

Stretching the Safety Net

How Are Colorado's Providers Adapting
Amid Change and Uncertainty?

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Stretching the Safety Net

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EXECUTIVE SUMMARY

In 2020, Colorado's safety net providers faced a combination of challenges that left them financially vulnerable. These clinics — many of which were established to serve people who have faced historic and economic inequities — were weakened at a time when access to health care was vital for Coloradans dealing with the effects of a pandemic. And safety net clinics are anticipating that even more Coloradans will use their services because of lost jobs and economic struggles.

Safety net clinics of all types, many of which over the past seven years had ramped up capacity to serve newly insured people after the state expanded Medicaid in 2013 under the Affordable Care Act (ACA), recently grappled with a statewide decline in Medicaid enrollment of 11.7% from the peak. This represents a decrease of over 100,000 Coloradans between May 2017 and March 2020. The decline was due to a combination of immigration policies, economic conditions, and administrative changes on the part of Health First Colorado, the state's Medicaid program.

The decrease in patients with Medicaid and an increase in uninsured and underinsured patients cut revenue at many clinics. Clinics responded in a variety of ways, including making budget cuts, laying off staff, and ramping up fundraising efforts.

Then came the COVID-19 pandemic. Hundreds of thousands of Coloradans have lost jobs and wages, and clinics now are planning for an anticipated surge in patients that may have long-term implications for the safety net. This is all while still ensuring that those who already lost access to coverage don't fall through the cracks.

To understand the dynamics affecting Colorado's safety net clinics in 2020, the Colorado Health Institute (CHI) conducted mixed-methods research. CHI interviewed a variety of stakeholders and collected annual counts of patients by coverage source from five types of safety net providers. The data focus on the impacts of

changing volumes of Medicaid and uninsured patients from the perspective of safety net providers.

This report outlines the findings of that research and offers context about the current state of Colorado's health care safety net.

The first section analyzes the factors to which clinics were responding as 2020 began and includes new data about the mix of payers at safety net clinics between 2013 and 2019. The second section describes how these factors have frayed the safety net and affected clinics' responses to the COVID-19 pandemic.

Each section includes key findings, illustrative quotes from people involved in the safety net community, links to supplementary material, and policy questions to inform further discussion. The report concludes with a Safety Net Opportunity Matrix that highlights examples of policies and strategies that could support the resilience of Colorado's health care safety net.

Despite the new challenges brought about by COVID-19, safety-net providers remain dedicated to meeting the needs of their patients. There are numerous opportunities to shore up the state's safety net providers in the short and long terms. Strategies include supporting safety net operations, mitigating a backslide on oral health services, and addressing fear and disenfranchisement within immigrant communities.

PART 1: Before COVID-19

Growth and Decline of Medicaid Enrollment Affects Colorado's Health Care Safety Net

The health care safety net is complex and dynamic. Safety net providers are constantly adapting to meet the health care needs of the Coloradans they serve. Many clinics originated as a response to a local community's health needs and have evolved with those communities. Clinics are sensitive to shifts within the broader health care system, the economy, and the policy environment. For example, many clinics have expanded beyond health care to provide connections to food, housing, and other social needs.

Colorado's health care safety net clinics serve hundreds of thousands of Coloradans who experience inequities that create barriers to health care. Many of these inequities are rooted in historic policies and discrimination that have kept people in poverty. People who are likely to use the safety net include those who have limited incomes, are covered by public health insurance — such as Medicaid — or lack health insurance altogether. They may be privately insured but unable to pay their deductible; live in a geographically isolated location; or face cultural, language, or other social barriers — such as immigration status — to accessing care.

Several types of providers — such as hospitals, private practices, or some local public health agencies — could be considered part of the health care safety net. This report focuses on five types of providers in particular: Community Mental Health Centers (CMHCs), Community Safety Net Clinics (CSNCs), Federally Qualified Health Centers (FQHCs), certified Rural Health Clinics (RHCs), and School-Based Health Centers (SBHCs).¹ (See the box on page 6 for descriptions of these clinics.)

CHI found that these clinics served at least 1 million Coloradans in 2019 — almost one in five of the state's residents. This is likely an underestimate, as not all safety net clinics are represented in the data. (See the box on page 7 for more information on methods.)

Funding from public insurance programs plays a crucial role for safety net clinics. Medicaid and, to a lesser extent, Medicare and the Child Health Plan Plus (CHP+), are major sources for safety net clinics.

Many safety net clinics have to identify additional revenue to fulfill their mission of providing services to people without insurance or who are underinsured.

Medicaid is an especially important revenue source for FQHCs and RHCs. These two types of clinics receive payments from Medicaid and Medicare based on the cost of care provided to the patient — a payment approach called cost-based reimbursement. This is in contrast to other providers and clinics that receive reimbursement from Medicaid based on a fee schedule established by Health First Colorado.

