2025
CCLP CASE STUDY
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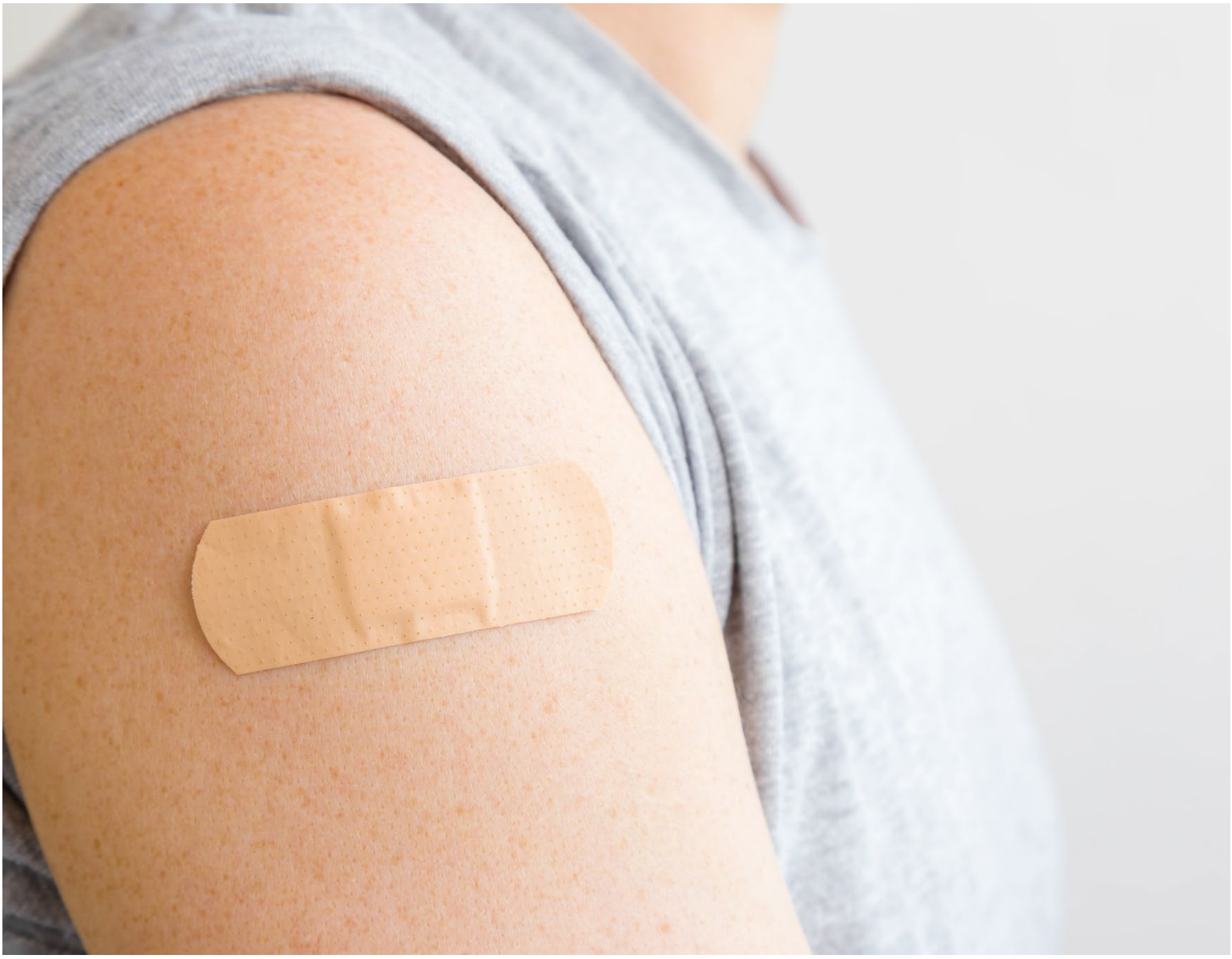
Colorado Center on Law and Policy

LESSONS FROM THE PUBLIC HEALTH EMERGENCY UNWIND IN COLORADO



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Acknowledgements

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Executive Summary

In May 2023, the COVID-19 Public Health Emergency (PHE) officially ended. Each state was required to begin reviewing the eligibility of everyone who had enrolled in Medicaid since the beginning of the pandemic. For Colorado, this was 1.8 million enrollees—far more than had ever been enrolled in the state's history. Unfortunately, some of the 64 counties responsible for determining eligibility began this work already behind in their processing of public benefits, and the technology systems they relied on had been plagued with errors for years.

Colorado Center on Law and Policy (CCLP) recognized these unique challenges and sought to establish avenues to gather information from community advocates during this process. Through recurring meetings with Medicaid enrollment assisters and disability advocates around the state, CCLP helped identify systemic issues as they arose. Together with data gathered from Open Records Act requests and national sources, CCLP advocated directly with the state's Medicaid agency, the Department of Health Care Policy and Financing (HCPF), to institute changes aimed at keeping vulnerable populations enrolled.

As Colorado struggled under the strain of eligibility renewals, the number of people being disenrolled from their coverage reached a crisis point. CCLP expanded its advocacy to include a wider range of stakeholders, including county workers, providers, and eventually, legislators. Together with the National Health Law Program (NHeLP), CCLP filed an Office of Civil Rights Complaint in February 2024 about the discriminatory treatment of people with disabilities. This complaint resulted in media coverage, alerted state and federal agencies to the alarming issues Coloradans were facing, and helped change HCPF's approach to the crisis.

