson,**

**SENATE SPONSORSHIP**

**Crowder,**

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**House Committees**

**Senate Committees**

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**A BILL FOR AN ACT**

101 **CONCERNING THE REVIEW OF LEGAL SUFFICIENCY OF MEDICAID**  
102 **APPEALS.**

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**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/bills/summaries>.)*

**Interim Study Committee on Communication Between the Department of Health Care Policy and Financing (HCPF) and Medicaid Clients.** The bill requires the administrative law judge hearing medicaid appeals to review the legal sufficiency of the notice of action from which the applicant or recipient is appealing at the commencement of the appeal hearing if the notice of action concerns the termination or

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*Capital letters indicate new material to be added to existing statute.*  
*Dashes through the words indicate deletions from existing statute.*



reduction of an existing benefit. If the notice is legally insufficient, the judge shall advise the appellant that he or she may waive the defense of insufficient notice and proceed to a hearing on the merits or may ask the judge to decide the appeal based on the judge's finding of insufficiency. The judge shall advise the appellant that a legally sufficient notice may be issued in the future and that the state may recoup benefits from the appellant.

The provisions of the bill apply to hearings conducted on and after a certain date.

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

2 **SECTION 1.** In Colorado Revised Statutes, 25.5-4-207, **add**  
3 (1)(d.5) as follows:

4 **25.5-4-207. Appeals - rules - applicability.** (1) (d.5) (I) AT THE  
5 COMMENCEMENT OF A HEARING THAT CONCERNS THE TERMINATION OR  
6 REDUCTION OF AN EXISTING BENEFIT, THE STATE DEPARTMENT'S  
7 ADMINISTRATIVE LAW JUDGE SHALL REVIEW THE LEGAL SUFFICIENCY OF  
8 THE NOTICE OF ACTION FROM WHICH THE RECIPIENT IS APPEALING. IF THE  
9 ADMINISTRATIVE LAW JUDGE DETERMINES THAT THE NOTICE IS LEGALLY  
10 INSUFFICIENT, THE ADMINISTRATIVE LAW JUDGE SHALL INFORM THE  
11 APPELLANT THAT THE TERMINATION OR REDUCTION MAY BE SET ASIDE ON  
12 THE BASIS OF INSUFFICIENT NOTICE WITHOUT PROCEEDING TO A HEARING  
13 ON THE MERITS. THE APPELLANT MAY AFFIRMATIVELY WAIVE THE  
14 DEFENSE OF INSUFFICIENT NOTICE AND AGREE TO PROCEED WITH A  
15 HEARING ON THE MERITS OR MAY ASK THE ADMINISTRATIVE LAW JUDGE  
16 TO DECIDE THE APPEAL ON THE BASIS OF HIS OR HER FINDING THAT THE  
17 NOTICE IS LEGALLY INSUFFICIENT. THE ADMINISTRATIVE LAW JUDGE  
18 SHALL ALSO INFORM THE APPELLANT THAT THE STATE DEPARTMENT MAY  
19 ISSUE LEGALLY SUFFICIENT NOTICE IN THE FUTURE AND THAT THE STATE  
20 DEPARTMENT MAY SEEK RECOUPMENT OF BENEFITS IF A BASIS FOR DENIAL

1 OR REDUCTION OF BENEFITS IS SUBSEQUENTLY DETERMINED.

2 (II) THIS SUBSECTION (1)(d.5) APPLIES TO HEARINGS CONDUCTED  
3 ON AND AFTER JANUARY 1, 2018.

4 **SECTION 2. Safety clause.** The general assembly hereby finds,  
5 determines, and declares that this act is necessary for the immediate  
6 preservation of the public peace, health, and safety.

