Beyond the Notice of Action:
Eligibility Member Communications

Colorado Department of Health Care Policy and Financing

Building Better Health

October 13-14, 2016

COLORADO
Department of Health Care Policy & Financing

Our Mission

Improving health care access and outcomes for the **people** we serve while demonstrating sound stewardship of financial **resources**

Objectives

- Overview of key eligibility member correspondence
- Q & A regarding frequent member questions
- Recommendations for improvement
- Changes moving forward

Joint System Partners

COLORADO
Department of Health Care Policy & Financing

CONNECT for HEALTH COLORADO

COLORADO
Department of Human Services

COLORADO
Governor's Office of Information Technology

Correspondence Challenges

- Incongruent program requirements
- Unclear or contradictory information
- Ambiguous requests for information or proof
- Improving accessibility
- Too many difficult words in confusing sentences & big blocks of text (hard to read)
- Too many letters
- Correspondence leads to more questions than answers

“There are rules and citations that I never read. It is way too much.”

– Member Testing Participant

Until We Reach the Finish Line

- Understand your concerns
- Taking steps to make changes (early 2017)
- Here to provide you with tools to assist members with current correspondence

Eligibility Correspondence

Notice of Action
(Approval, Denial, Termination)

Redetermination
(Renewal Letter)

Income Eligibility and Verification System
(Income Letter)

Verification Checklist
(Need More Information)

Notice of Action (NOA)

STATE OF COLORADO

CONNECT for HEALTH COLORADO

Case Number: 1BXXXXX
Rubber Duckie

100 COUNTY ROAD
PLACE CO 80000-0000

Client ID: 0000000000

ConnectforHealthCO
ConnectforHealthCO
PO BOX 35681
COLORADO SPRINGS CO 80935-3681
(855) 752-6749

Connect for Health Colorado
Customer Service Center
P.O. Box 35681
Colorado Springs, CO 80935
855-752-6749

Medical Assistance Contact: ConnectforHealthCO

Date and time of eligibility determination: 07/18/2016 06:58 PM

Authorization Number: 123456789

Please review the entire notice to see what your household qualifies for.

✓	**Approval: Your application has been approved for the following individual(s).**		
Benefit Category	**Individual Name and Medical Assistance ID**	**Application Date**	**Coverage Start Date**
CHP+ Assistance	Little Girl - O111111 Little Boy - O222222	07/15/2016	07/15/2016

Additional Information:

Your CHP+ medical and dental cards will be in a separate letter. If you need to see a doctor before you get your card in the mail, call (800) 414-6198 or visit www.chpplusproviders.com.You will still need to pick an HMO. If you know which HMO you want, call (800)359-1991 and select option #5. THE DENTAL BENEFIT IS NOT EFFECTIVE UNTIL YOU RECEIVE THE CARD. If you do not receive a dental packet within 6 weeks contact Delta Dental of Colorado at 303-741-9305 or 800-610-0201.

Supporting Rule:

10 CCR 2505-3, Section 140.1 & 410.2. B.

Additional Language Assistance	
English	If you need help understanding this document, please call 1-800-221-3943 / 1-855-752-6749. We can provide an interpreter for free.
Español	Si necesita ayuda para entender major este document comuníquese al 1-800-221-3943 / 1-855-752-6749. Le podemos asistir gratuitamente con un intérprete.
普通话	如果您在理解本文方面需要帮助，请致电 1-800-221-3943/1-855-752-6749。我们将免费提供口译服务。
Tiếng Việt	Nếubancầntrợgiúptìmhiểutàiliệunày, vuilònggọi 1-800-221-3943/1-855-752-6749. Chúngtôicóthểcungcấpphiêndịchviênmiễnphí.
한국어	이문서를이해하는데있어도움이필요할경우 1-800-221-3943/1-855-752-6749번으로전화하십시오. 무료 통역서비스를제공해드립니다.
Русский	Если вам нужна помощь, чтобы понять этот документ, пожалуйста, позвоните по номеру 1 800 221 3943/1 855 752 6749. Мы можем предоставить бесплатные услуги переводчика.
العربية	1-800-221-3943/1-855-752-6749. على الاتصال فالرجاء المستند هذا لفهم في مساعدة إلى حاجة كنت إذا مترجم توفير يمكننا.
Ntawv Hmoob	Yogkojxav tau kevpabqhiakomnkagsiabcovntaubntawvno, thovhurau 1-800-221-3943/1-855- 752-6749. Pebtuajyeempabib tug kwstxhaislus pub dawbraukoj.
አማርኛ	ይህን ሰነድ ለመረዳት እገዛ ከፈለጉ እባክዎ በስልክ 1-800-221-3943/1-855-752-6749 ይደውሉ። አስተርጓሚ በነፃ ልናቀርብልዎት እንችላለን።
नेपाली	यदि तपाईलाई यो कागजात बुझ्न सहयोगको चाहिन्छ भने, कृपया 1-800-221-3943/1-855-752-6749 मा टेलिफोन सम्पर्क गर्नुहोस् । हामी तपाईलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं ।
Soomaali	Haddii aad u baahantahay kaalmo si aad u fahanto xogtan, fadlan la soo hadal 1-800-221- 3943/1-855-752-6749. Waxa aannu kuu heli karaynaa afceliyeen (turjubaan) bilaa
Français	Veuillez téléphoner au 1-800-221-3943/1-855-752-6749 si vous avez besoin d'aide concernant l'explication de ce document. Nous pouvons vous proposer un interprète gratuitement.
Deutsch	Wenn Sie zum besseren Verständis dieses Dokuments Hilfe benötigen, rufen Sie uns unter 1-800-221-3943/1-855-752-6749 an. Wir können Ihnen kostenlos einen Dolmetscher zur Verfügung stellen.