The state ultimately paused disenrollments of people with disabilities to allow more time for processing, in addition to taking advantage of other flexibilities the federal government offered. HCPF increased transparency by sharing more data and information about their activities to stabilize the system. The advocate and assister meetings CCLP convened continued to act as information and resource exchanges, as well as an avenue for overwhelmed advocates to provide support to one another.

While there remain many challenges in Colorado's Medicaid eligibility system, including ongoing technical difficulties and inconsistencies between county offices, there is no doubt that these efforts helped limit the number of people who were ultimately kicked off the Medicaid rolls.

CCLP learned some key lessons in how best to approach statewide system changes through this work:

1. Diverse stakeholder engagement, directly with the communities affected by proposed changes, should take place as early and consistently as possible.
2. The state must engage in a thorough assessment of its limitations prior to launching any major effort, and should prepare contingency plans as part of preparing for implementation.
3. Robust data must be gathered, from multiple sources, and shared transparently in an ongoing way throughout a major change.
4. Stakeholders should consider all advocacy tools—direct appeals, media coverage, administrative advocacy, legal avenues, legislative work—and use them dynamically to make a broader impact.

Introduction: Medicaid and the Public Health Emergency

In March of 2020, the Trump administration declared a public health emergency due to the COVID-19 pandemic. This triggered a number of temporary policy changes to address both the ongoing public health crisis and the economic catastrophe the pandemic triggered. Among these policy changes was a continuous coverage requirement for Medicaid. People who were found eligible for Medicaid remained covered during the entirety of the PHE. This meant that the renewal process, which enrollees typically go through every year to demonstrate their ongoing eligibility, was suspended.

Two years later, the Biden administration declared the end of the PHE, effective May of 2023. This announcement obligated states to "unwind" the continuous enrollment provision, meaning states were required to conduct their annual eligibility reviews that had stopped during the emergency. States were to determine the eligibility status of all individuals currently enrolled in Medicaid, and to begin disenrolling those no longer deemed eligible. States had 12 months to conduct these reviews for everyone on their Medicaid lists.

This was an unprecedented undertaking, and it strained the resources states had to manage the workload. In Colorado, almost 1.8 million people were enrolled in Medicaid at the start of the unwind–the largest number to date. Each enrollee had to go through the renewal process over the course of 12 months.

Colorado's implementation of the unwind was uniquely challenging because of the state's benefit management systems and policies. In Colorado, county human services staff are responsible for processing Medicaid renewals and new applications for their county residents. Each county office has its own work management system, although some overlap, and resources and staffing vary widely. All 64 counties, however, rely on the state's multi-program benefits management system, the Colorado Benefits Management System (CBMS) to determine eligibility and generate eligibility notices. This system has long been plagued with problems, including a poor user interface, insufficient integration with other systems, a high learning curve for new county employees, and inaccuracies in the letters and notices it publishes.

The PHE unwind in Colorado resulted in significant disenrollments of Medicaid recipients. The percentage of recipients that fell off the rolls due to reasons unrelated to their eligibility (called "procedural disenrollments") was considerably higher than expected, and much higher than the percentages in comparable states.

As the scale of the disenrollment crisis grew, it became clear to CCLP that the problems experienced by recipients weren't isolated difficulties, but rather systemic issues that required systemic solutions. Identifying the nature of those systemic issues would be key to successfully advocating on behalf of those experiencing the devastating effects of disenrollment, and ensuring the systems were ready to handle changes in the future.

CCLP's investigation

Creating avenues to gather experiences from community members

For CCLP, getting accurate information about what was happening during the unwind required an understanding of the lived experiences of people on Medicaid, as well as the advocates and assisters serving them. To do that, we coordinated with community-based partners around the state.

CCLP worked with Covering Kids and Families, a subsidiary of the Colorado Community Health Network, to meet on an ongoing basis with enrollment assisters around the state. That work was generously funded through the Colorado Health Foundation. We also met regularly with disability advocates who provide support and services to those Medicaid members on waiver programs, including the Colorado Cross Disability Coalition (CCDC), Family Voices Colorado, home health agency providers, Arc chapters, and others.

Our intention was to work with these partners to ensure we had a clear viewpoint into what Medicaid members were experiencing as the unwind began. We particularly wanted to hear not only from individuals experiencing the renewal process, but also from community advocates who were able to identify trends in what they were seeing among their many clients. The diversity of the groups with whom we were meeting was a key component—they included different advocacy organizations that help support people with disabilities, provider organizations that advocate for patients' coverage and services, and enrollment assisters at many clinics across the state. This was paired with ongoing and open communication with HCPF, so that we could report back what we were learning and seek to understand the department's response.

This community-driven approach allowed us to gather documentation on an ongoing basis. We were given copies of notice letters and screenshots of renewal documentation, which showed what enrollees were being told about their coverage. Advocates shared copies of email exchanges showing how particular county workers were responding to the influx of renewals, as well as exchanges with the Office of Administrative Courts (OAC) and HCPF appeals staff. This documentation was invaluable in understanding the problems as they occurred, and allowed us to bring specific issues to the attention of HCPF.

These advocate and assister meetings also supported the direct sharing of information among community members that might not have happened otherwise. Advocates provided information, tips, and knowledge. They had the opportunity to tell their clients' stories in ways that helped each feel less alone and better understand which issues were shared among them. This insight into the advocates' experience also led CCLP to create more advocate-specific, accessible resources based on the needs that were expressed.

Through these regular meetings, we received immediate reports of what would become common themes throughout the unwind. They included systemwide tech problems, particularly interoperability between systems. Even when working properly, the systems' lack of automation made it easy for eligibility workers to make errors, which contributed to severe county delays and backlogs stretching back

weeks or even months. These delays were exacerbated by the lack of consistency across counties and their processes. Another area that was immediately identified by advocates as a source of concern was the appeals process. The administrative court that conducts these fair hearings seemed overwhelmed from the beginning. When appeal processes were adjusted to support enrollees, delays worsened.

