Report Highlights

Medicaid Correspondence

Department of Health Care Policy & Financing

Performance Audit • September 2023 • 2261P

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**