Safety net providers often piece together funding from a variety of sources to serve Coloradans who are uninsured or who are unable to afford the out-of-pocket expenses of private coverage — a circumstance known as underinsurance. Many patients pay a portion of the visit cost according to a sliding fee based on their income. FQHCs receive federal grants to serve patients who are uninsured. The Colorado Indigent Care Program reimburses providers for a portion of uncompensated care provided to eligible patients without insurance. A state program called the Primary Care Fund — supported by taxes on tobacco products — provides grants to clinics serving Coloradans who lack insurance and have low incomes. And many safety net clinics rely on fundraising, donations, and other local grants to cover the costs of serving Coloradans with little or no coverage.²

Medicaid has grown rapidly as a source of coverage for Coloradans for the past two decades. Enrollment hovered at or below 400,000

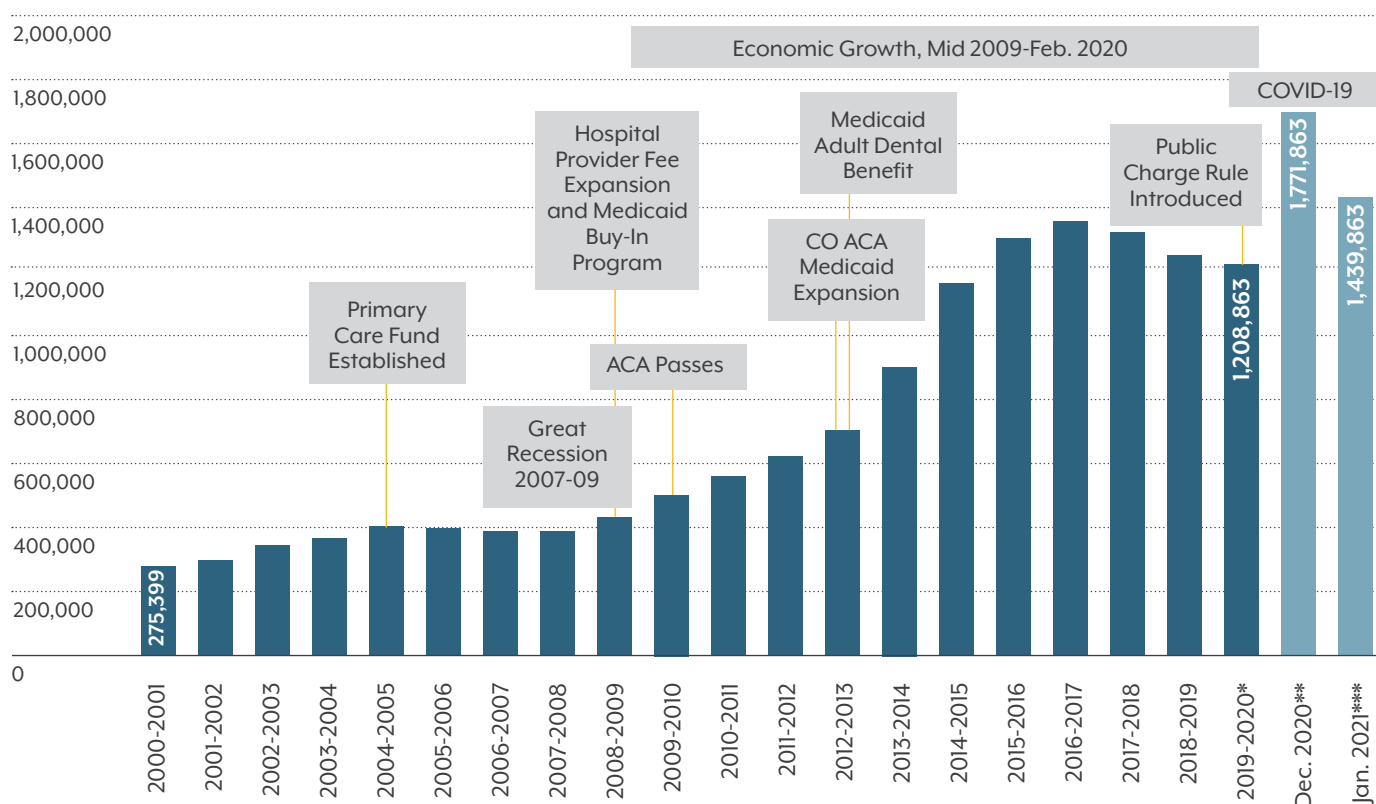
until 2008-09, when it began inching toward 500,000 as a result of economic recession and financing for expansion. Growth accelerated following the passage of the ACA in 2010, and in 2013, when Colorado's legislature expanded Medicaid eligibility to adults who previously had not qualified. As a result, the state's uninsured rate fell to an all-time low of 6.5 percent, though some areas of the state have significantly higher rates. Enrollment in Medicaid reached 1 million members in April 2014 — almost one fifth of the state's population — and peaked at 1,369,103 in May 2017.^{3,4}

Of the estimated 361,000 uninsured Coloradans in 2019, the health care safety net served roughly 60%.⁵

Beginning in 2014, most safety net clinics increased outreach and efforts to enroll eligible Coloradans in Medicaid and other programs. Many expanded their facilities and increased staffing to meet the health care needs of the newly insured.

But in 2017, trends in enrollment started shifting, and clinics had to adjust to a new decline in enrollment.⁶ By March 2020, average Medicaid enrollment for the state fiscal year (FY) 2019-20 stood at 1,208,863, an 11.7% drop from its peak in May 2017.⁷ Figure 1 displays annual changes in Colorado's Medicaid enrollment since 2000 — and projections moving forward — with key milestones highlighted.

Figure 1. Medicaid Caseload, Projections, and Key Policy Milestones, Colorado, 2000-2021⁸



Source: Caseload figures and projections from the Colorado Department of Health Care Policy and Financing (HCPF)

* July 2019-March 2020

** PROJECTED: Assumes April 2020 caseload in addition to HCPF's projection of 563,000 new members who will join throughout 2020.