Toward the end of July 2023, CCLP attended a broader meeting with state partners, including Case Management Agencies (CMAs), Regional Accountable Entities (RAEs), and HCPF leadership. There was a surprising level of concern raised by the attendees so early in the unwind, echoing what we had heard from our community partners. There were reports that CBMS worked poorly with other systems, a problem known as interoperability, and CCLP learned of rampant noticing issues.

In the face of the overwhelming accounts of terminations happening for people who should not be disenrolled, CCLP requested a pause of all terminations for people with disabilities to mitigate the potential harm to the most vulnerable enrollees. HCPF refused, opting to make improvements as renewals continued. The costs of that decision were high.

Figure 1. Colorado's Modified Adjusted Gross Income (MAGI) renewal process, determining an applicant's financial eligibility for Medicaid.

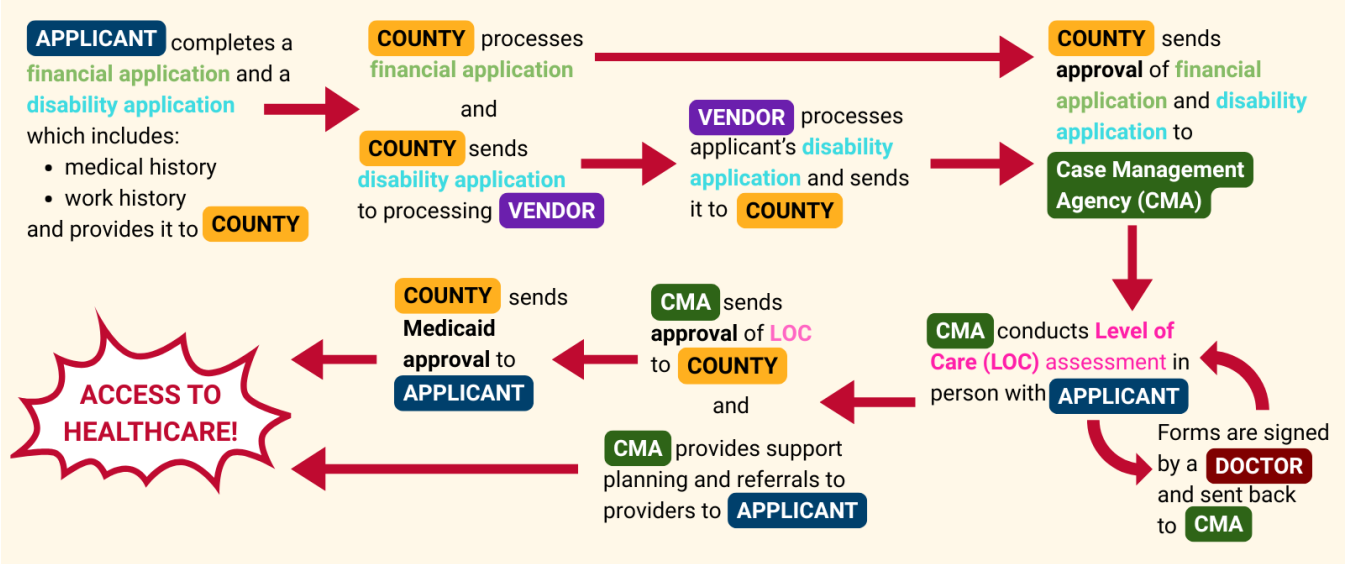

Figure 2. Colorado's Long-Term Services & Supports (LTSS) renewal process, determining an applicant with disability's eligibility for Medicaid. The steps for applicants with disabilities are considerably more time-consuming and complex than the MAGI renewal process in Figure 1.

Using data to set the record straight

In tandem with our community engagement efforts, CCLP worked to monitor the data being shared about how the unwind was going. We filed Open Records Act requests to receive data that was available but not yet shared widely, and analyzed caseload reports to better understand the impacts of the renewals. CCLP also gathered information from legal and technical organizations that specialized in eligibility systems and due process. Those meetings gave staff insight into how other advocates in other states were coping with eligibility problems, whether through advocacy or litigation.

Due process (or due process of law) in this context refers to the provision in the Fourteenth Amendment to the US Constitution that no one shall be "deprived of life, liberty or property without due process of law" by a state government. In the Supreme Court's decision in Goldberg v. Kelly[1], public benefits like Medicaid were affirmed to be property rights—meaning that an enrollee cannot be deprived of them without due process.

Additionally, CCLP staff attended presentations from HCPF and national partners, and collected and analyzed data from the Centers for Medicare and Medicaid Services (CMS). The CMS data, analyzed by the health policy research organization KFF, showed early on that Colorado was performing poorly.[2] By August 2023, CMS had expressed concerns about state errors in determining eligibility,[3] and KFF's analysis from October 2023 revealed Colorado's rates of procedural disenrollment were among the highest nationally.[4] By December 2023, it was clear that no expansion state was dropping enrollees at the rate Colorado was. Ultimately, Colorado dropped over 776,000 Coloradans from coverage, though data also shows that over 200,000 found their way back to Medicaid by reapplying, appealing, or later reinstating.

