Colorado Health Policy Coalition

The Consequences of Colorado's Medicaid Unwind and Collaborative Solutions for a Better Future

In 2013, state lawmakers recognized the economic advantage and opportunity for improved health and well-being afforded through the Affordable Care Act. State leaders wisely expanded Medicaid coverage to Coloradans with incomes up to 138 percent of the federal poverty level (about $15,060 annually for a single person or $31,200 for a family of four). The economic benefits of Medicaid expansion were quickly realized. A 2015 Colorado State University study found a 1.14 percent increase in the state's gross domestic product (GDP) due to Medicaid expansion. Medicaid expansion supported 31,074 additional jobs. The study also found that average household earnings in Colorado are $643 higher due to the stimulative effect of the Medicaid expansion. By FY 2034-35, Coloradans' annual average household earnings will be $1,033 higher.[1]

Unfortunately, the recent unwind of the COVID-19 Medicaid continuous coverage provision[2] has resulted in a new public health emergency for our state. Coloradans with disabilities have experienced dangerous disruptions in care, and low-income individuals have been cut off from important prescription medications and forced to forgo needed care as hundreds of thousands of Coloradans have abruptly been kicked off public health insurance. The coverage gains Colorado lawmakers achieved with Medicaid expansion have eroded, with more than 675,000 Coloradans disenrolled from the program. Of those, 65% **lost coverage for procedural reasons[3], not necessarily because they are ineligible for Medicaid**.

The economic consequences of the Medicaid unwind are extensive. Colorado's coverage gains under Medicaid have nearly evaporated, and along with it, the boost to our state's GDP, the additional jobs, and, the increase in household earnings. Still, there are more costs. Many Coloradans who were disenrolled from coverage are still eligible for Medicaid and will re-enroll when, for example, they obtain high-cost care in hospitals that could have been avoided with better ongoing care. **Medicaid "churning"** - the constant exit and re-entry of beneficiaries as they lose eligibility- interrupts the continuity of medical care and creates substantial

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[1] https://coloradohealth.org/articles/news-release/analysis-reveals-medicaid-expansion-sparks-economic-activity-colorado

[2] In January 2020, the U.S. Department of Health and Human Services declared a public health emergency (PHE) in response to the outbreak of COVID-19. Congress passed legislation under which anyone enrolled in Health First Colorado (Medicaid) was guaranteed to keep their health coverage during the PHE. This is known as the "continuous coverage requirement," and it also applied to kids and pregnant people covered by the Child Health Plan Plus (CHP+).

[3] Procedural" denials encompass every person who was terminated from Medicaid for any reason that is not about their eligibility. No determination on that person's eligibility was made—they were kicked off for a different reason--their county may have a backlog in processing applications or there may be issues with renewal paperwork, or the member may have moved and never received their renewal paperwork.

administrative costs for Medicaid, as the state has to reprocess applications repeatedly. A 2015 analysis found that the administrative cost of one person churning once (dis-enrolling and re-enrolling) could be from $400 to $600.[4] Given national trends,[5] it's likely that at least 50% of the 395,850 Coloradans disenrolled from Medicaid due to procedural reasons will ultimately reenroll in the program. **The total administrative costs to our Medicaid program from unnecessary disenrollment and re-enrollment could range from $79-$118 million.**

Churning also contributes to **increased Medicaid expenditures for medical care**. Studies demonstrate that people who have care-sensitive conditions such as diabetes, heart disease, and respiratory diseases had double the rate of emergency department visits and hospitalizations in the month they returned to coverage.[6] Families report missing scheduled surgeries, cancer treatments, behavioral health treatment, and vital medications, all of which can result in the need for more intensive treatment when they regain Medicaid coverage.