**First Regular Session  
Seventy-first General Assembly  
STATE OF COLORADO**

**BILL C**

LLS NO. 17-0161.01 Brita Darling x2241

**HOUSE BILL**

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**HOUSE SPONSORSHIP**

**Landgraf,**

**SENATE SPONSORSHIP**

**Crowder,**

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**House Committees**

**Senate Committees**

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**A BILL FOR AN ACT**

101      **CONCERNING AUDITS OF CORRESPONDENCE SENT TO MEDICAID**  
102      **CLIENTS.**

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**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/bills summaries>.)*

**Interim Study Committee on Communication Between the Department of Health Care Policy and Financing (HCPF) and Medicaid Clients.** The bill directs the office of the state auditor (OSA) to conduct or cause to be conducted an audit of client communications, including letters and notices, sent to clients or potential clients in medicaid programs. The audits will be conducted in 2020 and 2023 and

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
*Capital letters indicate new material to be added to existing statute.*  
*Dashes through the words indicate deletions from existing statute.*

thereafter at the discretion of the state auditor.

Among other items set forth in the bill, the performance audits will review client communications for readability, understandability, and accuracy. In addition, the audits will review available county data regarding customer contacts relating to client confusion with client communications.

The OSA will report audit findings, conclusions, and recommendations to the legislative audit committee, the joint budget committee, the public health care and human services committee of the house of representatives, the health and human services committee of the senate, and the joint technology committee, or any successor committees.

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

2           **SECTION 1.** In Colorado Revised Statutes, **add** 25.5-4-213 as  
3 follows:

4           **25.5-4-213. Audit of medicaid client communications.**

5 (1) DURING THE 2020 CALENDAR YEAR AND THE 2023 CALENDAR YEAR,  
6 THE OFFICE OF THE STATE AUDITOR SHALL CONDUCT OR CAUSE TO BE  
7 CONDUCTED A PERFORMANCE AUDIT OF CLIENT COMMUNICATIONS,  
8 INCLUDING LETTERS AND NOTICES, THAT AFFECT OR CONCERN ELIGIBILITY  
9 FOR PROGRAM BENEFITS AND SERVICES, SENT TO CLIENTS OR APPLICANTS  
10 IN COLORADO MEDICAID PROGRAMS. THEREAFTER, THE STATE AUDITOR  
11 IN THE EXERCISE OF HIS OR HER DISCRETION MAY CONDUCT OR CAUSE TO  
12 BE CONDUCTED ADDITIONAL PERFORMANCE AUDITS OF CLIENT  
13 COMMUNICATIONS PURSUANT TO THIS SECTION. THE AUDIT SHALL  
14 INCLUDE COMMUNICATIONS GENERATED THROUGH THE COLORADO  
15 BENEFITS MANAGEMENT SYSTEM, AS WELL AS COMMUNICATIONS THAT  
16 ARE NOT GENERATED THROUGH THE COLORADO BENEFITS MANAGEMENT  
17 SYSTEM.

18           (2) THE PERFORMANCE AUDIT CONDUCTED PURSUANT TO THIS  
19 SECTION SHALL INCLUDE BUT NEED NOT BE LIMITED TO:

1 (a) A REVIEW OF AVAILABLE COUNTY DATA REGARDING CUSTOMER  
2 SERVICE CONTACTS THAT ARE RELATED TO CLIENT CONFUSION REGARDING  
3 COMMUNICATIONS RECEIVED BY MEDICAID CLIENTS OR APPLICANTS;

4 (b) A REVIEW OF THE ACCURACY OF CLIENT COMMUNICATIONS;  
5 AND

6 (c) A REVIEW OF WHETHER CLIENT COMMUNICATIONS SATISFY THE  
7 REQUIREMENTS OF ANY STATE OR FEDERAL LAW, RULE, OR REGULATION  
8 RELATING TO THE SUFFICIENCY OF ANY NOTICE.

9 (3) IF AUDIT FINDINGS INCLUDE FINDINGS THAT INFORMATION  
10 CONTAINED IN CLIENT COMMUNICATIONS IS INACCURATE AT THE TIME THE  
11 COMMUNICATION WAS GENERATED, THE AUDIT SHALL IDENTIFY, IF  
12 POSSIBLE, THE SOURCE OF THE INACCURATE INFORMATION, WHICH MAY  
13 INCLUDE BUT IS NOT LIMITED TO COMPUTER SYSTEM OR INTERFACE ISSUES,  
14 COUNTY INPUT ERROR, OR APPLICANT ERROR.