You have the right to a fair hearing if you disagree with the decision

Your right to appeal	Medicaid Determination – If you think any part of this decision is wrong, you may ask for (1) a State Hearing (2) a County or Medical Assistance (MA) site conference; or (3) both. Tell your worker if you need help with your appeal. If you are appealing a Qualified Health Plan, a Colorado Young Adult Plan, Tax Credits and/or Cost Sharing Reductions eligibility determination, please see the Connect for Health Colorado Appeals Rights section below. If you think the conference decision is wrong, you may ask for a state level hearing within ten (10) days from the date of the conference decision. You may also skip this meeting altogether and ask for a state level hearing. Also, you may contact your local legal services office about getting free legal help. If your benefits end, you may reapply at any time.
Legal help	If you want to apply for free legal help, call Colorado Legal Services' Denver office at 303-837-1313 or contact your local Colorado Legal Services office.
County or Medical Assistance Conference	You may request an informal meeting (conference) with county staff, other than the worker taking the action, to go over your case with you. If you want a county conference you need to: (1) send or take a letter to your county worker as shown on page 1 of this notice; (2) include the following information in the letter: your name, your mailing address, your daytime telephone number and either a copy of this notice or the "Case Number" number at the bottom of each page of this letter; (3) for medical or cash assistance, your request must be received before the effective date on page 1 of this notice; for food assistance, you have until 10/18/2016. Be sure to keep a copy of your request for your records. At a county conference you have the right to represent yourself, or you may choose a lawyer, a relative, a friend or any other person to act as your authorized representative. Please contact your Eligibility Worker at the number listed on the first page of this notice with any questions or concerns about this notice. If there is an error in the information in this notice, please contact your worker right away.
State Hearing	You may ask for a formal hearing with an Administrative Law Judge. Your request must be received on or before08/19/2016, even if you have asked for a county conference. For Food Assistance: Your request must be received on or before 08/19/2016 to ask for a state level hearing or within ten (10) days the date of the county conference decision. To ask for this State Hearing you need to either (1) sign this notice and send or fax it to the Office of Administrative Courts or (2) send or fax a

Verification Checklist (VCL)

Providing Verifications

If CBMS cannot verify information the applicant included on his/her application with the electronic data sources (Interfaces), then the client will receive a notice in the mail

The notice that the client will receive is called a Verification Checklist or a VCL.

The VCL will inform the client of what they need to provide and by when.

The client may be allowed an ROP (Reasonable Opportunity Period) to provide the requested verifications.

STATE OF COLORADO

April Apricot
APT 1
123 MAIN STREET
DENVER CO 80000-0000

Eligibility Technician
CNTY
1200 FEDERAL BLVD
DENVER CO 80204-3221

Fax: (720) 111-1111

Case #

02/23/2016

Subject: Verification Checklist

Dear April Apricot

This letter is to tell you that we need proof of some information. The following page(s) lists the following information:

- **Name** - the person that the proof is needed for
  If there is no name listed, the information needed is household information. For example, if your date of birth needs to be verified, your name would be listed. If your housing cost needs to be verified, no individual's name would be listed.
- **Need Proof of** - lists the information that we need proof of
- **Program Group** - the name of the program that needs the proof
- **Due Date** - the date the proof must be returned
- **Notes** - more about what is needed

The proof must be returned to the address shown above by the Due Date. If it is not received by the Due Date, a decision will be made based on the information that we have.

You may continue to receive this notice for Medical Assistance until the proof is returned. This is a reminder to your household that you still need to return proof of this information. The Due Date listed is the original date that the proof needed to be returned. Returning the proof of the expense may change your patient payment to the nursing facility.