Other costs fall on individuals who experience churning. When people lack health coverage, they are more likely to miss work[7] and must pay for necessary health care out-of-pocket. To re-enroll, Coloradans have to provide extensive documentation to re-establish eligibility, fill out lengthy forms, spend hours in county offices or on the phone, and experience the substantial stress of losing their own or family members' coverage. They may have to change health care providers, a process that disrupts medical care and contributes to health problems. Research has also shown that people with short episodes of coverage have poorer quality of health care than people enrolled for longer episodes. **In short, the Medicaid unwind in Colorado is substantially increasing costs to states, taxpayers, and eligible individuals.**

Avoidable Costs

Claims that disenrolled Coloradans have found coverage elsewhere are unsubstantiated. Safety net clinics and hospitals statewide are seeing a dramatic rise in the number of their patients who are now uninsured. Federally Qualified Health Centers report a 30% spike in uncompensated care. Our state's safety net health system is in jeopardy, with many healthcare providers asking for provisional payments to keep their doors open. Connect for Health Colorado, our state's health exchange, revealed at their April board meeting that 26%[8] of those terminated from Medicaid for a reason (not procedural) and sent to the exchange for coverage were found to still be eligible for Medicaid. **This tells us our problem is greater than suspected.** A quarter of denials *for cause* (i.e., household income that is too high) are apparently also incorrect.

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[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4664196/ Churning-related administrative costs, multiplied by the number of people who churn in a year, generate a significant share of Medicaid expenses.

[5] A recent Kaiser Family Foundation survey found that 47% of those who lost coverage for ANY reason (not just a procedural denial) returned to Medicaid.

[6] https://www.macpac.gov/wp-content/uploads/2022/07/Effects-of-churn-on-hospital-use_issue-brief.pdf

[7] A worker with health coverage misses on average 76.54% fewer workdays than uninsured workers

[8] https://www.google.com/url?q=https://c4-media.s3.amazonaws.com/wp-content/uploads/2024/05/15120347/20240513_C4_M2M.pdf&sa=D&source=docs&ust=1717186493549814&usg=AOvVaw31-Afmcxjc54WHahk3irPD

The rate of new Medicaid applications began to spike within a month after Health First Colorado began disenrolling people from health coverage. When counties must process applications of those inappropriately terminated, backlogs worsen not just in Medicaid but in other public programs.

The costs of the Medicaid unwind are consequential, and many are avoidable.
As of May 23, 2024, more than 675,000 Coloradans had been disenrolled from Medicaid because of the PHE unwind.

- Colorado is one of 10 states nationally with child enrollment that by December 2023 was already *below* pre-pandemic levels.[9]
- Colorado is 7th highest in the nation for the total rate of disenrollment (48% compared to 30% nationwide).[10]
- Colorado is 9th in the nation for the highest rate of procedural terminations as a percentage of completed renewals (31% in Colorado compared to 21% nationwide).[11]
- Colorado is second in the nation on the percentage of enrollment decline, based on the cumulative change in Medicaid/CHP enrollment from baseline enrollment in 2023.[12]
- Colorado has terminated thousands of members due to county processing backlogs, even though the member returned their renewal paperwork on time. This is a violation of Centers for Medicare and Medicaid Services regulations.[13]

Policy Solutions

Policy solutions for this problem are complex and multifaceted. Below, we've provided short— and long-term solutions. The recommended Steering Committee will ensure Coloradans have a voice in fixing their system and that healthcare providers, consumer advocates, and the experts on the ground supporting low-income individuals to navigate our enrollment system are at the table to transform Health First Colorado into a cost-effective, consumer-friendly health coverage program.

Short-Term Solutions

1. Establish a steering committee of members and local experts to work with the Department to implement the short-term and long-term solutions requested here.

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[9] https://ccf.georgetown.edu/2024/05/02/child-medicaid-disenrollment-data-shows-wide-variation-in-state-performance-as-continuous-coverage-pandemic-protections-lifted/
[10] https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/
[11] Ibid.
[12] Ibid.
[13] https://www.cms.gov/newsroom/press-releases/hhs-takes-additional-actions-help-people-stay-covered-during-medicaid-and-chip-renewals

- This steering committee could provide progress updates and recommend the next steps at the September JBC hearing.

2. Leverage technical assistance from the Centers for Medicare and Medicaid Services (CMS)
   - In a March 15 CMS Bulletin, CMS offers to help states experiencing problems.