The picture presented by HCPF, however, included faulty reasoning and misstated data. Throughout 2023, HCPF stressed that renewal rates during the unwind were similar to those before the pandemic, ignoring the fact that Colorado's earlier rates lagged far behind national averages and were objectively sub-standard. It wasn't until March 2024 that the state, while repeating the language about pre-pandemic rates, acknowledged that rates were not where they wanted them to be. The state's low unemployment rate and robust economy was repeatedly shared alongside the numbers of people losing their benefits,[5] despite no connection between these figures.[6] The number of people who were able to get their benefits reinstated after being terminated was also hailed as a sign of success—when in fact this data demonstrated just how many people had been terminated inappropriately. This reductive figure also ignored the reality of being terminated incorrectly and its impacts, including delaying needed care, missing medications, incurring large out-of-pocket costs, and experiencing panic or stress.

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[1] ***Goldberg v. Kelly***, 397 U.S. 254 (1970)
[2] https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker
[3] https://www.medicaid.gov/resources-for-states/downloads/state-ltr-ensuring-renewal-compliance.pdf
[4] https://www.kff.org/medicaid/medicaid-enrollment-and-unwinding-tracker, accessed on September 12, 2024.
[5] https://www.cpr.org/2024/07/08/colorado-dropped-medicaid-enrollees-as-red-states-have-alarming-advocates-for-the-poor/
[6] https://copolicy.org/wp-content/uploads/2024/07/Issue-Brief-Medicaid-Eligibility-and-Wages.pdf

Our findings: systemic issues leading to inappropriate terminations

Through our advocate and assister meetings, CCLP continued to piece together information, attempting to identify whether problems were unique or systemic. To evaluate whether a problem was systemic, we relied on repeat examples, research, and input from HCPF eligibility staff. With exposure to specific interactions with technology systems, county human services departments, case management agencies, and the appeals process, we were able to draw connections, identify causes, and consider solutions.

1. Common problems across counties

We saw certain problems repeatedly. Many issues were common to multiple counties, but the extent of the problems varied. The inconsistencies between the approaches of the 64 counties exacerbated these challenges and made it difficult for a statewide response. Among the examples:

- Counties were weeks or months behind in processing renewal packets that members had submitted. Delays were exacerbated because many who lost coverage reapplied, resulting in an even higher volume for county workers to process.
- For months prior to the unwind, the state encouraged enrollees to use the online public benefits app, called PEAK, to submit renewal documentation and update their addresses. However, there were inconsistencies among the counties in how they processed PEAK documents and account changes. Often, we learned that county staff had simply failed to look for documents uploaded to PEAK. In some rural counties, staff told Medicaid members and advocates that the county office did not use PEAK.
- Many counties lacked the staffing to resolve member questions, or at times to answer the phone. The state help line was also not equipped to help with cases that required a determination of disability.

2. Technological difficulties

Other problems involved system-wide technological barriers:

- Notices that were incorrect, contradictory, or lacked necessary information, often confusing members and interfering with their ability to appeal the terminations. We knew this was a CBMS problem because of two illuminating audits of Medicaid communications in 2020[7] and 2023, with the second audit confirming that the 2020 problems were still present three years later.[8]
- People, especially children, whose eligibility should have been renewed automatically via technology systems, requiring no additional steps (called the ex parte process) were instead seeing their coverage terminated.

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[7] https://leg.colorado.gov/sites/default/files/documents/audits/1936p_medicaid_client_correspondence_-_september_2020.pdf

[8] https://leg.colorado.gov/sites/default/files/documents/audits/2261p_medicaid_correspondence.pdf

- Coverage was terminated automatically on the renewal date if county staff had not completed processing documents. This occurred even when documents had been submitted physically or electronically before the renewal date deadline, despite a federal rule[9] that requires maintaining coverage in that circumstance.
- PEAK did not allow for uploads of more than a few pages, and failed to inform members when an upload was rejected due to size.

In addition to system-specific glitches, there were also problems of interoperability between technological systems. Multiple technological systems needed to work together for the Medicaid enrollment ecosystem to function, but the systems did not work seamlessly with one another. Information or documents added through PEAK did not automatically insert into CBMS, requiring additional steps to be taken by overworked county staff. Communication between counties and case management agencies was cumbersome because their systems did not work well with each other. MMIS, the provider billing system, sometimes conflicted with the information in CBMS, resulting in enrollees learning from their providers that they had been terminated from Medicaid months before. Though this wasn't accurate, these enrollees were required to pay out of pocket for their care. The design of the technological systems available, including their lack of automation, made resolving issues like these especially challenging.