Each Program Group listed may need the same proof. The Due Dates could be different for each Program Group. To make sure that the proof is returned in time for each Program Group, please return the proof by the earliest Due Date. Your household must provide the proof for each program listed on the following pages.

- If your household has applied for assistance for the program(s) listed; all of the

NAME	NEED PROOF OF	PROGRAM GROUP	DUE DATE
Mark Melon	Identification	Medical Assistance	05/13/2016

Notes : We need proof of your identification. Documents include, but are not limited to, U.S. Driver's License, Identification card, or a U.S. military card.

Mark Melon	U.S. Citizenship	Medical Assistance	05/13/2016

Notes :

April Apricot	Identification	Medical Assistance	05/13/2016

Notes : We need proof of your identification. Documents include, but are not limited to, U.S. Driver's License, Identification card, or a U.S. military card.

April Apricot	U.S. Citizenship	Medical Assistance	05/13/2016

Notes :

Income and Eligibility Verification System (IEVS) Letter

What is IEVS?

IEVS is the source HCPF uses to verify income

Compares applicant/member self-reported income data with employer-reported income in IEVS

IEVES Discrepancies or "Hits"

What is an IEVS "hit"?

What is reasonable compatibility?

IEVS Wage Request Timeline for 2016/2017 Year

Month	Request Quarter/Year	CBMS Match Period Months
September 2016	02/2016	4/1/2016 – 6/30/2016
October 2016	02/2016	4/1/2016 – 6/30/2016
November 2016	03/2016	7/1/2016 – 9/30/2016
December 2016	03/2016	7/1/2016 – 9/30/2016
January 2017	03/2016	7/1/2016 – 9/30/2016
February 2017	04/2016	10/1/2016 – 12/31/2016
March 2017	04/2016	10/1/2016 – 12/31/2016
April 2017	04/2016	10/1/2016 – 12/31/2016
May 2017	01/2017	1/1/2017 – 3/31/2017
June 2017	01/2017	1/1/2017 – 3/31/2017
July 2017	01/2017	1/1/2017 – 3/31/2017
August 2017	02/2017	4/1/2017 – 6/30/2017
September 2017	02/2017	4/1/2017 – 6/30/2017
October 2017	02/2017	4/1/2017 – 6/30/2017
November 2017	03/2017	7/1/2017 – 9/30/2017
December 2017	03/2017	7/1/2017 – 9/30/2017

Example

8/2015 — **Four (4) Months** = **4/2015 (2nd Quarter)**

Quarters:

Quarter 1 = January February, March
Quarter 2 = April, May, June
Quarter 3 = July, August, September
Quarter 4 = October, November, December

STATE OF COLORADO

Case Number: 1BXXXXX
Beyonce Butterfly
1234 MAIN ST
DENVER CO 80000-0000

10/01/2016

We are required to check work income through the Colorado Department of Labor and Employment (CDOLE) for all individuals who receive Medical Assistance.

You are receiving this letter because the income reported by CDOLE for an individual in your household is different from the income you had previously reported.

The income reported by CDOLE was $5612.50 for the time period of 04/01/2016 to 06/30/2016. This amount is over the income limit for medical assistance and will disqualify some or all members of your household for the program.

CDOLE reported this income information for Beyonce Butterfly from COLORADO COMPANY INC. If Beyonce Butterfly does not work for this employer, please contact me and also contact the employer.

If this income amount is correct, you do not need to respond. The information received from CDOLE will be considered correct and some or all members of your household may no longer get medical assistance. If this is the case, you will receive a letter after 12/31/2016 stating you are no longer eligible.

If the income reported from CDOLE is not correct, you must respond by 12/31/2016.

You may respond by explaining the reason (below) why the income is not correct:

- ☐ Stopped working
- ☐ Hours changed
- ☐ Wage or salary changed
- ☐ Change in employment

Redetermination, Recertification, and Reassessment (RRR)

MAGI Health First Colorado RRR

- Once every 12 months
- Most MAGI Health First Colorado (Colorado's Medicaid Program) and CHP+ cases will Auto Re-Enroll annually
  - Also known as passive renewal
- The member will receive an RRR packets 60 days prior to their RRR due date
- If the member has no changes to report they do not need to take any action

STATE OF COLORADO

Bono Beanie
1BXXXXX

1111 STREET ST
PLACE CO 80000-0000

09/03/2016

Redetermination Notice for Medical Assistance

Dear Bono Beanie,

It is time to see if you are, or your family, is still eligible for your medical benefits. Please review the current information we have in **Section I below**. If there are changes to current information or missing information, please complete **Section II** and return the information to us or you can enter your changes on PEAK Redetermination at www.Colorado.gov/PEAK by 10/05/2016.