3. Stop all procedural denials and reenroll any members disenrolled due to a procedural denial.
   - CMS waivers make this option available. CMS technical assistance (in bullet 2) could help CO with implementation.

4. Allow more Medical Assistance (MA) Sites.
   - Colorado limits the ability of heatlh care providers, local public health agencies, and community-based organizations to help process applications. Many counties have processing backlogs, and local partners can help. Other states allow more MA sites.

5. Publish county-specific disaggregated data on disenrollments, along with the reason for the disenrollment, on a dashboard that is updated regularly.
   - This data will help counties, the state, and partner organizations spot trouble areas and collaborate on immediate solutions. Other states are publishing it.

Long-Term Solutions

1. Replace the Colorado Benefits Management System (CBMS).
   a. CBMS' errors and programming challenges are well-known to the state, harm state residents, and continue to put the state in jeopardy of legal action or federal sanctions.
   b. According to the 2020 and 2023 Medicaid communications audits, most CBMS-generated notices are defective. Inadequate notices violate federal due process requirements and result in additional calls and visits to county offices, confusion, and extra paperwork. **Auditors found at least 1 problem in 90 percent of CBMS communications to Medicaid members**.
   c. Corrections from the 2020 legislative audit have not been made; corrections from the 2023 audit are not budgeted.
   d. The 2018 CBMS Transformation does not appear to have significantly improved eligibility processing. Programming changes needed to respond to ongoing issues take a significant amount of time to design and implement. County workers—many of whom are recent hires—make frequent errors with this complex system.

e. Reprocurement of the eligibility module in CBMS is scheduled for 2029. This needs to be moved up to NOW.

f. Counties should transition to a single work management system by 2025. This will allow for more work sharing and more efficient task prioritization.

2. The steering committee should continue to support all facets of reform to our Medicaid eligibility and enrollment system and provide regular updates to the JBC.

Colorado Health Policy Coalition

The CHPC is a cross-sector coalition of 90+ Colorado organizations aligned to advance health equity in our state. At our May meeting, approximately 30 CHPC member organizations were present and decided to contact the JBC for help addressing the consequences of the Medicaid unwind. After the meeting, an ad hoc committee of the CHPC compiled this document. Below is a list of our larger membership. The CHPC has supported Colorado lawmakers in efforts to correct health disparities and advance health equity for the past five years. We offer our hand in partnership and look forward to supporting the JBC in reclaiming the gains we made from your decision to expand Medicaid in 2013. **For more information or to join the Colorado Health Policy Coalition, contact Elizabeth Baskett at embaskett@gmail.com**

COLORADO MEDICAL SOCIETY

COLORADO RURAL HEALTH CENTER

COLORADO COMMUNITY HEALTH NETWORK
Access for All Colorado

CBHC | Colorado Behavioral Healthcare Council

Medicaid Unwind Provider Impact Statement:

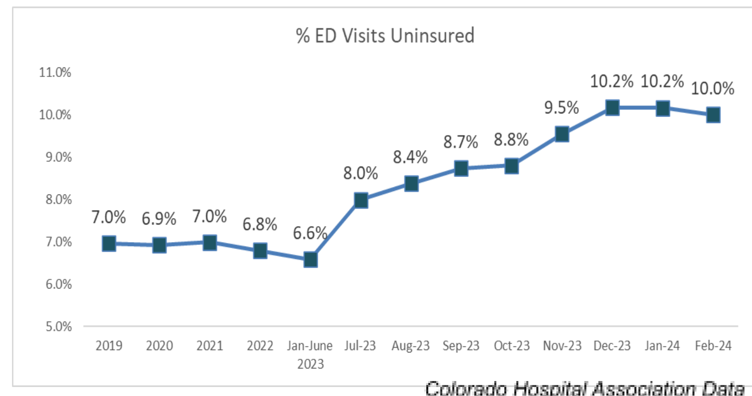
Providers across Colorado's safety net are seeing dramatic increases in the uninsured rate. This data shows catastrophic concerns for both Medicaid enrollment processes and the viability of the safety net. This also hamstrings providers' efforts to participate in broader value-based payment reform or transformations that are underway.