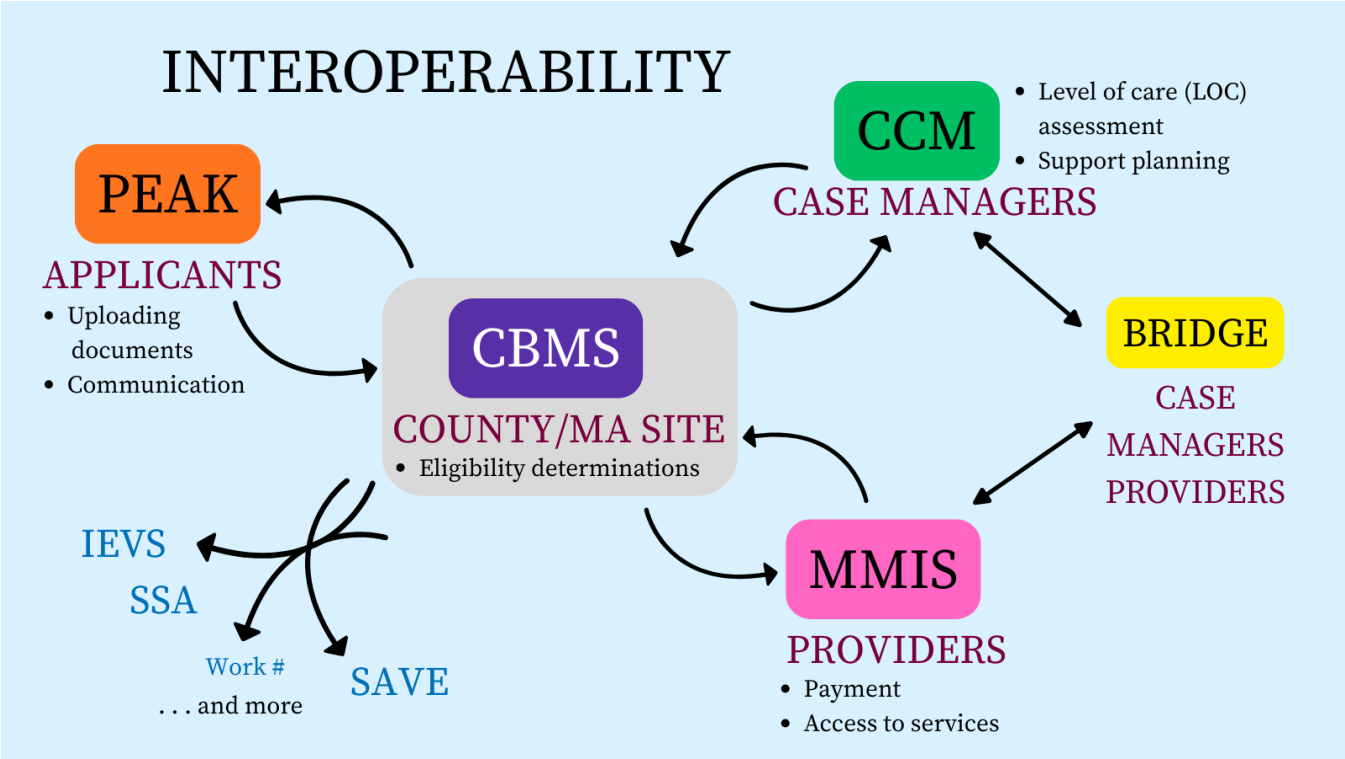

Figure 3. The complex web of interoperability between the different systems used by applicants, county personnel, case managers, providers and others.

[9] 42 CFR § 435.930(b).

3. Problems in the appeals system

With all the terminations and confusion stemming from notice problems, the number of administrative appeals, also known as fair hearings, shot upward. The fair hearing process faced more challenges as the unwind continued. There were many reports of counties simply not appearing at the hearing to explain the reason for the termination. Many appeals were not decided within the 90-day period allowed by law. In October 2023, in response to these many problems, the state applied for—and was granted—an extension on the time it had to process appeals. While this extension helped provide more enrollees with continued benefits pending the appeal, the backlog of fair hearings continued to climb.

4. Unique challenges for people with disabilities

For Medicaid enrollees with disabilities, the renewal process requires additional steps [see breakout above]. But during this time, counties and case management agencies frequently failed to initiate steps in the disability renewal process that should have been completed prior to the renewal date. Even if initiated, those steps would take months due to additional backlogs and understaffing that plagued the vendors responsible for the additional disability-specific processes. In the meantime, some of the most vulnerable, high-use enrollees were terminated from their coverage.

On top of those issues, a "triggering mechanism" malfunctioned in CBMS. Instead of automatically sending enrollees with disabilities their renewal packets in enough time to be processed, many didn't receive them until it was far too late to complete the additional, disability-specific renewal steps. In a system already plagued with delays and backlogs, this was catastrophic, because those determinations can take months to complete.

5. A case management redesign at the worst possible time

At the same time the unwind was in full swing, Colorado's Case Management Redesign was officially launched November 2023.[10] Over a course of nine months, members would move from agencies that had served specific waiver programs to larger agencies that were able to serve all waiver programs. Assignments to the new agencies were based on home addresses, and the first wave of transfers began on November 1.

There was immediate cause for concern, as many case managers were overwhelmed with their new responsibilities. Many enrollees were unaware of what agency they were assigned to which hampered their ability to access services. Some agencies began telling enrollees in November that they could not even apply for a waiver for four months, irrespective of an individual enrollee's level of need. In group meetings, advocates began requesting a pause in unwind terminations while the redesign process stabilized. The department denied these requests.

The case management redesign process compounded the issues already facing the struggling system and resulted in even more terminations. As new (or newly expanded) case management agencies struggled with the influx of enrollees and high caseloads, some enrollees had to wait weeks to get a case

[10] https://hcpf.colorado.gov/case-management-redesign

manager assigned to them. This delayed some of the required steps of their renewal process before the paperwork even reached the overwhelmed county staff members to be processed in CBMS.

The redesign also introduced a new technological system to the mix. The newly created Care and Case Management (CCM) system was supposed to help case managers access the information they needed and bridge with CBMS. Unfortunately, the system had immediate challenges with interoperability with the other technologies it was supposed to communicate with. One initial, impactful challenge was that the CCM system had no access to clients' previous history—meaning all of the assessments, care plans, medical records, and other documents in a person's file were unavailable to newly assigned case managers.

Due to the number of technical problems with the CCM system, case managers were required to perform an incredibly long list of technology workarounds that required so much extra time that they were unable to conduct actual case management. The result was that many people could not identify their case manager. Several others were terminated from coverage because of their inability to get paperwork required to be completed by their case manager processed.