*** PROJECTED: Assumes federal maintenance of effort ends with federal public emergency period on Dec. 31, 2020. HCPF estimates 332,000 members will not meet eligibility criteria as of Dec. 31, 2020.

What Is the Health Care Safety Net?

The “safety net” is a term used to describe the providers and clinics offering medical, dental, and behavioral health care to people who have low incomes, are uninsured or underinsured, or enrolled in publicly funded health insurance programs, regardless of their ability to pay. This report focuses on five types of providers. The services listed by each are not intended to be exhaustive; clinics provide a variety of services addressing other patient needs such as home visitation, enrollment services, and connection with food, housing, and other social supports.⁹

Community Mental Health Centers

(CMHCs): Provide outpatient, emergency, day treatment, and partial hospital mental health and substance use disorder services for residents of designated geographic service areas with low incomes. Colorado has 17 CMHCs, most of which operate multiple clinical sites.¹⁰

Community Safety Net Clinics (CSNCs):

Offer free, low-cost, or sliding-fee primary care services for people who have low incomes, are uninsured or underinsured, and/or are enrolled in Medicaid. Can include faith-based clinics, clinics serving children or other specific populations, those staffed by volunteer clinicians, stand-alone dental clinics, and family practice residency clinics. Services can include physical, dental, and behavioral health services, depending on the clinic. Colorado has approximately 40 CSNCs, some of which operate multiple locations.¹¹

Federally Qualified Health Centers (FQHCs), also known as Community Health Centers:

Provide primary care, including preventive physical, dental, and behavioral health services. Located in medically underserved areas and among medically underserved populations. FQHCs receive federal grant funding as well as cost-based reimbursement from Medicaid and Medicare. Colorado has 20 FQHCs that operate over 200 clinic sites.¹²

Rural Health Clinics (RHCs): Provide primary care and additional services differing by clinic. Located in non-urban areas with medically underserved populations and/or documented



shortages of health care providers. Colorado has 53 RHCs with a specific federal certification allowing them to receive cost-based reimbursement from Medicaid and Medicare.¹³

School-Based Health Centers (SBHCs):

Provide primary health care services in schools with many children from households with low incomes. These include immunizations, well-child checks, sports physicals, mental health care, chronic care management for conditions such as asthma and diabetes, and acute medical care. May also provide dental care, reproductive health care services, substance use disorder services, and violence prevention. A SBHC is often a partnership between a school, school district, and a medical sponsor such as a CSNC or FQHC. Colorado has 63 SBHCs.¹⁴

Sources and Methods

CHI conducted both qualitative and quantitative research to address five guiding questions:

- To what extent are safety net providers seeing changes in their patients' coverage source (also called payer mix) from 2013 to the present?
- What is the relative contribution of different factors to changes in payer mix?
- What is the impact of these factors on patients and their ability to access care that they need?
- What is the range of approaches clinics are taking to adjust to these conditions?
- In what ways has the COVID-19 pandemic affected clinics? What changes have clinics made due to COVID-19 and the economic downturn?

In March and April 2020, CHI conducted phone interviews with 25 key informants including safety net clinic administrators, clinicians, patients, patient advocates, associations representing safety net clinics, and other stakeholders. The interviewees were chosen to ensure representation by type of clinic as well as representation among clinics serving rural areas, immigrants, and a variety of age groups. Some interviews were conducted in Spanish and translated to English. CHI collected additional qualitative data from survey questions included in the forms on which a limited number of RHCs and CSNCs submitted their quantitative data.

To assess changes in the coverage composition of safety net clinics' patients prior to the COVID-19 pandemic, CHI worked with clinics and clinic associations to obtain data on annual unduplicated patient counts by payer between 2013 and 2019. CHI chose 2013 as the baseline because it was the year immediately preceding Colorado's implementation of the ACA Medicaid expansion and establishment of the health insurance marketplace, Connect for Health Colorado. Data for 2020 were not available because of the timing of data collection early in the year.

Quantitative sources and considerations include:

- CMHCs: The Colorado Behavioral Healthcare Council provided statewide counts for 2014-2019 for all CMHCs. Data for 2013 were not available.
- CSNCs: In partnership with the Colorado Safety Net Collaborative, CHI collected patient counts directly from clinics. Out of 42 CSNCs participating in the Collaborative, 11 responded.*
- FQHCs: The Colorado Community Health Network (CCHN) provided counts for 2013-2019 for all FQHCs. The data exclude one provider designated as an "FQHC look-alike" that had previously been a CSNC. This designation allows the provider to receive cost-based reimbursement from Medicaid and Medicare but not federal FQHC grant funding.
- RHCs: In partnership with the Colorado Rural Health Center (CRHC), CHI collected patient counts directly from clinics. Out of 53 RHCs, seven clinics responded.*
- SBHCs: Of the 63 SBHCs open in 2019, 38 had an FQHC that served as medical sponsor. Patients from these 38 clinics are included in the FQHC patient counts described above. To avoid double-counting, CHI compiled aggregate data from 17 SBHCs sponsored by non-FQHC organizations. The two data sources were 1) survey data collected from SBHCs by CHI and the Colorado Association for School-Based Health Care (CASBHC) for the years 2013-2016; and 2) aggregate counts for the years 2017-2019 in coordination with the Colorado Department of Public Health and Environment, CASBHC, and Apex Evaluation. A few SBHCs were not included due to incomplete data.