You may receive two separate Medical Assistance Redetermination Notices due to your household circumstances. If you have changes to each notice, please report changes for both notices.

Please review **Section II** for new information needed as of October 1, 2013. You may call to provide this information or return this form. We will check to see if you are still eligible for benefits with the information we have. You may need to give us documents to see if you are, or your family, is still eligible. If we need documents from you, we will let you know.

If you are a member of Child Health Plan Plus (CHP+) you have 90 days from the date of this letter to change the CHP+ Health Plan you are enrolled with. If you would like to change, please call HealthColorado (303) 839-2120 / Outside of Denver: 1-888-367-6557), and they will assist you.

You must report your changes. If you have changes and don't report them, you may have to pay back medical payments paid by Health First Colorado (Colorado's Medicaid Program) or CHP+.

Want fast and convenient access to your Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+) benefit information on the go? Download the PEAKHealth app on your smartphone for free at the iTunes and Android stores to manage your Health First Colorado (Colorado's Medicaid Program) and CHP+ benefits.

Section I: Your information on file

Client's Name: Bono Beanie		
Client's Date of Birth: 01-01-1980	**Requesting Medical Assistance Y/N:** Y	**Employed Y/N:** Y

Section I: Your Information on File

Section I: Your information on file

Client's Name: MOON DOGGY			
Client's Date of Birth: 01-01-1980	**Requesting Medical Assistance Y/N:** Y		**Employed Y/N:** Y
Employer Name	**Inc Type**	**Amount**	**Frequency**
[redacted] 1	WAGE - CDLE	3510.67	Quarterly
[redacted] 1	Wages, Salaries	662.89	Twice a month

Self-Employed Y/N: N	**Amount**	**Frequency**

Unearned Income Y/N: N	**Type**	**Amount**	**Frequency**

Roomers/Boarders Y/N: N	**Amount**	**Frequency**

Tax Payer Y/N: N
Livings with both parents, but parents do not expect to file a joint return Y/N: N
Expects to be claimed by a non-custodial parent Y/N: N
Expects to be claimed as a tax dependent on someone else's tax return Y/N: N

Client's Name: MOON PUPPY			
Client's Date of Birth: 01-01-2015	**Requesting Medical Assistance Y/N:** Y		**Employed Y/N:** N
Employer Name	**Inc Type**	**Amount**	**Frequency**

Section II: Report Your Changes

Section II: Report Your Changes-

Starting October 1, 2013, changes in Federal law require Colorado to ask additional questions about you and your family. We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it.

Instructions: Please complete for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. If you don't file a tax return, remember to still add family members who live with you. (Use More Paper if Necessary)

Do You Plan to File a Federal Income Tax Return NEXT YEAR?	☐ Yes If yes, answer questions 1-3 ☐ No If no, answer question 3	*You can still apply for Medicaid, CHP+, or health insurance even if you do not file a federal income tax return.*
1. Will you file jointly with a spouse?	☐ Yes If yes, please list full legal name of spouse ☐ No	

RRR: Report Your Changes

☐ **Person added to my home:**

Name: _____ Date of birth: _____

Does this person plan to file a federal income tax return NEXT YEAR? ☐ Yes ☐ No
Does this person have any dependents? ☐ Yes ☐ No
If yes, list name(s) of dependents: _____

Is this person claimed as a dependent on someone else's tax return? ☐ Yes ☐ No
If yes, please list the name of the tax filer: _____
How is this person related to the tax filer? _____

*If this person is requesting Medical Assistance, please include the information below.
Social Security Number or Date Applied: _____
Date entered my home: _____
Relationship of this person to you: _____
For more information, call me or visit www.Colorado.gov/HCPF

☐ **Changes to Work (For Example: new job, change in hours, lost job, new self-employment):**

Name of person working: _____
Name of Employer: _____
Gross amount received: $ _____
Date received: _____
Type of income: _____

*If anyone is currently self employed, please send a copy of a profit and loss statement or business ledger from this or last month

☐ **Changes to Non-Work Income (For Example: child support, social security, unemployment, gifts or cash) :**

Name of person receiving: _____
Gross monthly amount received: $ _____
Date received: _____
Type of income: _____

☐ **Other Changes: (For Example: Social Security Number for a newborn children, name change, marriage, divorce, change in immigration status, school attendance, etc.)**

Please explain:
_____
_____
_____

Last, But Not Least

Signature Date

If you have any questions, please call me right away.