Clinics:

- More than 40 primary care safety net clinics across Colorado that don't receive federal support have seen the number of uninsured patients increase between 10 percent and 25 percent each month compared to the previous year.
- For those that take Medicaid it has more than doubled the number of uninsured they see and for those that do not take Medicaid, there are significant increases in demand for services.

Hospitals:

- Colorado's hospitals have seen over a 50 percent increase in patients without insurance in the emergency department. Over 10% of patients seeking care in the emergency department are now uninsured, up from 6.6% to 7.0% before and throughout the pandemic.
- Hospital charity care costs are up 159% compared to 2019.



Colorado Hospital Association Data

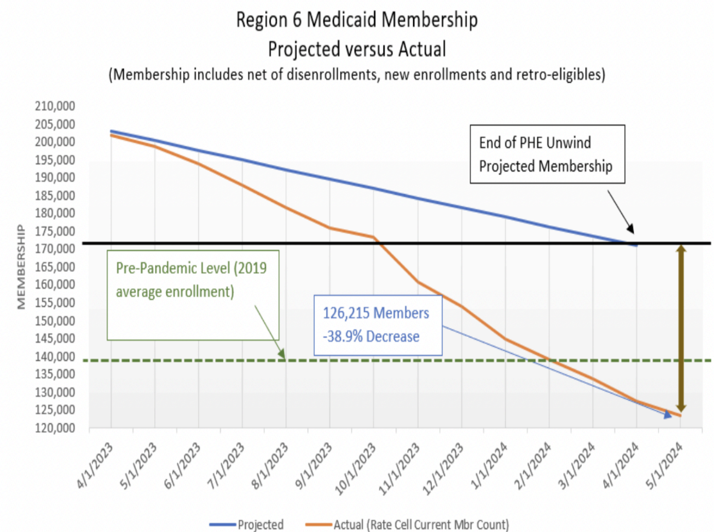
Community Health Centers (CHCs):

- Statewide attribution to FQHCs has decreased by around 34%, or 177,000 people, from May 2023 to March 2024. Based on the trends in decrease, attribution is expected to decrease by another 16,000 people in April 2024, or a total decrease in attribution during the unwind to 37%. This brings CHC Medicaid attribution to the pre-pandemic record low of CHC attribution, around 340,000, in early 2020.
- A few CHCs have had to consolidate services or pause hiring new staff given financial constraints. CCHN is aware of at least three CHCs that have made layoffs.

- One CHC estimates that the decline in Medicaid attribution has resulted in a <u>$6M loss per year</u> in Medicaid revenue, or <u>8% of its budget.</u> Due to this, the rise in labor costs, and the end of ARPA funds, the CHC had to close some clinics and lay off 46 employees.

Community Mental Health Centers (CMHC):

- The deficit across Colorado CMHCs was estimated <u>at minimum $24 million</u> in February—and it's only worsened since then. One CMHC alone is facing an <u>$8 million shortfall with a 60% increase</u> in the number of uninsured patients coming to them.
- Two CMHCs have laid off significant numbers of administrative staff (including, at one rural center, 3 of 5 executive staff) as a direct result of the increase in the uncompensated care they provide; others are on the brink of doing so. Some programs are at risk of closure.
- One CMHC is not filling <u>50 of its 90</u> open positions because of the uncertainty of their funding.



Colorado Behavioral Healthcare Council Data

Primary Care Providers[1]:

- The majority of those disenrolled following the April 2023 PHE Medicaid unwind, remain uninsured. This has resulted in delays or a patient's inability to access care and medications, exacerbating health conditions and contributing to hospitalizations. Only in settings with a dedicated enrollment specialist individuals are getting support to remain covered.
- Limited English proficiency and Latinx populations have been impacted the most. Another population mentioned was children with long term disabilities.
- Decreased enrollment has resulted in financial losses for primary care resulting in staff and provider layoffs, budget cuts, and clinic closures or service changes.

Durable Medical Equipment Suppliers:

- Durable medical equipment providers have been caring for an increasing number of uninsured patients, especially since the COVID pandemic.
- This has resulted in enormous outstanding costs, and in many cases, the closure of smaller DME businesses.