**CSNCs and RHCs were offered financial assistance to defray the costs of compiling and submitting data. Despite the financial assistance, the relatively low response rate from CSNCs and RHCs is likely due to the unanticipated timing of soliciting data during the initial stages of the COVID-19 pandemic. CHI consulted with CRHC to ensure the sample of clinics was representative of all RHCs. The 26% of CSNCs that responded represent a self-selected cross-section of the wide variety of CSNCs in Colorado.*

Safety Net Providers Identify the Pre-COVID Drivers of Enrollment Changes

Many safety net providers witnessed the decrease in Medicaid patient volume accompanied by an increase in uninsured and private insurance volume. A 2019 research brief from the Colorado Center on Law and Policy (CCLP) identified two primary drivers of the drop: a “chilling effect” of changes in immigration policy and rhetoric on enrollment, and changes in Colorado Department of Health Care Policy and Financing (HCPF) administrative policies. The brief also explored rising employment rates as a third potential driver.

While CCLP did not find an association between employment rates and Medicaid enrollment, the brief described a need to further explore the impact of a minimum wage increase Colorado voters passed in 2016 and that went into effect in 2018.¹⁵

Safety net clinics also identified these three factors as the primary drivers of the decline in patients with coverage through Medicaid. The extent of the impact of each factor varied from clinic to clinic. Most clinics do not have a systematic way of assessing the reasons people drop off Medicaid, so their responses are primarily based on their staff’s interactions with patients. Figure 2 outlines how safety net clinics described the factors affecting Medicaid enrollment.

Diagram 1. Safety Net Clinics Report Intersecting Drivers of Changes in Patient Mix

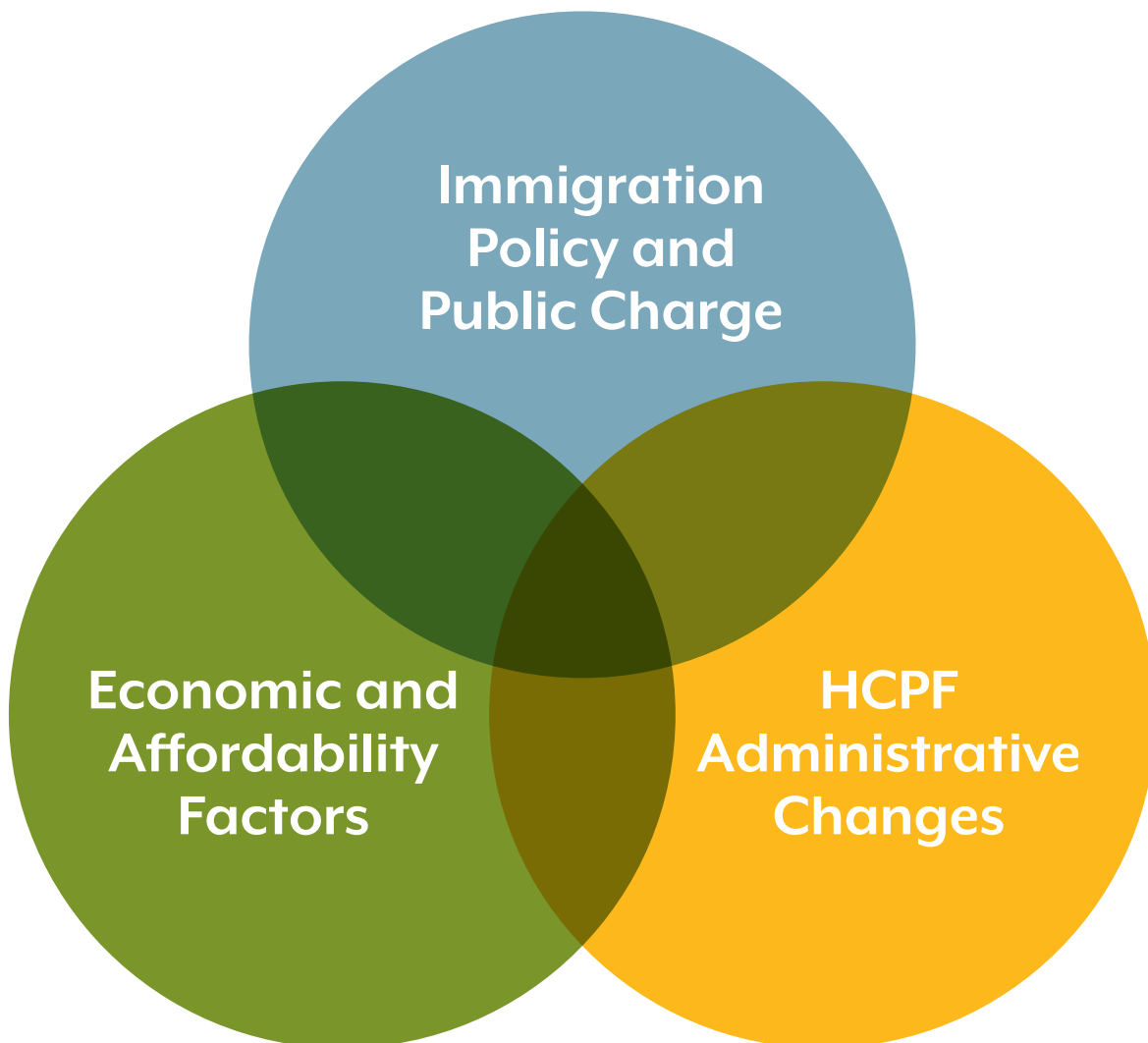


Figure 2. Three Key Factors Drove Medicaid's Enrollment Decline Through Early 2020