Thank you,

Community Support TM

[redacted]

[redacted]

Group Brainstorming

- ✓ Break into small groups
- ✓ Write your questions on index cards
- ✓ Seven minutes per letter
- ✓ No case or client specific questions

GROUND RULES

Current Efforts

Member testing is priority

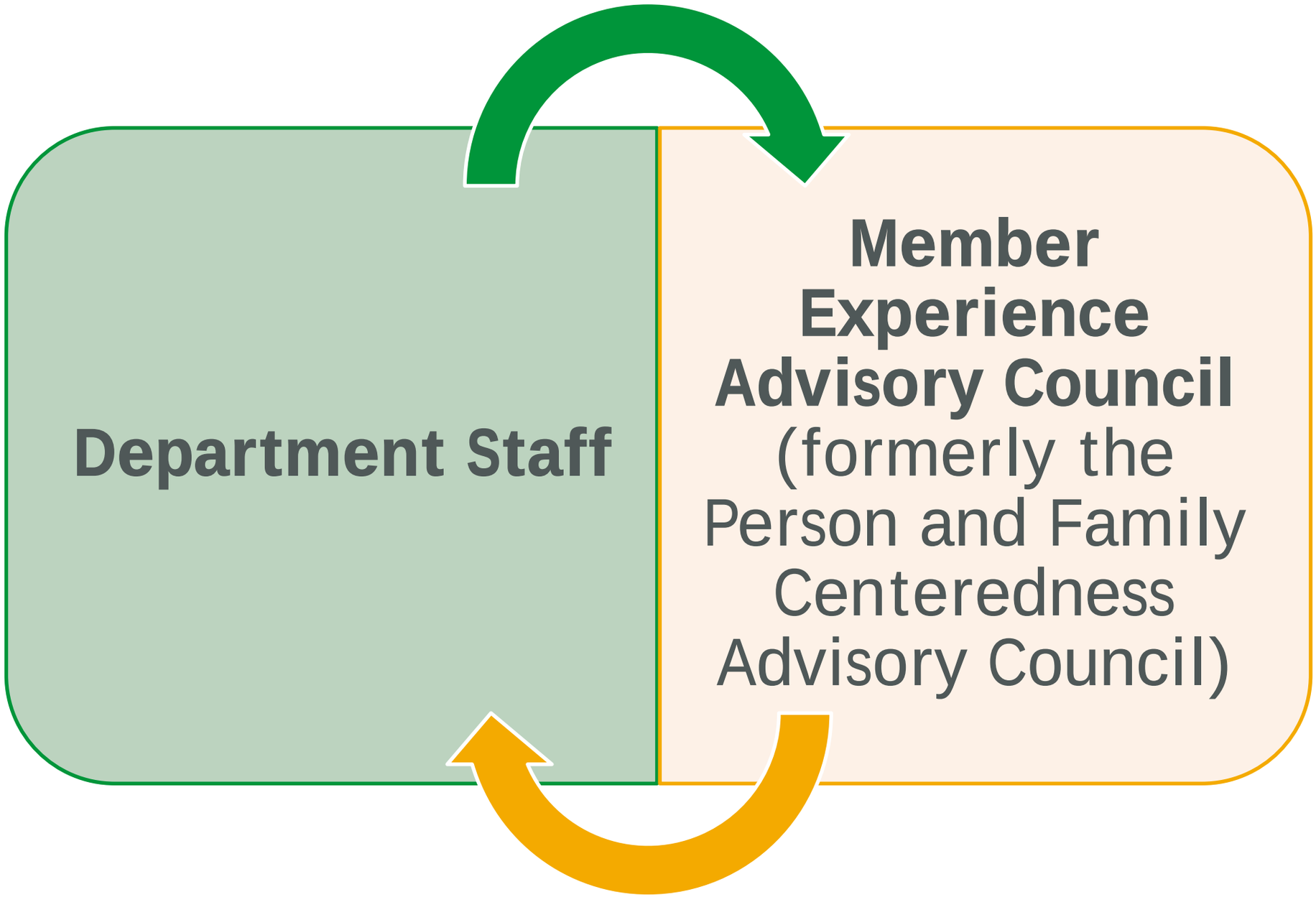
Evidence-based approach

New concepts & partners

More than language & layout

Plain language experts

Ongoing Member Feedback

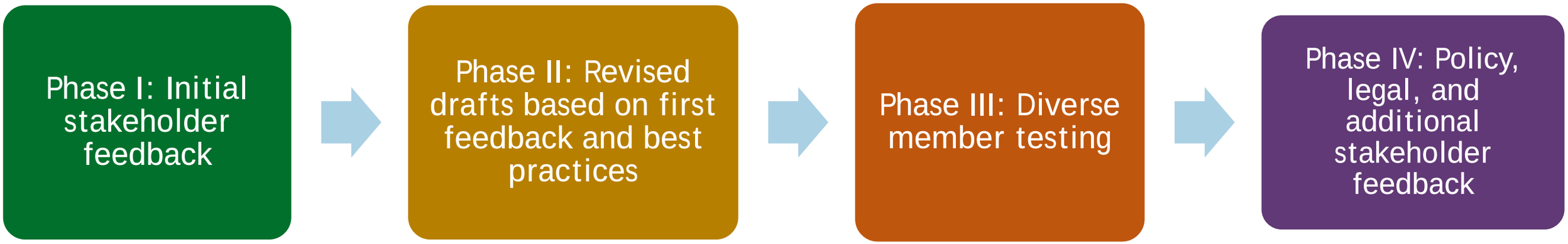


Goals

We seek to:

- Improve use of plain language to reduce confusion
- Be forward-looking when making improvements
  - Consider more than just paper
- Improve information accessibility
- Improve efficiency & effectiveness
  - Allow county workers, assistance sites, & customer/member service representatives more time to assist higher-need members

Research Phases



More information: Colorado.gov/HCPF/PlainLanguage

Phase I: Stakeholder Feedback

Key Informant Interviews

(8 county/assistance site staff; 1 lawmaker; 1 legal advocate)

Stakeholder Meeting

(40 partners)

Survey

(990 responses)