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[1]Feedback from a December 2023 Colorado Academy of Family Physicians survey.

Assessing the negative economic impact of Medicaid contraction: What can Colorado learn from previous studies of expansion?

INTRODUCTION

The Colorado Futures Center (CFC), and its predecessor entity the Center for Colorado's Economic Future, have been assessing the impact of Medicaid expansion on the state's economy since the pre- Affordable Care Act expansion undertaken in HB 09-1293. In the wake of the 2010 passage of the Affordable Care Act (ACA) and the subsequent Supreme Court 2012 ruling, and with the 2013 passage of SB 13-200, Colorado opted to expand Medicaid under the extended provisions of the ACA. This provided CFC, in continued partnership with the Colorado Health Foundation, the opportunity to revisit and update the economic impact. As our previous research demonstrates, each Medicaid expansion resulted in not only private benefit to those Coloradans who received access to health coverage, but in a benefit to all Coloradans who enjoyed a larger state economy as a result of the expansion. Due to the end of the COVID-19 Public Health Emergency and the corresponding end to Medicaid continuous coverage requirement, it is estimated that more than 765,000 Coloradans[1] have been disenrolled from Medicaid in Colorado, the majority for procedural reasons. This memo revisits the public economic and fiscal benefits estimated from the post ACA expansion in order to highlight the potential costs to the state from the current disenrollments.

PREVIOUS RESEARCH

The Colorado Futures Center has been a partner and then the lead investigator on three studies assessing the economic and fiscal impacts of health care expansion. In the first of these assessments of the 2009 health care expansion, we established the methodological approach that we deployed on each of the subsequent assessments of the impact of the expansion undertaken under the ACA. These subsequent assessments were completed in the immediate wake of the Colorado decision to expand Medicaid under the ACA and two years later to validate and update the estimates of economic and fiscal impact.

The methodological approach is important. For each of the three assessments, we comported with best practices in economic impact analysis by developing a multiplier model of the impact of expansion, however with an important variation. Most multiplier analyses consider only the expansionary impact of the spending without regard for the source of the financing for the spending. This is particularly relevant for publicly funded programs.

[1] Kaiser Family Foundation (KFF) Medicaid Enrollment and Unwinding Tracker: https://www.kff.org/report-section/medicaid-enrollment-and-unwinding-tracker-overview/ (updated June 14, 2024)

Our analysis was one of the first to explicitly recognize that government programs require tax revenues to finance. Taxation reduces other household spending in order to meet the tax burden, thus reducing economic activity elsewhere. By explicitly modeling the contractionary impact of the taxation as an offset to the expansionary impact of the public spending, our assessment renders economic and fiscal impact estimates deemed to be as conservate as multiplier analysis can yield. Even with that conservative bias, our 2016 update, the most recent of our studies, found the following positive impacts from Medicaid expansion:

- In FY2015-16 expansion results in
  - 1.14% more economic activity (GDP)
  - $643 increase in household earnings
  - Cumulatively 31,074 more jobs in the state's economy
  - $102.4 Million in additional General Fund tax revenue
- In FY2034-35 expansion results in
  - 1.38% more economic activity (GDP)
  - $1,033 increase in household earnings
  - Cumulatively 43,018 more jobs in the state's economy
  - $248.3 Million in additional General Fund tax revenue

A major driver of the expansionary effects of Medicaid is the significant federal support for the program.

WHAT WILL DISENROLLMENT MEAN?

Currently, Colorado is facing a circumstance that we have not yet explicitly modeled – a contraction in Medicaid enrollment. Much has happened since our 2016 assessment, both to the structure of the economy and as a result of the pandemic. For that reason, we cannot extrapolate the negative impact of Medicaid disenrollments from the 2016 findings. However, the basic structure of Medicaid financing (substantial federal contributions) and the general Colorado economy have not changed significantly. For these reasons, we are confident that our forthcoming model update will find that the disenrollments contract all economic and fiscal parameters: GDP, employment, household income and tax revenue. Our confidence results largely from the fact that the federal contributions as well as the state spending on health care will continue to provide more expansionary pressure than the offsetting reductions that result from the household burden of financing the taxes. But those are not the only negative economic and fiscal impacts of disenrollment.