Immigration Policy and Public Charge

Immigrants and mixed-status families and households — in which some members are immigrants and others are not — are often reluctant to enroll in public programs. Some with family members who lack legal documentation fear their information will be shared with immigration agencies and lead to a family member's deportation. In addition, a recent change in the public charge rule could block lawfully present immigrants from getting or renewing permission to live and work in the U.S. if they have enrolled in Medicaid or other public programs.^{16,17}

Key Findings:

- Fear is motivating some immigrant families to disenroll from public programs or not enroll in the first place.
- This phenomenon seems to have affected a variety of safety net clinics. Many of these clinics have a larger proportion of patients who are immigrants due to providing culturally responsive care and services in their language.
- It is unclear the extent to which families forgo needed care altogether because of fear.
- A number of clinic representatives believe that the Trump administration's immigration and refugee policies have had a chilling effect on enrollment as far back as 2017.

Community Voices and Voices of the Safety Net:

"We have noticed that when patients are screened during intake for Medicaid eligibility and referred to enrollment specialists, they have been declining enrollment services at a higher rate, particularly in [the six weeks prior to the interview in March 2020], which is entirely due to growing uncertainty and fear related to public charge."

— La Clinica Tepeyac, FQHC in Denver

"People feel more pride around not getting something for 'free from the government' and so will go without Medicaid willingly sometimes. There is also a lot of both annoyance and fear around privacy being infringed that is related to the hoops you must jump through to get services as well as public charge-related issues." — Lake County Build-a-Generation, a community advocacy organization in Leadville

"Our outreach and enrollment workers report daily that people don't want to get their citizen child enrolled. They used to hear this on a monthly basis, but now they hear it daily." — Mountain Family Health Centers, a Glenwood Springs-based FQHC

Key Questions:

- To what extent do patients forgo needed care because of fear?
- Do people who dropped their Medicaid coverage continue to seek care at their medical home?
- How can clinics help immigrants and their families access care when needed?
- Are clinics still seeing patients who were formerly covered by Medicaid but are now uninsured? To what extent is this sustainable for the clinic?
- What are long-term consequences of the chilling effect?

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Economic and Affordability Factors

Economic conditions such as a change in wages or employment cause people to “churn” on and off public coverage as their eligibility changes. Rising wages can disqualify people for Medicaid, and although some may become eligible for financial assistance through Connect for Health Colorado to pay for private insurance premiums, they might not be able to afford the out-of-pocket costs. People may not have sufficient options for affordable private coverage that allows them to access needed care.

Key Findings:

- As wages increased in the pre-pandemic economic boom, some people became ineligible for Medicaid. One clinic indicated that the increases in Colorado’s minimum wage since 2017 also caused some to become ineligible.¹⁸
- Rural safety net providers tend to be particularly vulnerable to changing economic factors at the local and state levels.
- Most safety net clinics — especially those in rural areas — cite the lack of affordable private health insurance as a contributor to increasing numbers of patients without insurance. Some safety net clinics in mountain resort areas support local employer-based initiatives aimed at creating more affordable coverage options for residents in these communities. Examples include the Peak Health Alliance in Summit County and Valley Health Alliance in the Roaring Fork Valley.¹⁹
- Many CSNCs do not accept private insurance, so obtaining that type of coverage means patients have to find a new provider.
- The rising cost of living, including food and housing, makes it harder to afford coverage.
- Some of those who are ineligible for Medicaid may remain uninsured because they cannot afford private coverage. Others may purchase a plan with a high deductible that they can’t afford. Clinics consider the second group to be underinsured.
- Some clinics charge patients on a sliding scale when they cannot afford their copay or deductible, essentially treating them as though they do not have insurance at all.
- Clinics serving high-cost mountain resort areas report that many people make too much to qualify for Medicaid or financial assistance through Connect for Health Colorado but do not make enough to afford private insurance, which is particularly expensive in these regions.
- Many rural areas have less economic diversification than urban areas, so when a particular industry is hit hard — a mine closes or the price of commodities falls — workers go uninsured and have difficulty affording care.

Community Voices and Voices of the Safety Net:

“It’s a repeating cycle of Medicaid patients consistently going to a clinic and improving health outcomes. The healthier Medicaid patient then secures employment or a better job than before because they feel better. Then, they lose their Medicaid because they make slightly more than before (in one patient’s case it was a difference of \$40).”— Heartlight Family Clinic, a CSNC in Castle Rock

“The biggest change was as the minimum wage goes up, people start falling off of Medicaid. It’s happened to employees that work for me. They both fell off. That was a year and a half ago.” — a CSNC in a rural area

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“We saw a Medicaid spike where there were job losses due to a coal mine closing and coal-fired transmission site closing. It had a ripple effect in the community due to layoffs.” — Basin Clinic, an RHC serving the Western Slope

“Rural communities have not had similar economic gains as urban communities and are still struggling. People have to make choices to pay housing and food vs. insurance.” — Colorado Rural Health Center, an association representing RHCs

Key Questions:

- What are the demographic and geographic characteristics and health needs of people likely to lose eligibility for Medicaid and become uninsured or underinsured?
- To what extent did wage increases cause people to lose eligibility for affordable health insurance options?
- What options exist for people to access care when they become ineligible for Medicaid?
- To what extent will local initiatives like the Peak Health Alliance or the Valley Health Alliance address the affordability of coverage in high-cost areas?