Themes: Literacy Level & Readability, Navigation & Layout, Tone & Usability

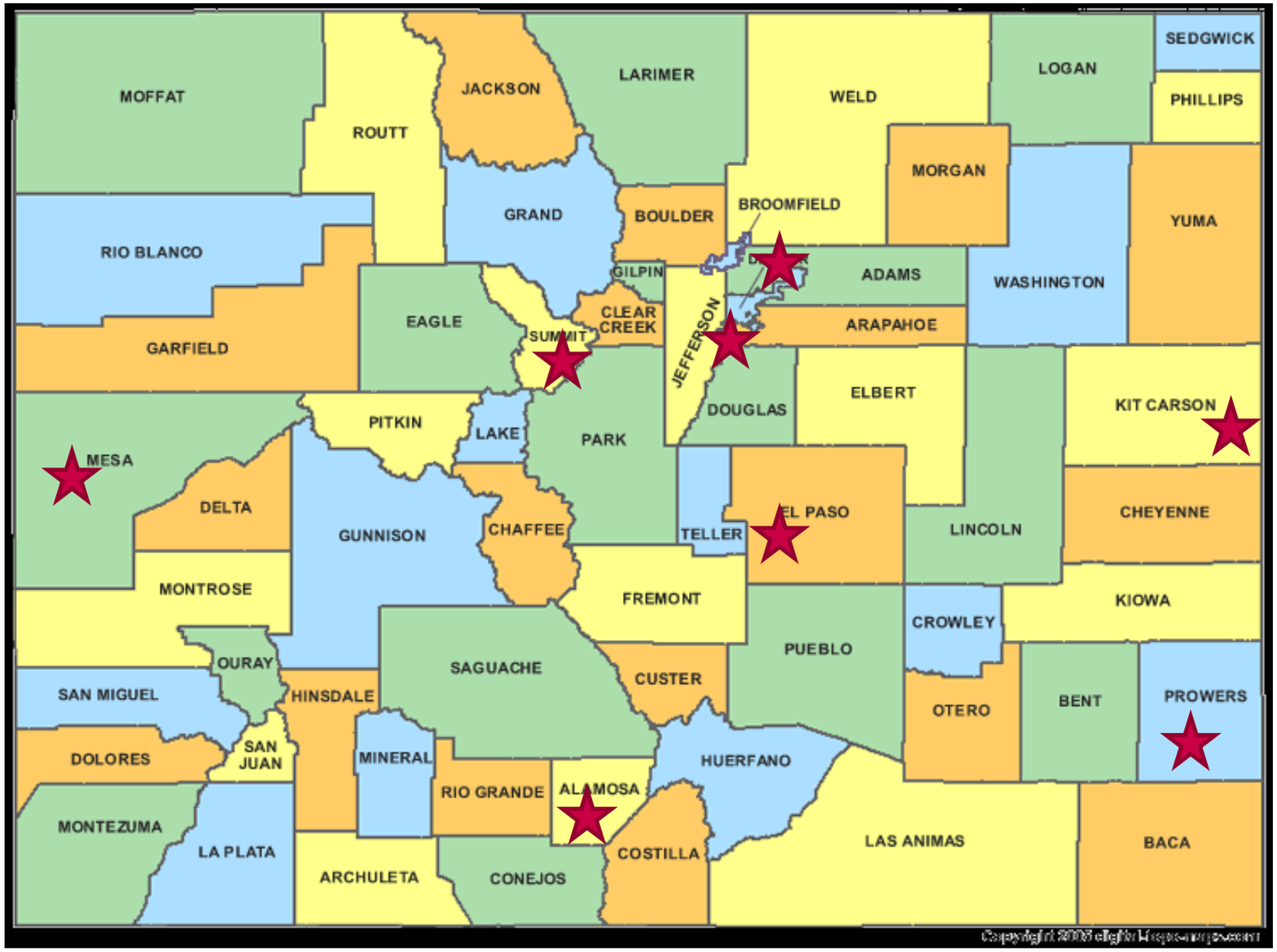
Phase II: Revising Correspondence

Each revised letter was developed with the following in mind:

- ✓ Existing language
- ✓ Industry best practices for readability and usability
- ✓ Experience gathered from other states
- ✓ A comprehensive legal review would be needed

Phase III: Member Testing

- 62 members
- 8 locations
- Mix of members receiving medical, food, or cash assistance
- Varying ages, Spanish speakers and individuals with disabilities