6. The role of misinformation in damaging relationships and slowing progress

The experience of Medicaid members, county eligibility staff, managed care entities, case management staff, and community advocates was at odds with the information presented publicly by HCPF. Most acutely, Medicaid members knew what their experience had been with PEAK failures, bad notices, processing delays, coverage gaps, and with being put on hold for hours. Public meetings were tense. People felt—and for good reason—that their experience and their distress was being ignored.

Ultimately, the refusal of HCPF leadership and Governor Polis' office to acknowledge the scope of renewal problems made those problems exceedingly hard to fix. For months, misinterpretations or unwillingness to accept the facts slowed the response of policymakers and led to confusion on the part of the public. While other states sought federal waivers to help them deal with systemic eligibility problems, Colorado was much slower to follow suit and ultimately adopted just eight out of a possible twenty-six waivers. Nineteen states—all of which had better track records than Colorado in terms of keeping eligible people enrolled—adopted more.[11]

Expanding our advocacy

Late in January 2024, CCLP attended another valuable meeting with top leadership at HCPF. We continued to raise the alarm and advocate for the state to apply for more federal waiver flexibilities, but Colorado lacked the funds necessary to do so. Budgetary constraints related to Colorado's Taxpayers Bill of Rights (TABOR) required the unwind to be completed in as little time as possible. This is because TABOR

[11] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals#CO

caps the state's revenue, so there wouldn't be additional funds available for HCPF to allow the unwind work to continue past a single fiscal year. We were also informed that the pause in terminations that advocates had requested would require programming changes which might take months or longer. In other words, the pause was not an option because the technological systems could not accommodate such a change.

Broadening the advocacy circle to more disability advocates

Around this time, we began convening a broader group of advocates to meet with HCPF leadership. These advocates included members of the local Arc offices, CCDC, Family Voices, El Grupo Vida, and others. We aimed to bring more voices to the table with HCPF leadership to raise the alarm about the profound impacts of the ongoing systemic problems. Advocates repeatedly requested to pause not only the terminations of members with disabilities on Long Term Services and Supports (LTSS), but also the second wave of the case management redesign. This was rejected by the department. Instead, advocates were asked to continue escalating individual cases for triage and response.

Legal action

When later requests were also not heeded, NHeLP and CCLP, working closely with disability advocates, filed a complaint in February 2024 with the Office of Civil Rights in the U.S. Department of Health and Human Services. The complaint alleged that the additional barriers to renewal process for people with disabilities amounted to discrimination. More information was provided to the Office of Civil Rights through supplements filed in March and September 2024.[12]

By March 2024, HCPF had taken steps to pause disenrollments for people with disabilities.[13] The department's expressed intention was to provide a full pause in terminations only temporarily. Longer term, the department would give counties an additional 60 days to process disability renewals. However, continued challenges with the CCM system, delays at the disability vendor, and system interoperability stalled those plans until January 2025.[14] The department also set up a system to proactively reach out to people whose coverage had been terminated and had not been reinstated. This step was valuable but painfully late—a full nine months into the unwind process.

Addressing problems with administrative appeals

The huge volume of terminations had also created a need for more legal representation. Few legal organizations in Colorado provide representation for people who lose public benefits, and the primary provider—Colorado Legal Services—has a small staff which often lacks capacity to take public benefits

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[12] https://copolicy.org/news/cclp-nhelp-medicaid-complaint-feb2024/

[13] https://hcpf.colorado.gov/ltss-stabilizing-actions#Protect

[14] https://hcpf.colorado.gov/sites/hcpf/files/HCPF%20OM%2024-056%20Long%20Term%20Care%20and%20Buy-In%20Eligibility%20Extension.pdf. A system fix adding an extra 60 days did go into effect on January 1, 2025, and will continue until December 31, 2025.

cases outside the Front Range.[15] Medicaid eligibility rules are immensely complicated, and few appellants begin the process knowing how to file an appeal, assemble evidence, and argue their case before a judge.

As a result, although the administrative system is meant to serve self-represented, or *pro se* appellants, appeals are daunting. Prior to start of the unwind, CCLP refined its *pro se* guides on the appeal and fair hearing processes. We continued to conduct how-to presentations to community groups. As processes changed throughout the unwind, we continued to update and share out new versions of the guides in English and Spanish. Disability advocates that formerly took no or few appeals worked with hundreds of Coloradans to get hearing requests filed, prepare their cases, and provide non-attorney representation.

In response to the calls for more legal help, the Colorado Lawyers Committee stepped up in early 2024, working with CCLP and Colorado Legal Services to help Coloradans who had received defective Medicaid notices get representation in administrative appeals. A small team of private firm attorneys received training from attorneys at Colorado Legal Services about administrative appeal processes, as well as on trauma-informed lawyering from CCLP, and then accepted referrals.

Expanding our role in educating others and broadening advocacy methods

As coverage losses continued, state hospitals and clinics began to see financial impacts. The share of patients seeking care who lacked coverage had shot up. Clinics that saw patients regardless of ability to pay began to consider ending programs, closing clinics, or reducing staff. As the impact of the challenges grew, CCLP began joining broader conversations that included clinics, hospitals, and county human services representatives. CCLP also began broadening our advocacy to the legislative arena. We created a fact sheet and met with individual members of the Joint Budget Committee to educate them about what Coloradans were facing and the impacts of HCPF's leadership.

When HCPF leadership continued to understate the magnitude of eligibility system problems in presentations to the state legislature, a set of advocates, county representatives, and health care providers joined together to present information to the state's Joint Budget Committee.[16] The June 2024 presentation, kicked off by CCLP, identified where Colorado had landed due to poor planning, lack of prompt attention to issues identified by the public, and inadequate investment in the eligibility infrastructure.