HCPF Administrative Changes

The Department of Health Care Policy and Financing (HCPF), which administers Colorado’s Medicaid program, has made a number of changes to its administration of Medicaid in the past few years. The biggest change occurred in July 2018 when HCPF launched the second phase of its effort to reform how services are delivered and paid for in Medicaid, called the Accountable Care Collaborative (ACC). ACC Phase II replaced Regional Collaborative Care Organizations (RCCOs) with Regional Accountable Entities (RAEs), which are contracted to continue coordinating members’ physical health care needs and took over management of behavioral health care needs previously managed by Behavioral Health Organizations.²⁰

The same year, HCPF tightened its policy on returned mail. The revised policy allows HCPF to disenroll a member after one piece of mail is returned by the postal service as undeliverable and the department is unable to contact the individual. The previous policy was disenrollment after three pieces of returned mail.^{21,22} The updated policy was aimed at avoiding making improper payments on behalf of ineligible individuals while reducing the administrative burden on county human services offices. It was also in response to increased pressure on and guidance from the U.S. Centers for Medicare and Medicaid Services (CMS) to state Medicaid agencies.^{23,24}

Key Findings:

- Some stakeholders point to the returned mail policy, other administrative changes related to enrollment, and increased pressure from the federal government in the form of eligibility audits of HCPF as contributing to the decrease in enrollment. Some clinics and community partners have taken to contacting people who were disenrolled to verify that they knew they were disenrolled.
- Some CMHCs point to a variety of changes related to the establishment of the RAEs — such as arrangements that RAEs established with providers to reimburse for behavioral health services or how behavioral health reimbursement rates are calculated — as affecting revenue and potentially impacting their ability to provide a full array of services to Medicaid members.
- Administrative rule changes have made it harder for people to enroll or re-enroll in Medicaid. One safety net clinic linked the impact of this change to housing instability: When families “double up” to make rent more affordable, their mail does not always follow. They often do not realize they have been disenrolled until they seek services.

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Voices of the Safety Net:

“Prior to COVID-19, safety net providers were dealing with a decline in Medicaid enrollment that was a challenge. That trend, when combined with other reductions in system funding for the full behavioral health continuum of care and the movement of key contracts to the RAEs, has made managing the health care safety net issues more challenging and complicated.” — Axis Health Systems, an FQHC and CMHC in southwest Colorado

“Medicaid doesn’t clearly communicate with patients when they lose their health care coverage, and so many patients don’t even know they have lost their health care coverage until the day before or day of an appointment [when] their coverage eligibility is confirmed by the clinic.” — Heartlight Family Clinic, a CSNC in Castle Rock

“At the federal level, there’s a lot of pressure on the Medicaid department to make sure everyone is qualified and meets all the criteria — a lot of pressure to make sure everyone with public benefits is quadruply qualified to be on it.” — Every Child Pediatrics, a CSNC operating clinics and SBHCs in the Denver area, Fort Collins, Basalt, Cortez, and Dolores.

Key Questions:

- What is the right balance of ensuring accurate enrollment records while also ensuring those who are eligible aren’t disenrolled?
- What data exist to track what happens to people who become disenrolled?
- To what extent should communication policies be reviewed or revised to ensure people receive proper notification of disenrollment from Medicaid?
- What effect has ACC Phase II had on access to needed behavioral health services among Medicaid members?

HCPF conducted an analysis looking at the public charge and churn. The department found that, among people likely to be impacted by the public charge, children had higher disenrollment rates than adults. The analysis did not find movement from Medicaid to CHP+ among children and pregnant women, which would have suggested that people were disenrolling due to improved income, since families have to make more money to qualify for CHP+ than Medicaid. HCPF advised caution in interpreting the findings, as the analysis did not establish direct causal connections between these factors and declining enrollment.²⁵

There are many other factors that influence the mix of patient-related revenue at safety net clinics, particularly in rural areas. For example, when another provider in the community limits the number of patients who are uninsured or covered by Medicaid or Medicare — or goes out of business altogether — more patients will seek services at the safety net clinic. A few rural clinics mentioned changing demographics. Relatively isolated

communities are aging, so they are seeing more patients with Medicare, which imposes its own set of administrative and reimbursement challenges. Some of the patients have been uninsured for a long time, so when they become eligible for Medicare, they have pent-up need for services. A final factor is that when a new provider opens, some patients may seek services at the new facility, or be attributed — in other words, assigned — to the provider through a HCPF process to connect members to a primary care provider.

Revenue and Patient Numbers Shift Rapidly

In spring 2020, safety net providers shared quantitative data with CHI that illustrate how these trends in enrollment have affected patient volume. (See the box on page 7 to learn more about CHI’s data collection methods, sources, and which clinics were included.)

When the state expanded Medicaid in 2014 under

Figure 3. Growth In Patients Served By Colorado's Safety Net Outpaced Population Growth Between 2014-2019 ²⁶

	2014	2015	2016	2017	2018	2019	Growth 2014-2019
Safety Net	775,943	842,235	913,752	961,595	984,942	1,007,078	+ 29.8%
Colorado	5,352,866	5,454,707	5,542,951	5,616,567	5,694,311	5,769,985	+ 7.8%

Source: CHI analysis of safety net payer mix data and Colorado State Demography Office data.

the ACA, Colorado safety net providers reported serving an estimated 776,000 Coloradans (see Figure 3). This number grew steadily to over a million Coloradans in 2019 – a 30% increase in just five years. That means close to one in five Coloradans was served by the clinics represented in the data. The number of safety net patients served is likely an underestimate, given that data from many RHCs and CSNCs were not available for the analysis.