15 (4) BASED ON THE FINDINGS AND CONCLUSIONS IDENTIFIED  
16 DURING THE PERFORMANCE AUDIT CONDUCTED PURSUANT TO THIS  
17 SECTION, THE OFFICE OF THE STATE AUDITOR SHALL MAKE  
18 RECOMMENDATIONS TO THE STATE DEPARTMENT FOR IMPROVING CLIENT  
19 COMMUNICATIONS. ON OR BEFORE DECEMBER 30, 2020, DECEMBER 30,  
20 2023, AND DECEMBER 30 IN ANY CALENDAR YEAR IN WHICH AN AUDIT IS  
21 CONDUCTED PURSUANT TO THIS SECTION, THE OFFICE OF THE STATE  
22 AUDITOR SHALL SUBMIT THE FINDINGS, CONCLUSIONS, AND  
23 RECOMMENDATIONS FROM THE PERFORMANCE AUDIT IN THE FORM OF A  
24 WRITTEN REPORT TO THE LEGISLATIVE AUDIT COMMITTEE, WHICH SHALL  
25 HOLD A PUBLIC HEARING FOR THE PURPOSES OF A REVIEW OF THE REPORT.  
26 THE REPORT SHALL ALSO BE SUBMITTED TO THE JOINT BUDGET  
27 COMMITTEE, THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE

1 OF THE HOUSE OF REPRESENTATIVES, THE HEALTH AND HUMAN SERVICES  
2 COMMITTEE OF THE SENATE, AND THE JOINT TECHNOLOGY COMMITTEE, OR  
3 ANY SUCCESSOR COMMITTEES.

4 **SECTION 2.** In Colorado Revised Statutes, 25.5-4-213, **amend**  
5 (2)(b); and **add** (2)(d), (2)(e), and (2)(f) as follows:

6 (2) The performance audit conducted pursuant to this section shall  
7 include but need not be limited to:

8 (b) A review of the accuracy of client communications; **and**

9 (d) A DETERMINATION AS TO WHETHER CLIENT COMMUNICATIONS  
10 COMPLY WITH THE REQUIREMENTS OF SECTION 25.5-4-212;

11 (e) A REVIEW OF THE SUFFICIENCY OF THE STATE DEPARTMENT'S  
12 CLIENT COMMUNICATIONS TESTING PROCESS PURSUANT TO SECTION  
13 25.5-4-212 AND WHETHER TESTING IS UNDERTAKEN PRIOR TO  
14 IMPLEMENTING NEW OR SIGNIFICANTLY REVISED CLIENT  
15 COMMUNICATIONS; AND

16 (f) A REVIEW OF THE UNDERSTANDABILITY OF CLIENT  
17 COMMUNICATIONS, INCLUDING A SAMPLING OF MEDICAID CLIENTS,  
18 INCLUDING BOTH CLIENTS WHO ARE TRAINED AS ADVOCATES AND CLIENTS  
19 WHO ARE NOT, AND A REVIEW OF THE FEEDBACK FROM THE STATE  
20 DEPARTMENT'S CLIENT COMMUNICATIONS TESTING PROCESS PURSUANT TO  
21 SECTION 25.5-4-212.

22 **SECTION 3. Effective date.** (1) Except as provided in  
23 subsection (2) of this section, this act takes effect upon passage.

24 (2) Section 2 of this act takes effect only if \_\_\_ Bill 17-\_\_\_  
25 becomes law.

26 **SECTION 4. Act subject to petition - effective date.** This act  
27 takes effect at 12:01 a.m. on the day following the expiration of the

1 ninety-day period after final adjournment of the general assembly (August  
2 9, 2017, if adjournment sine die is on May 10, 2017); except that, if a  
3 referendum petition is filed pursuant to section 1 (3) of article V of the  
4 state constitution against this act or an item, section, or part of this act  
5 within such period, then the act, item, section, or part will not take effect  
6 unless approved by the people at the general election to be held in  
7 November 2018 and, in such case, will take effect on the date of the  
8 official declaration of the vote thereon by the governor.