Around the same time, CCLP shifted its focus to provide more public-facing information. In addition to testimony[17] provided to the Medical Services Board (the rulemaking body for HCPF) we began to publish

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[15] Legal Services in Colorado are chronically underfunded, especially compared to peers in Nevada, Wyoming, and New Mexico. https://www.coloradoaccesstojustice.org/legalaidfundinginthewest

[16] https://copolicy.org/news/facing-the-facts-advocates-present-to-the-jbc-on-glitch-plagued-phe-unwind/

[17] https://copolicy.org/news/phe-unwind-aug-2023/

more information on our website[18] and talk to reporters.[19] Once the Office of Civil Rights complaint was filed, we helped get the word out about it through print,[20] radio,[21] and television.[22]

Outcomes

Results worth celebrating

While the unwind of the Public Health Emergency was a challenging time for everyone—members, county workers, advocates, agency staff, and providers included—there were many positive results of the collective work to acknowledge.

The eventual pause of disability terminations helped to keep some of the most vulnerable Coloradans able to access their needed coverage. The allowance for increased processing time for applications continued through December 31, 2025. That extra time allowed the county workers and state vendors who processed various steps of the application or renewal to meet their deadlines and ensure that people weren't separated from their coverage due to problems outside of their control.

Further, many of the specific cases that ground-level advocates and CCLP were able to raise to department leadership were eventually processed appropriately, with those beneficiaries being reconnected with coverage. If that work had not been undertaken, both by the tireless advocates as well as the HCPF staff that responded, there would have been an increased loss of medical care, treatments, and perhaps even life.

The flexibilities the state applied for and received from CMS also had positive effects on the unwind process. Half of the flexibilities Colorado received helped increase our rate of automatic, or *ex parte*, renewals. Colorado also took steps to make renewals easier by allowing an authorized representative to sign an application, and by accessing federal databases to ensure correct contact information was available. The state also took advantage of two flexibilities that helped get those inappropriately removed from coverage back on. There is no question that each of these measures helped keep more Coloradans covered.

Another shift worth celebrating is the change in the narrative that eventually came from HCPF about the impacts of the unwind. After reports from the community, national data continuing to show just how poorly Colorado was performing, and pointed questions from legislators, the department shifted how they described the problems facing the state. Soon after CCLP filed our civil rights complaint, HCPF

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[18] https://copolicy.org/news/systemic-failure-in-colorados-phe-unwind/
[19] https://www.denverpost.com/2023/12/18/colorado-medicaid-coverage-review-pandemic/
[20] https://coloradosun.com/2024/02/28/medicaid-disabilities-civil-rights-complaint/
[21] https://www.publicnewsservice.org/2024-03-04/health/colorados-medicaid-insurance-terminations-seventh-highest-in-nation/a89144-1
[22] https://www.cbsnews.com/colorado/news/medicaid-mayhem-tech-problems-colorados-medicaid-delay-critical-money-disabilities/

launched a new website entirely dedicated to members with disabilities.[23] This site outlined the steps the department was taking to address what was admitted to be an enrollment crisis among this population. This increased transparency is ongoing, and HCPF continues to meet with advocates, case management agencies, and county staff on a regular basis. These meetings allow for the sharing of information, and the ongoing building of trust.

Among the most profound outcomes are the ongoing, regular meetings that continue to be held by the community that CCLP helped convene at the start of the unwind. These meetings remain a source of valuable information as we learn from advocates—many of whom are Medicaid enrollees themselves—who interact daily with Medicaid members seeking coverage and care. It has allowed CCLP to continue to identify concerning trends and raise them to HCPF or the Governor's office. It has also served as an outlet for advocates to express their frustrations and successes, as well as to learn from each other and recognize they are not alone in their experience. We periodically check in with meeting attendees to see if these convenings continue to have value and we have consistently heard a resounding *yes*.

Challenges that remain

Alongside these successes, there are still challenges that remain. The instability resulting from the crises that sprung from the unwind and the redesign of case management have yet to be fully resolved as of this publication. There remain inconsistencies across counties in how they process renewal documentation, how they manage their workflow, and even their access to technologies to automate more of their work. Backlogs continue in some counties, particularly in relation to steps in the disability process. Similarly, case management agencies often still struggle to meet the needs of their clients, even though many have worked through the majority of their backlogs. As new policies have been launched since the conclusion of the unwind, some case managers have struggled to keep up with them and the training required to advise their clients.

The state's technology platforms continue to be woefully inadequate and plagued with problems. Since the conclusion of the unwind, new problems within systems have cropped up, and many of the interoperability problems the unwind highlighted have not yet been resolved. One of the major hinderances to improving Colorado's technology is our state budget crisis. Costs are rising faster than the revenue our state is allowed to collect under TABOR. With TABOR's limits on what revenue the state can bring in, the legislature is forced to continuously make painful decisions about what to cut. There is no money to be spent to fix what is broken, which puts Colorado in a precarious position as it faces new challenges.

The state is already faced with a monumental shift with the passage of House Resolution 1, or HR1 on July 4, 2025. The requirements the law puts on states to change their renewal processes—not just in an increase of documentation required but also with an increase in frequency—will require technological changes that Colorado does not have the funds to pay for. Further, the law shifts significant costs from the federal government onto the states, forcing them to pay a bigger share to implement these programs. With these new changes coming around the corner, the recommendations we gleaned from the unwind are all the more important and necessary.

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[23] https://hcpf.colorado.gov/stabilizing-LTSS

Recommendations

While the details of Colorado's disenrollment crisis are unique to the unprecedented challenges of the COVID-19 pandemic, the lessons learned from this experience are broadly applicable. The CCLP team identified the following recommendations for facilitating future problem solving, applicable to both state and local government agencies, as well as to community advocates.