The growing volume of safety net patients dramatically outpaced the state's 7.8% population growth estimated between 2014 and 2019 (see Figure 3). The growth in the safety net is also due to a combination of factors affecting supply and demand. First, the safety net has grown to meet increasing demand for services associated with behavioral health, an aging population, and the increased prevalence of chronic diseases such as diabetes and asthma.²⁷ To meet some of the unmet demand, the legislature in past years allocated limited state funds to increase safety net capacity, including an annual line item in the state budget to expand SBHC programs. A number of Colorado philanthropies have provided support for expanding access to behavioral health services in particular.^{28,29} And some of Colorado's FQHCs have been awarded federal "new access point" grants created by the ACA to expand the reach of these providers.³⁰

The growth was further spurred by an increase in patients with Medicaid. Figure 4 shows that Medicaid patient volume in safety net clinics followed a similar trajectory as the overall Medicaid caseload. (See Figure 1.) Volume grew substantially after 2014, peaked in 2017, and gradually declined.



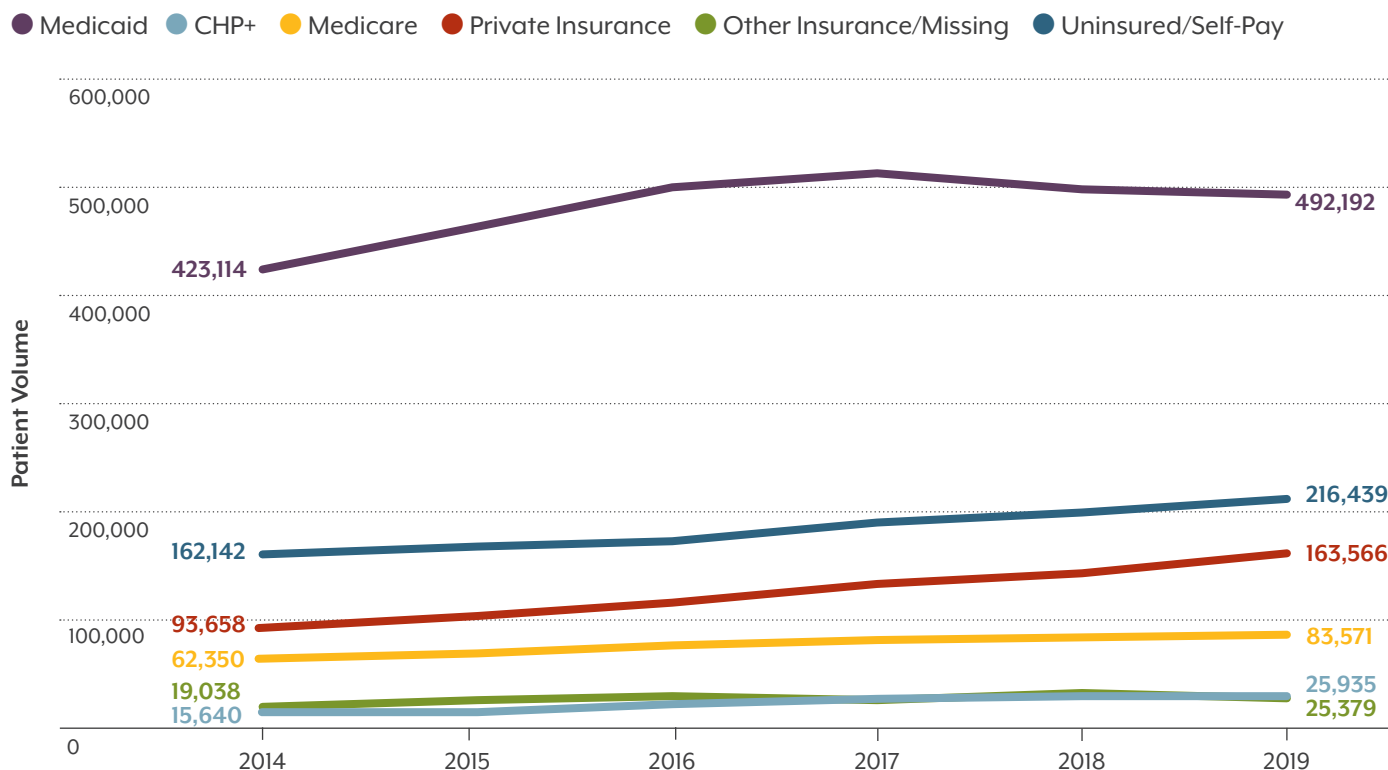
The number of patients with private insurance, Medicare, and CHP+ also grew steadily but did not decline after 2017. This may be due to people aging into Medicare, as well as the establishment of the state's health insurance marketplace, Connect for Health Colorado.

The marketplace allowed more people to buy private health plans. But safety net clinics consider an increasing number of privately insured patients to be underinsured, meaning that they cannot afford their copays and deductibles. Safety net clinics would consider a proportion of the privately insured patients displayed in Figure 4 to be underinsured, but they do not consistently collect underinsurance data, so the size of that proportion is unknown.