**First Regular Session  
Seventy-first General Assembly  
STATE OF COLORADO**

**BILL D**

LLS NO. 17-0162.01 Brita Darling x2241

**SENATE BILL**

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**SENATE SPONSORSHIP**

**Crowder and Lundberg,**

**HOUSE SPONSORSHIP**

**Danielson and Landgraf,**

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**Senate Committees**

**House Committees**

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**A BILL FOR AN ACT**

101 **CONCERNING IMPROVING MEDICAID CLIENT CORRESPONDENCE.**

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**Bill Summary**

*(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the reengrossed version of this bill will be available at <http://www.leg.state.co.us/billsummaries>.)*

**Interim Study Committee on Communication Between the Department of Health Care Policy and Financing (HCPF) and Medicaid Clients.** The bill requires the department of health care policy and financing (department) to engage in an ongoing process to improve medicaid client communications, including client letters and notices, that concern eligibility for or the denial, reduction, suspension, or termination of a benefit. Among other requirements included in the bill, the department shall ensure that client communications are accurate,

Shading denotes HOUSE amendment. Double underlining denotes SENATE amendment.  
*Capital letters indicate new material to be added to existing statute.  
Dashes through the words indicate deletions from existing statute.*



readable, and understandable, clearly conveying the purpose of the letter or notice and the specific action or actions that the client must take in response to the letter or notice.

The bill requires the department to include in certain notices a specific and plain language explanation of the basis for the denial, reduction, suspension, or termination of a benefit; specific and detailed information concerning household composition, income sources and amounts, and assets; and a description of necessary information or documents that the client has not provided.

To the extent practicable, the department shall test new or significantly revised client communications against the requirements included in the bill with a representative sample of medicaid clients, advocacy organizations, and counties prior to implementing the client communications. As part of the testing, the department shall solicit feedback from a workgroup established by the department to provide customer and community partner feedback regarding client communications.

The department shall also ensure that letters and notices affecting clients with disabilities, seniors, and other vulnerable populations are appropriately prioritized for improvement consistent with the requirements in the bill. The department shall receive feedback from the workgroup established to provide customer and community partner feedback regarding client communications as part of the department's involvement in state-level decision-making relating to computer system changes and training.

The department shall provide information concerning medicaid client communications improvements as part of its annual presentation to its legislative committee of reference.

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

2           **SECTION 1.** In Colorado Revised Statutes, **add** 25.5-4-212 as  
3 follows:

4           **25.5-4-212. Medicaid client communications improvement**  
5 **process - legislative declaration.** (1) (a) THE GENERAL ASSEMBLY FINDS  
6 AND DECLARES THAT:

7           (I) UNDERSTANDABLE, TIMELY, INFORMATIVE, AND CLEAR  
8 COMMUNICATIONS FROM THE STATE DEPARTMENT ARE CRITICAL TO THE  
9 LIFE AND HEALTH OF MEDICAID RECIPIENTS, AND, IN SOME CASES, ARE A

1 MATTER OF LIFE AND DEATH FOR OUR MOST VULNERABLE POPULATIONS;

2 (II) UNCLEAR, CONFUSING, AND LATE CORRESPONDENCE FROM THE  
3 STATE DEPARTMENT CAUSES AN INCREASED WORKLOAD FOR THE STATE,  
4 COUNTIES ADMINISTERING THE MEDICAID PROGRAM, AND NONPROFIT  
5 ADVOCACY GROUPS ASSISTING CLIENTS; AND

6 (III) GOVERNMENT SHOULD BE A GOOD STEWARD OF TAXPAYERS'  
7 MONEY, ENSURING THAT IT IS SPENT IN THE MOST COST-EFFECTIVE  
8 MANNER.