Recommendation No. 1: Conduct intentional, robust stakeholding

The most important and impactful lesson from the unwind is the need for decisionmakers to conduct intentional stakeholder engagement early in the consideration of any new policy or process. The partners invited must be diverse, ranging from Medicaid members, their families and caregivers, to those who play a role at every stage of the process—county workers and their leadership, case managers, representatives from the vendors carrying out the work, health care providers and clinics, and the state actors as well. The goal of stakeholder engagement should be multifaceted, not just running ideas by those gathered, but also providing them with opportunities to talk to and learn from each other. Ongoing, regular meetings can serve as a valuable pipeline to gather community knowledge, and expertise on a variety of topics from around the state. This information can then be used to identify systemic issues and develop broader solutions.

Recommendation No. 2: Engage in frank assessment of limitations

Before engaging in any effort to make changes, the state must engage in a frank assessment of its limitations. If there is shared understanding of what systems—be they technology platforms, enrollment processes, or communication methods—are able and unable to accomplish, it can help lead people to practical solutions much faster. It is necessary to be forthcoming about the weaknesses and challenges of the current systems in place, as this will allow the state and its stakeholders to actively plan for contingencies when things don't work as expected. Preparation on the front end for potential challenges that may arise leaves the state better prepared to weather the storms, and the stakeholders with more trust in their government.

Recommendation No. 3: Plan for data gathering and sharing

When approaching a new policy change, the state must actively consider what data they will need to gather to measure the outcomes of the change. The data should come from different sources, outside of the silos created to get the work done. Transparency is also key; stakeholders should be aware of what outcomes the state is measuring to ensure they are meeting their goals and staying true to their priorities. To that end, the planning process should establish the frequency and format of data sharing. Moreover, stakeholders should be given the opportunity to engage in that planning process. The sharing of data should be consistent and regular so that experts around the state are given the opportunity to learn from

the numbers. This also demonstrates a clear and steadfast commitment to transparency, ensuring data is shared in ways that allow for clear communication.

Recommendation No. 4: Stakeholders should use a variety of tools for advocacy

Advocates should consider a wide variety of tools and deploy them as needed. Direct advocacy for individual cases can result in better outcomes for those facing dire circumstances. Likewise, meetings with decision-makers can have a powerful impact. Raising issues with state personnel provides the state with direct insight into what is taking place on the ground and what Medicaid members are experiencing and hearing from various entities around the state.

These stories, alongside the big picture viewpoint that data can provide allow stakeholders to develop more informed and broader perspectives on the issues they are seeing. Data sources might include published resources by national advocacy groups, original research by local advocacy groups, or responses to open records act requests.

Legislative advocacy must also play a role, particularly in ensuring lawmakers are informed on what is taking place, how it is affecting their constituents, and what is behind those impacts. Testifying to legislative committees and providing fact sheets and other resources is both a proactive opportunity as well as a necessary defensive move. In the absence of enrollee perspectives, decision-makers face a knowledge gap that may be filled by opposition interested in crafting false narratives and one-sided appeals.

Communication with media and reporters can also be a valuable strategy, particularly when patients and stakeholders have little voice in the public sphere, or when important data isn't shared widely.

And finally, legal action, like the civil rights complaint CCLP filed with NHeLP, should not be avoided—particularly when repeated requests for action go unheeded. The state's responsibility as the single state agency in conducting their work is not a choice but a legal requirement. When the state fails to meet its obligations, it must be brought to task using all pathways available.

As the state must prepare itself to pivot when new things arise, so must advocates and stakeholders try out different strategies that respond to the current moment.

Appendix: Additional Resources

The following resources may be of use to advocates interested in more detailed information on CCLP's work. Past articles on the PHE unwind may also be found at copolicy.org/news. Please note that the specific details of some of the following resources may now be out of date, or specific only to the laws and regulations of the state of Colorado.

CCLP's Guide to Medicaid Appeals

A three-part guide to *pro se* appeals of Medicaid denials in Colorado, designed to help community members better understand their rights and how best to utilize these resources. These guides were updated based on the latest state policies and guidance as they were understood on July 1, 2025. Available in English and Spanish.

https://copolicy.org/resource/medicaid-appeals-guides-las-guias-de-apelaciones-de-medicaid/

Webinar Introduction to the Medicaid Appeals Guides

In this May 17, 2023, recording, CCLP Legal Director Katherine Wallat walks webinar attendees through the three Medicaid Appeals Guides. The recording references state policies as they were written in May of 2023. They have since been updated several times. Includes Q&A with attendees. Available in English and Spanish.

https://copolicy.org/resource/intro-to-medicaid-appeals-guides-intro-a-las-guias-de-apelacion-de-medicaid/

June 2024 presentation notes on the PHE unwind

On June 2024, CCLP Chief Legal and Policy Officer Bethany Pray joined a panel assembled by the Colorado Health Policy Coalition, to testify on the subject of the COVID-19 Public Health Emergency (PHE) Unwind. This presentation was made to the Joint Budget Committee of the Colorado General Assembly (Colorado's legislature.)

https://copolicy.org/resource/jbc-presentation-june-2024/

Issue brief: Medicaid eligibility and wages

In this July 2024 issue brief, CCLP Income and Housing Policy Director Charles Brennan illustrates, using Bureau of Labor Statistics data and KFF reporting, that upward changes in wages did not explain the high rates of Medicaid disenrollment in the state of Colorado during the PHE unwind.

https://copolicy.org/resource/issue-brief-medicaid-and-wages/