Lower income households who lose Medicaid coverage will be forced to redirect some household spending to meet medical expenses, further slowing the local economy. This exacerbates the structural contraction described above as local household spending is crowded out by medical expenses. Previously, those medical costs would have been covered by Medicaid, with its

significant federal match, freeing up other household spending to circulate throughout the Colorado economy.

Fiscally, our 2014 analysis highlighted state programs that were likely to see reduced burden as Medicaid expansion was complete. At the time we identified the following programs:

- The Old Age Pension medical program
- The Community Mental Health program
- The Drug and Alcohol Abuse Treatment program
- Offsite inpatient hospitalization treatment costs for the Colorado Department of Corrections

While the specifically impacted programs likely will change, we expect that there are current state programs that will experience additional demand as Medicaid rolls shrink. Exacerbating the burden, this will occur in an economy contracting from Medicaid disenrollments, generating lower levels of tax revenue, all else equal.

TO CONCLUDE: ALL COLORADANS SHOULD CARE ABOUT DISENROLLMENTS

Disenrollment from Medicaid, particularly for those otherwise eligible, will place a private burden and hardship on those who lose coverage. Patient advocates are in a better position than we to share the effects of that private burden. But all Coloradans should care about disenrollments and reduced coverage for those eligible for support. Medicaid coverage expands the state's economy, providing a public benefit to all and fiscally strengthening the state's budget. Ensuring that all eligible Coloradans receive coverage ensures that the public economic and fiscal benefits persist. Disenrollments and coverage contractions serve to undermine those benefits.

The Colorado Futures Center is a 501c3 organization dedicated to informing about economic, fiscal and public policy issues impacting community economic health and quality of life.

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Joint Budget Committee
200 E 14th Ave #300
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June 20, 2024

Members of the Joint Budget Committee,

In 2020, Congress enacted the Families First Coronavirus Response Act (FFCRA), which included a requirement that Medicaid members retain coverage through the end of the COVID-19 public health emergency (PHE). Members who became eligible for Medicaid during the PHE were able to retain coverage and were not required to re-enroll in benefits during the PHE, called the continuous enrollment provision. The federal government announced on February 9, 2023 that on May 11, 2023 the Public Health Emergency for COVID-19 would expire.

At the same time, and as a consequence of the pandemic and striking increases in inflation and cost of living, the state of Colorado experienced significant increases in enrollment in Medicaid and food assistance (SNAP) programs. Additionally, permanent federal changes to the Medicaid program also went into effect. Those changes required eligibility workers to spend significantly more time processing cases. Therefore, the caseload increased significantly, while the workload broadly skyrocketed, contributing to an already serious workforce crisis for counties. As we will discuss in more detail, counties are confronting significant challenges, including:

- Managing an increased workload and constantly changing program requirements without adequate funding.
- Staff are seeing an increase in the complexity of the work with greater levels of need among community members trying to access Medicaid and other benefit programs.
- Recurring technical delays or outages in the Colorado Benefits Management System (CBMS), which results in loss of staff productivity and their ability to serve community members.

The PHE and resulting unwind have highlighted for counties the need for changes to program requirements, improvements to the system, and policies in order to improve the experience for Medicaid members. The significant impacts on community members currently enrolled in Medicaid or trying to access Medicaid is creating confusion, delays, and a declining morale among those who do the work to keep families and individuals enrolled.