9 (b) THEREFORE, THE GENERAL ASSEMBLY FINDS THAT IMPROVING  
10 MEDICAID CLIENT COMMUNICATIONS, TESTING NEW AND REVISED CLIENT  
11 COMMUNICATIONS WITH CLIENTS, ADVOCATES, AND COUNTIES, AND  
12 PUTTING IN PLACE ACCOUNTABILITY FOR THE STATE DEPARTMENT AND  
13 THE SYSTEM AS A WHOLE TO ENSURE SUCCESSFUL CLIENT  
14 COMMUNICATIONS IS CRITICAL AND NECESSARY NOT ONLY FOR THE  
15 HEALTH AND WELFARE OF MEDICAID CLIENTS BUT ALSO TO HELP CONTAIN  
16 RISING COSTS IN THE MEDICAID PROGRAM.

17 (2) THE STATE DEPARTMENT SHALL ENGAGE IN AN ONGOING  
18 PROCESS TO CREATE, TEST, AND IMPROVE MEDICAID CLIENT  
19 COMMUNICATIONS THAT CONCERN ELIGIBILITY FOR OR THE DENIAL,  
20 REDUCTION, SUSPENSION, OR TERMINATION OF A BENEFIT. AT A MINIMUM,  
21 THE STATE DEPARTMENT SHALL ENSURE THAT CLIENT COMMUNICATIONS,  
22 INCLUDING CLIENT LETTERS AND NOTICES:

- 23 (a) ARE ACCURATE;
- 24 (b) ARE READABLE AT A SIXTH-GRADE READING LEVEL OR BELOW;
- 25 (c) ARE WRITTEN USING PERSON-FIRST, PLAIN LANGUAGE;
- 26 (d) ARE WRITTEN IN A LETTER FORMAT THAT INCLUDES THE DATE  
27 OF THE COMMUNICATION AND A CLIENT GREETING;

1 (e) USE A POSITIVE, FRIENDLY TONE;

2 (f) ARE CONSISTENT, USING THE SAME TERMS THROUGHOUT,  
3 INCLUDING COMMONLY USED PROGRAM NAMES;

4 (g) ARE TRANSLATED ACCURATELY AND IN A CULTURALLY  
5 APPROPRIATE MANNER WHEN TRANSLATION IS REQUIRED;

6 (h) ARE UNDERSTANDABLE, CLEARLY CONVEYING THE PURPOSE OF  
7 THE CLIENT COMMUNICATION, THE ACTION BEING TAKEN BY THE STATE  
8 DEPARTMENT, IF ANY, AND THE SPECIFIC ACTION OR ACTIONS THAT THE  
9 CLIENT MUST OR MAY TAKE IN RESPONSE TO THE COMMUNICATION;

10 (i) INCLUDE CONTACT INFORMATION FOR CLIENT QUESTIONS THAT  
11 IS CLEARLY IDENTIFIED AS RELATING TO SPECIFIC CONTENT IN THE CLIENT  
12 COMMUNICATION, INCLUDING A TELEPHONE NUMBER, E-MAIL ADDRESS,  
13 AND PHYSICAL ADDRESS, AND THE HOURS OF OPERATION; AND

14 (j) IF POSSIBLE, SEPARATE LEGAL, PRIVACY, OR EDUCATIONAL  
15 INFORMATION FROM THE MAIN CONTENT OF THE COMMUNICATION, EITHER  
16 BY INCLUDING IT IN A SEPARATE BUT ENCLOSED DOCUMENT THAT IS  
17 REFERENCED IN THE CLIENT COMMUNICATION OR BY PLACING THE  
18 INFORMATION AFTER THE MAIN CONTENT OF THE COMMUNICATION TO  
19 HELP MINIMIZE CONFUSION.

20 (3) (a) THE STATE DEPARTMENT SHALL INCLUDE WITHIN OR AS  
21 PART OF A CLIENT COMMUNICATION:

22 (I) IN ANY COMMUNICATION, THE PURPOSE OF WHICH IS TO  
23 PROVIDE NOTICE OF THE DENIAL, REDUCTION, SUSPENSION, OR  
24 TERMINATION OF A BENEFIT, A SPECIFIC AND PLAIN LANGUAGE  
25 EXPLANATION OF THE BASIS FOR THE DENIAL, REDUCTION, SUSPENSION, OR  
26 TERMINATION OF THE BENEFIT;