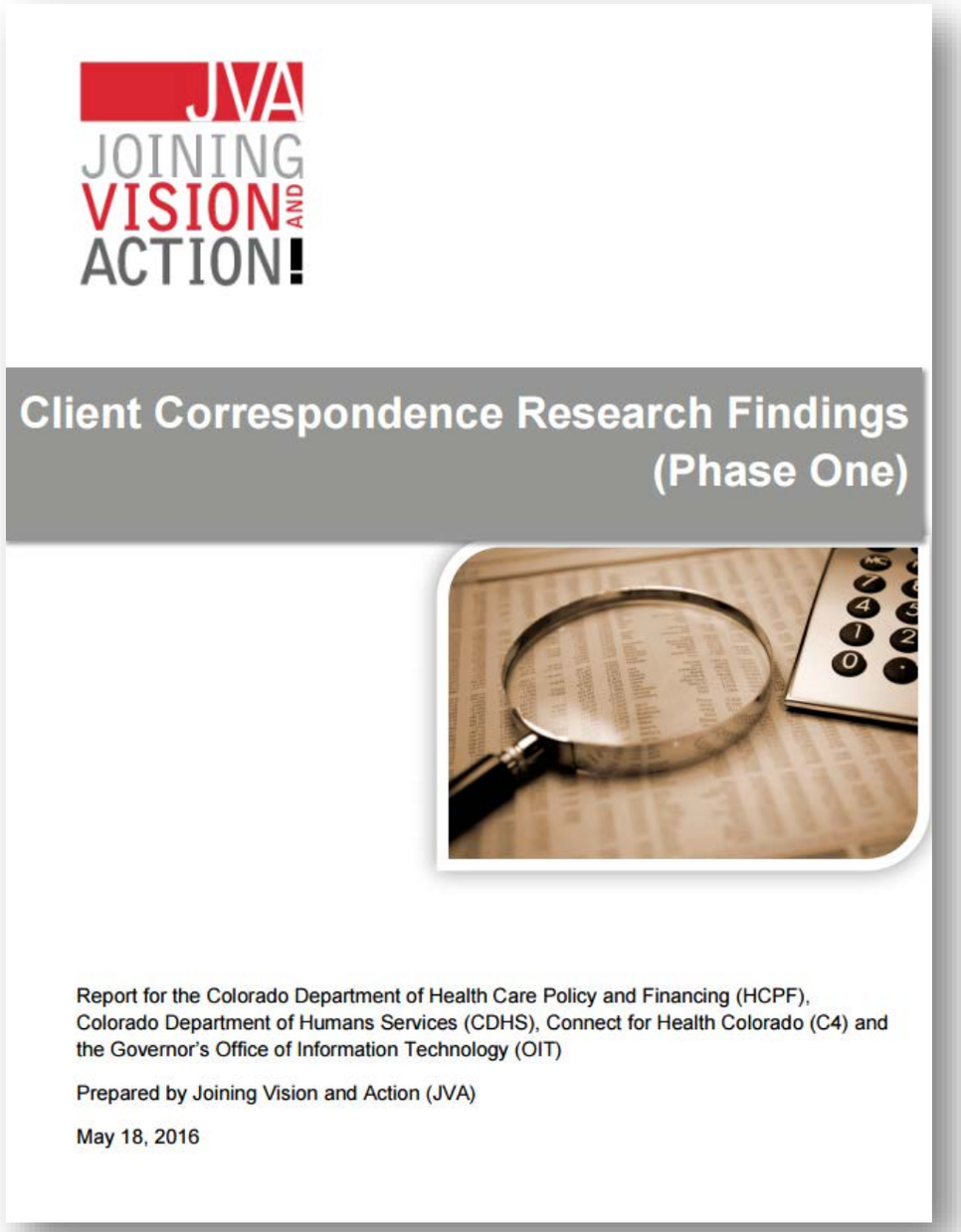
Key Learnings

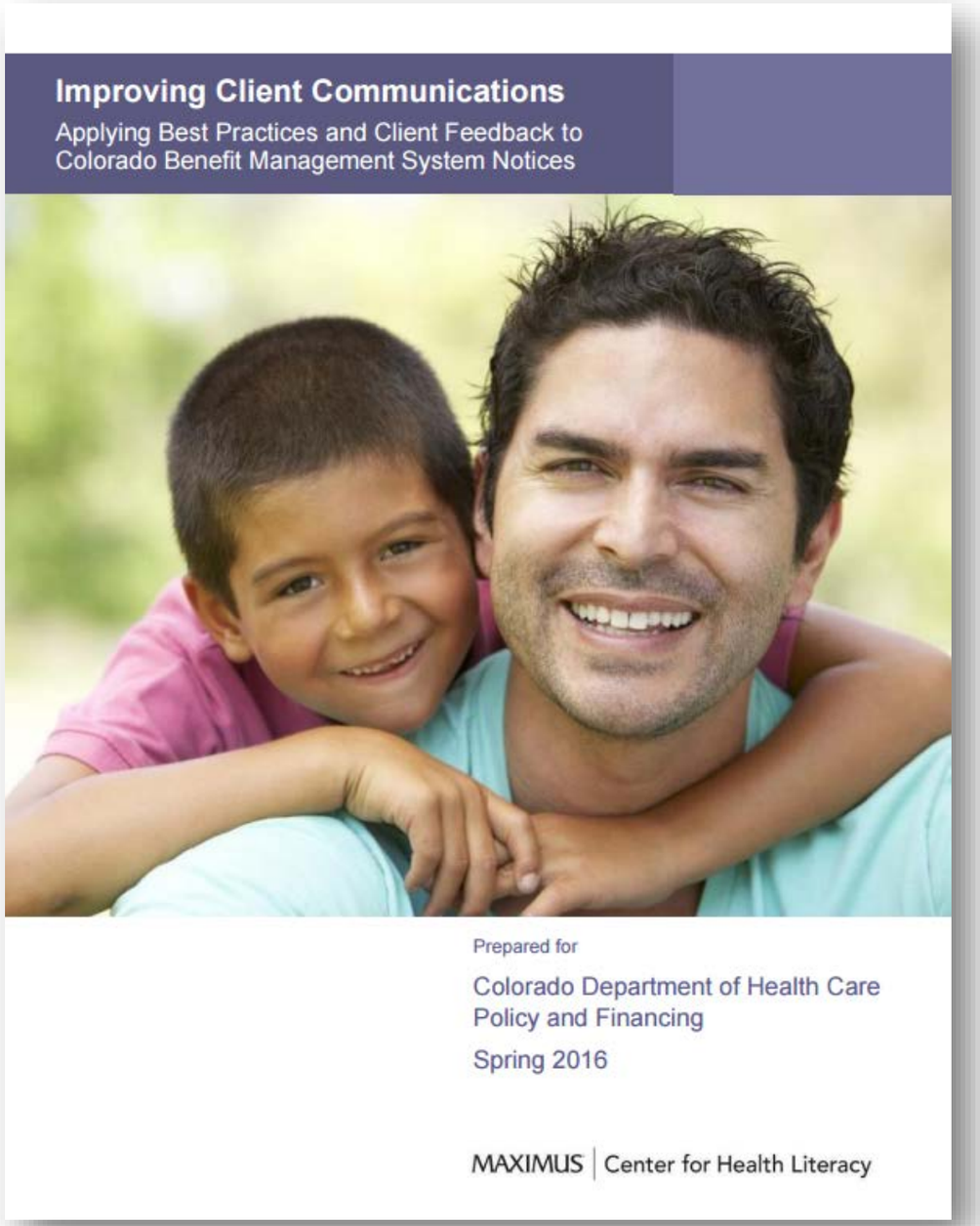
- ✓ Want more information about certain concepts, *and* a shorter letter
- ✓ Testing reveals nuances in understanding
- ✓ Need to balance informing with readability
- ✓ Provide only information pertinent to members on letter

Phase IV: Policy, Legal & County Feedback

- Forthcoming review by agency experts and legal partners
- We will also continue engaging our county and community partners in reviewing the revised notices.

Reports & Recommendations





Colorado.gov/HCPF/PlainLanguage

Questions?

Thank You!