Workload:

Over the three years of the PHE, Colorado saw historic demand for public assistance benefits driven by the COVID-19 pandemic, economic uncertainties, and a significant increase in cost of living. Between

2019 and November 2023, SNAP experienced a 26.41% increase in the number of individuals with active cases and Medicaid members grew by 31.19%. At the same time as enrollments increased, federal requirements on renewals changed the way members re-enroll, causing a massive increase in work for members and county staff. Prior to the federal change, most people were automatically re-enrolled and did not have to submit detailed renewal forms to the county unless their circumstances changed. Now, most Medicaid members are required to send back renewal forms, provide a signature, and submit proof of things like income. Due to these changes, counties are receiving significantly more Medicaid renewal forms; about 18,300 more each month at the end of 2023 compared to 2021. Another effect of the new federal rules is the increase in verification requests. In 2021, counties asked for about 3,700 verifications each month. Counties now request almost 19,000 verifications each month. This equates to an additional 15,300 verifications that Medicaid clients need to provide and county workers need to process each month in order to meet the eligibility process requirements.

To better understand workload increases, in January 2021, the largest 11 counties began to internally collect and analyze all current work-on-hand for applications, renewals, verifications, and case changes each month to determine which areas of work were most impacted by caseload size increases as well as staffing and retention challenges. Between November 2021 and November 2023, the number of tasks reported in county offices drastically increased in all of these categories. Applications increased 92%, renewals increased 84%, and changes and verifications increased by 188%. Overall, workload in the big 11 counties increased 134%. Workload increases at the county level to this magnitude negatively impact service delivery, particularly when combined with staff turnover and training challenges.

Once the end of the PHE went into effect, otherwise known as Medicaid unwind, the workload for counties shifted further while remaining at this high volume. Since the beginning of the unwind, HCPF data indicates that 432,634 individuals lost Medicaid coverage from June 2023 through November 2023. Counties, HCPF, and others have engaged in thorough public awareness campaigns to try to reach all members and ensure they understand the need to submit renewals. As a result, counties have fielded a tremendous amount of questions from members, and have done their best to help members – many of whom are on Medicaid for the first time and trying to navigate the confusing unwind period. As many of those disenrolled now begin to reapply for Medicaid, the resulting churn has led to significant re-work of cases. We are seeing on average 10,600 more applications per month statewide than we were just 2 years ago in 2021. HCPF estimates that as many as 33% of Medicaid members who lost benefits during the unwind are now reapplying.

In addition to the PHE continuous enrollment provision, federal regulation changes in Medicaid renewal processes have necessitated significant business process restructuring efforts at the county level. These changes decreased the number of individuals who can auto re-enroll through the “ex-parte” process which ultimately increased the number of Medicaid renewals that require county worker action to determine eligibility. In April 2024, HCPF implemented a renewal medical assistance (MA) strategy for the ex-parte process for members with income at or below 100% of the federal poverty level (FPL). We are still waiting on preliminary data on how this has improved our ex-parte rate and look forward to additional enhancements in this area.

CBMS Functionality:

Problems with CBMS fall into two categories. The first is the instability of the existing system. The second is the limitations to making changes to improve functionality, incorporate policy changes, and streamline eligibility processing.

There have been numerous CBMS outages, downtimes, errors, and delays in the past several months. While we continually meet to analyze the information related to these issues, little has been done to remedy the root cause, which is lack of Service Level Agreements with the companies that operate our system platforms. Without these in place, there is little ability to hold the vendors accountable for their services that our system applications run on.

In the big 11 counties, we estimate that for every 30 minutes the system is down, we miss out on assisting 850 families. In October 2023 alone, CBMS was impacted for 33 hours. Even though the system was not entirely down, we were unable to authorize (or complete) a case during most of this time. That means, just for the 11 largest counties, we missed the opportunity to help 40,600 families due to system issues in just one month. CBMS had a total of 63 system issues in 2023 totaling 126 hours with diminished productivity. Between April and December 2023, 73 of these hours were considered heavy impact, which means we missed out on serving approximately 124,000 families timely. To date in 2024 counties have experienced a total of 17 system issues totaling approximately 35 hours. Additionally, the system was completely down for three days due to the Palo Alto firewall issue. An outage of this significance has a compounding impact on county workload and our ability to serve our members timely.

Regarding the ability to make changes to CBMS to incorporate policy changes and improve functionality, it easily takes one to two years to get county recommendations prioritized and we are regularly told there is no capacity or funding to do so. In fact, many of the policy changes we have recommended and which we outline in the next section have not been made because they would require changes to CBMS.