27 (II) SPECIFIC AND DETAILED INFORMATION ON THE CLIENT'S

1 HOUSEHOLD COMPOSITION, INCOME SOURCES, AND INCOME AMOUNTS, IF  
2 RELEVANT TO THE DETERMINATION FOR WHICH THE CLIENT  
3 COMMUNICATION WAS ISSUED, AND INCLUDING INFORMATION RELATING  
4 TO HOUSEHOLD ASSETS, IF RELEVANT TO A MEDICAID WAIVER PROGRAM;  
5 AND

6 (III) A SPECIFIC DESCRIPTION OF ANY INFORMATION OR NECESSARY  
7 DOCUMENTS THAT THE CLIENT HAS NOT PROVIDED;

8 (b) THE REQUIREMENTS SET FORTH IN SUBSECTION (3)(a) OF THIS  
9 SECTION APPLY TO THE NOTICE OF ACTION, PRIOR AUTHORIZATION  
10 REQUEST NOTICE, THE REDETERMINATION OR RENEWAL LETTER, THE  
11 INCOME AND ELIGIBILITY VERIFICATION SYSTEM LETTER, THE  
12 VERIFICATION CHECKLIST, AND THE INCOME TRUST LETTER.

13 (4) THE STATE DEPARTMENT IS ENCOURAGED TO PROMOTE THE  
14 RECEIPT OF CLIENT COMMUNICATIONS ELECTRONICALLY OR THROUGH  
15 MOBILE APPLICATIONS FOR CLIENTS WHO CHOOSE THOSE METHODS OF  
16 DELIVERY.

17 (5) THE STATE DEPARTMENT, IN ITS DISCRETION AND UPON RECEIPT  
18 OF ANY NECESSARY FUNDING, MAY IMPLEMENT THE CENTER FOR HEALTH  
19 LITERACY FINDINGS RESULTING FROM A MULTI-AGENCY EFFORT IN 2016 TO  
20 IMPROVE MEMBER ELIGIBILITY CORRESPONDENCE.

21 (6) AS PART OF ITS ONGOING PROCESS TO CREATE AND IMPROVE  
22 CLIENT COMMUNICATIONS, TO THE EXTENT PRACTICABLE, THE STATE  
23 DEPARTMENT SHALL TEST CLIENT COMMUNICATIONS AGAINST THE  
24 CRITERIA SET FORTH IN SUBSECTION (2) OF THIS SECTION WITH A  
25 REPRESENTATIVE SAMPLE OF MEDICAID CLIENTS, INCLUDING CLIENTS WITH  
26 A DISABILITY, SENIORS, AND OTHER VULNERABLE POPULATIONS, AND WITH  
27 CLIENT ADVOCATES AND COUNTY CUSTOMER SERVICE PERSONNEL AND

1 ADMINISTRATORS PRIOR TO IMPLEMENTING THE CLIENT COMMUNICATIONS.  
2 AS PART OF ITS TESTING PROCESS, THE STATE DEPARTMENT SHALL SOLICIT  
3 FEEDBACK FROM A WORKGROUP ESTABLISHED BY THE STATE DEPARTMENT  
4 TO PROVIDE CUSTOMER AND COMMUNITY PARTNER FEEDBACK REGARDING  
5 MEDICAID CLIENT COMMUNICATIONS.

6 (7) UNDERSTANDING THAT CLIENT COMMUNICATIONS THAT ONLY  
7 AFFECT A SMALL NUMBER OF CLIENTS, INCLUDING CLIENTS WITH  
8 DISABILITIES, SENIORS, AND OTHER VULNERABLE POPULATIONS, MAY,  
9 NONETHELESS, HAVE A SIGNIFICANT IMPACT ON THE LIVES OF THOSE  
10 CLIENTS DUE TO THE URGENT NEED FOR SERVICES, THE STATE  
11 DEPARTMENT SHALL ENSURE THAT CLIENT COMMUNICATIONS IMPACTING  
12 THOSE CLIENTS ARE APPROPRIATELY PRIORITIZED FOR REVISION AND  
13 TESTING AND THAT RELATED COMPUTER SYSTEM CHANGES AND TRAINING  
14 ARE IMPLEMENTED AS SOON AS PRACTICABLE. IN ORDER TO  
15 APPROPRIATELY PRIORITIZE THE IMPROVEMENT OF CLIENT  
16 COMMUNICATIONS FOR CLIENTS WITH DISABILITIES, SENIORS, AND OTHER  
17 VULNERABLE POPULATIONS, AND THE IMPLEMENTATION OF RELATED  
18 COMPUTER SYSTEM CHANGES AND TRAINING, THE STATE DEPARTMENT  
19 SHALL PROVIDE FEEDBACK FROM THE WORKGROUP DESCRIBED IN  
20 SUBSECTION (6) OF THIS SECTION AS PART OF THE STATE DEPARTMENT'S  
21 INVOLVEMENT IN STATE-LEVEL DECISION-MAKING RELATING TO  
22 COMPUTER SYSTEM CHANGES AND TRAINING.

23 (8) (a) AS PART OF ITS ANNUAL PRESENTATION MADE TO ITS  
24 LEGISLATIVE COMMITTEE OF REFERENCE PURSUANT TO SECTION 2-7-203,  
25 THE STATE DEPARTMENT SHALL PRESENT INFORMATION CONCERNING:

26 (I) ITS PROCESS FOR ONGOING IMPROVEMENT TO CLIENT  
27 COMMUNICATIONS;

1 (II) CLIENT COMMUNICATIONS REVISED PURSUANT TO THE  
2 CRITERIA SET FORTH IN SUBSECTION (2) OF THIS SECTION DURING THE  
3 PRIOR YEAR AND CLIENT COMMUNICATIONS IMPROVEMENTS THAT ARE  
4 PLANNED FOR THE UPCOMING YEAR;

5 (III) A DESCRIPTION OF THE RESULTS OF TESTING OF NEW OR  
6 SIGNIFICANTLY REVISED CLIENT COMMUNICATIONS PURSUANT TO  
7 SUBSECTION (6) OF THIS SECTION, INCLUDING A DESCRIPTION OF THE  
8 FEEDBACK FROM THE STATE DEPARTMENT'S WORKGROUP FOR CUSTOMER  
9 AND COMMUNITY PARTNER FEEDBACK; AND

10 (IV) A DESCRIPTION OF AVAILABLE COUNTY DATA RELATING TO  
11 THE FREQUENCY AND TYPE OF CLIENT CUSTOMER SERVICE INTERACTIONS  
12 THAT ARE GENERATED BECAUSE OF CLIENT CONFUSION RELATED TO THE  
13 ORGANIZATION, FORMATTING, OR LANGUAGE USED IN EXISTING CLIENT  
14 COMMUNICATIONS.

15 (b) NOTWITHSTANDING THE PROVISIONS OF SECTION 24-1-136(11)  
16 TO THE CONTRARY, THE REQUIREMENT TO REPORT TO THE LEGISLATIVE  
17 COMMITTEE OF REFERENCE PURSUANT TO THIS SUBSECTION (8) CONTINUES  
18 INDEFINITELY.

19 **SECTION 2.** In Colorado Revised Statutes, 25.5-4-212, **amend**  
20 (8)(a)(III) and (8)(a)(IV); and **add** (8)(a)(V) as follows:

21 **25.5-4-212. Medicaid client communications improvement**  
22 **process - legislative declaration.** (8) (a) As part of its annual  
23 presentation made to its legislative committee of reference pursuant to  
24 section 2-7-103, the state department shall present information  
25 concerning:

26 (III) A description of the results of testing of new or significantly  
27 revised client communications pursuant to subsection (6) of this section,

1 including a description of the feedback from the state department's  
2 workgroup for customer and community partner feedback; and

3 (IV) A description of available county data relating to the  
4 frequency and type of client customer service interactions that are  
5 generated because of client confusion related to the organization,  
6 formatting, or language used in existing client communications; AND

7 (V) A SUMMARY OF THE FINDINGS AND RECOMMENDATIONS OF  
8 ANY AUDIT OF CLIENT COMMUNICATIONS PURSUANT TO SECTION  
9 25.5-4-213 COMPLETED DURING THE PRIOR YEAR.