County Recommended Solutions:

In an effort to manage and prioritize the competing pressures and demands on the work in this very important space, counties have made several requests of both HCPF and CDHS but want to formally share them with the Joint Budget Committee.

Counties challenges and recommendations largely fall into four categories: 1) CBMS and PEAK functionality, 2) federal policy flexibility, 3) statewide policy changes, and 4) appropriate funding.

1. Statewide Technology Enhancements to CBMS and PEAK

- Conduct a system analysis to quantify the excessive instability of the current system and impacts, including the impact to members not receiving benefits timely, county worker down time and inability to perform job functions resulting in mandatory overtime and staffing challenges, and overall cost. Determine the cost and feasibility of building a new system in comparison to the cost and feasibility of continuing to layer fixes to the already complex existing system.
- Limit or improve the functionality of what data maps over from PEAK to CBMS that is creating duplicate tasks in the system and requires significant re-work by county staff.
- Send verification checklists with the renewal packet to Medicaid recipients rather than through separate correspondence.

- Prioritize the Work Management System functionality for Medicaid to recognize receipt of signed renewal packets and initiate the renewal in CBMS, without causing unnecessary re-work in other specific areas.
- Focus on PEAK improvements to help with efficiency and ensure accurate data is populating into CBMS.

2. Explore Federal Policy Opportunities

- Counties believe that there are opportunities to promote continuous coverage and to streamline eligibility determinations that are being disregarded. After compiling recommendations a year ago that were not adopted, CHSDA recommended, and CDHS and HCPF agreed to, a convening of state and county partners to form a Strikeforce that would review and prioritize competing policy changes, workload demands, and other modifications in expectations and requirements. While we have made some progress through this convening, counties continue to advocate for key changes that would improve the experience for members and practices for workers.
- To alleviate administrative burdens, many states have secured temporary waivers through Section 1902 (e)(14)(A) of the Social Security Act. For example, a commonly adopted state waiver strategy includes utilizing SNAP data without requiring a separate Medicaid determination. Additional waiver options include automating data checks, expanding electronic data sources, and establishing a reasonable compatibility threshold for income and/or assets. Despite counties repeatedly requesting that the state explore waivers and additional support, they have often been informed that such measures would not be implemented with little discussion or reasoning provided.

3. Statewide Policy Changes

- Automate renewals for Medicaid whenever possible through the "ex parte" process.
- Allow counties to process Medicaid cases of Coloradans who have been found eligible per their financial information submitted when applying for other means-tested benefit programs.
- Provide clear and simple communication to Medicaid recipients. Reduce procedural errors by eliminating confusing correspondence and unnecessary transactions.
- Simplify the renewal packet and process. Leveraging revisions to the lengthy renewal packet could reduce the size of the packet by 35%. This would significantly improve customer experience and streamline county worker workflow.
- Implement recommendations from the report produced based on S.B.22-235, including enhancing cross-agency and state-county collaboration, aligning administrative requirements, and better documenting policies.

4. Funding Needs

As counties have shared previously with the Joint Budget Committee, counties are significantly underfunded in County Administration – the funding line that pays for Medicaid and food

assistance eligibility workers, supervisors, and other county staff that support eligibility determinations. County Administration funding is critical to ensure counties can appropriately staff to provide timely and accurate benefits to our community members who are most in need. S.B.22-235 required HCPF and CDHS to create a funding model that would determine the overall funding needs for eligibility work in Colorado. While not yet public, recent iterations of the study indicate that Colorado is significantly underfunded in County Administration (~$30 million), with the largest underfunding attributed to HCPF (~$20 million).

Conclusion:

In closing, we implore the Joint Budget Committee to support Medicaid recipients, providers, and counties by investing in CBMS stability, creating a steering committee to prioritize and provide accountability for the system changes identified before you today, and increasing funding to County Administration with the completion of the S.B.22-235 report. More people will be able to access their Medicaid entitlements and health care, and overall Colorado will save money by being able to draw down more federal Medicaid dollars that infuse our state and local economies.

www.ColoradoHSDA.org

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