10 **SECTION 3. Effective date.** (1) Except as provided in  
11 subsection (2) of this section, this act takes effect upon passage.

12 (2) Section 2 of this act takes effect only if \_\_\_ Bill 17-\_\_\_  
13 becomes law.

14 **SECTION 4. Safety clause.** The general assembly hereby finds,  
15 determines, and declares that this act is necessary for the immediate  
16 preservation of the public peace, health, and safety.

Rep. Dianne Primavera, Chair  
Rep. Jessie Danielson  
Rep. Lois Landgraf

Sen. Kevin Lundberg, Vice-Chair  
Sen. Larry Crowder  
Sen. Linda Newell



**Interim Study Committee on  
Communication Between the  
Department of Health Care Policy and  
Financing and Medicaid Clients**

State Capitol Building, Room 029  
Denver, Colorado 80203-1784  
(303) 866-3521



October 14, 2016

Anne Marie Costello  
Director, Children and Adults Health Programs Group  
Center for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services  
7500 Security Blvd.  
Mail Stop S2-01-16  
Woodlawn, Maryland 21244

Dear Director Costello:

During the 2016 legislative interim, a joint study committee of the Colorado General Assembly was appointed to examine issues relating to client communications for Medicaid and other public assistance programs. Eligibility-related communications are often confusing and difficult for clients to understand, especially when they are applying for multiple assistance programs such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP).

The Colorado Department of Health Care Policy and Financing is currently taking steps to improve the readability of client correspondence and their technical accuracy, and our committee is proposing legislation to improve agency operations and oversight of client correspondence processes. However, state-level action cannot address a key source of confusion for clients, which is the unaligned eligibility criteria for Medicaid and SNAP. While these programs serve many of the same clients, the different definitions of "household" for the two programs and other differences in eligibility criteria add complexity and confusion to the eligibility determination process and the correspondence sent to clients.

Given that federal law governs the eligibility criteria for these programs and legal requirements for eligibility notifications, any efforts to align the eligibility and notice requirements for Medicaid and SNAP require federal action. Therefore, our committee requests that the Centers for Medicare & Medicaid Services (CMS) and the Food and Nutrition Service (FNS) in the U.S. Department of Agriculture examine ways, including any required federal legislation, to:

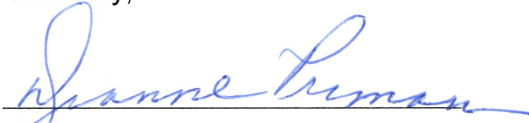


- align eligibility criteria for Medicaid and SNAP, including the manner that income is counted and household membership defined;
- allow states to pursue strategies to align program eligibility requirements at the state level; and
- allow states to simplify the notifications provided to clients applying for multiple assistance programs.


Persons applying for public assistance are often in a vulnerable position and helping them understand their eligibility for public assistance is a vital and important function. Thank you for your time and consideration of our committee's concerns. If you would like more information about our committee, our findings, or this request, please contact our committee staff person, Bill Zepernick at Legislative Council Staff ([bill.zepernick@state.co.us](mailto:bill.zepernick@state.co.us), 303-866-4777). We would also encourage you to discuss these issues with Zach Lynkiewicz, the legislative liaison at the Colorado Department of Health Care Policy and Financing ([zach.lynkiewicz@state.co.us](mailto:zach.lynkiewicz@state.co.us), 720-854-9882).

A copy of this letter is being sent to the FNS and to the members of the Colorado congressional delegation.

Sincerely,



Representative Dianne Primavera  
Chair

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Senator Kevin Lundberg  
Vice-Chair

c: Senator Michael Bennet  
Senator Cory Gardner  
Representative Diana DeGette  
Representative Jared Polis  
Representative Scott Tipton  
Representative Ken Buck  
Representative Doug Lamborn  
Representative Mike Coffman  
Representative Ed Perlmutter  
Rich Lucas, Deputy Administrator, Office of Policy Support, Food and Nutrition Service