Since revenue from Medicaid, grant funding, and fundraising allows many clinics to keep their doors open, the drop in Medicaid over the past four years and an increase in uninsurance and underinsurance put some clinics in a challenging financial situation. The drivers and implications of these trends are discussed later in the paper.

Figure 4. Medicaid Patient Volume Peaked in 2017 and Then Declined, While Private Coverage and Self-Pay Grew

Patient Volume by Payer, Health Care Safety Net Providers, Colorado, 2013-2019



Source: CHI analysis of data collected from Colorado safety net providers. For more information, see Sources and Methods box on page 7.

As Medicaid enrollment began to decrease in 2017, many clinics reported an increase in the number of patients who were uninsured. The number of safety net patients lacking insurance increased from 162,142 in 2014 to over 200,000 patients in 2019. The two trends are likely related: People who had been enrolled in Medicaid may now be without coverage. Or they may have purchased a private plan with a deductible they could not afford. The consequence for clinics is that fewer of their patients are able to pay for the services that they provide.

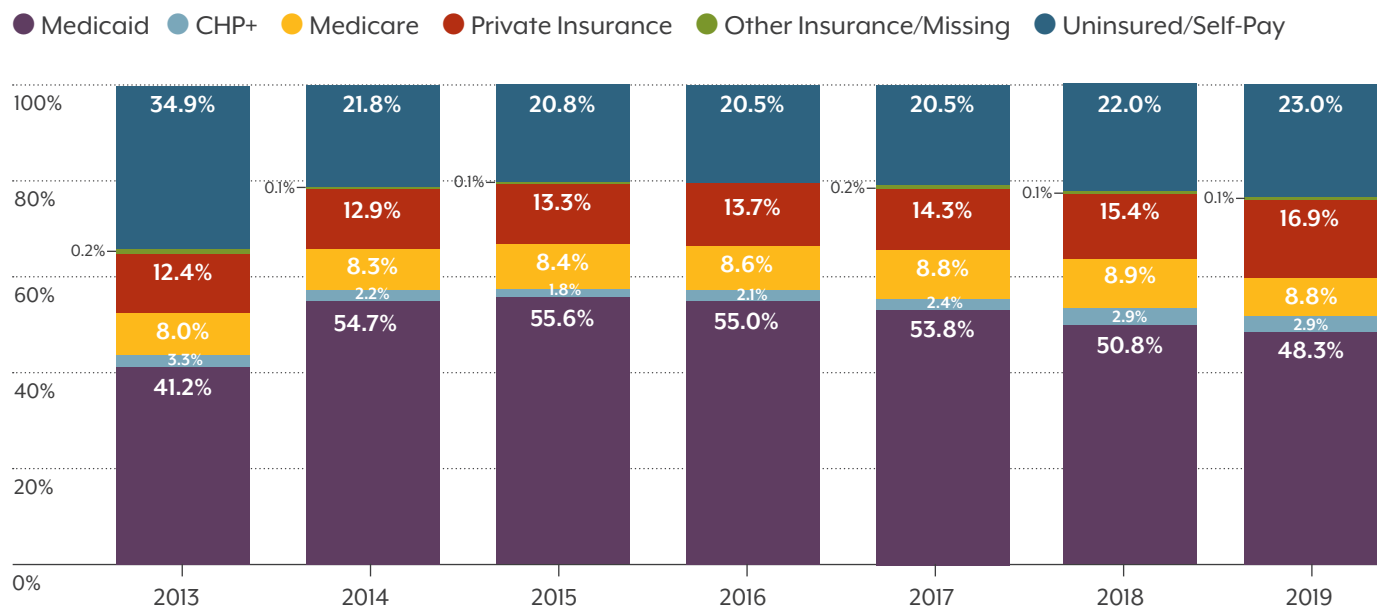
In 2019, the proportion of safety net patients who lacked insurance reached its highest point (23%) since the ACA took effect (see Figure 5). The year 2019 also marked the first time since the expansion of Medicaid through the ACA that fewer than half of safety net patients were on Medicaid. It also was

the year the safety net clinics saw the highest share of patients enrolled in private insurance.

The 2019 Colorado Health Access Survey (CHAS) did not show a statistically significant change from 2017 in either the proportion of Coloradans who were uninsured or covered by Medicaid. But since so many safety net patients are uninsured or enrolled in Medicaid, smaller fluctuations might be more noticeable in their figures. Safety net clinics also serve patients that the survey cannot reach, such as people experiencing homelessness, or who may be less inclined to respond to a survey, such as immigrants lacking legal documentation. The 2019 CHAS did find, however, that the uninsured rate among Hispanic/Latinx children rose from 2.7% in 2017 to 7.9% in 2019, which could reflect changes in enrollment due to immigration policies described previously.³¹

Figure 5. The Proportion of Safety Net Clinics' Patients Covered by Medicaid Dropped Below Half in 2019, A First Since ACA Expansion

Safety Net Payer Mix (Percentage), Colorado, 2013-2019



Note: Figure 5 does not include CMHCs as there was not complete data for 2013 for these clinics.

Figure 6 displays the payer mix over time among the five types of clinics included in this brief. Commonalities across most clinic types include:

- Growth in the proportion of Medicaid patients through 2017, followed by a decline in 2018 and 2019;
- Declines among uninsured patient volume through 2017, followed by an increase in 2018 and 2019; and
- Growth in the proportion of patients covered by private insurance.

It is important to note that not all clinics or regions of the state experienced these trends to the same degree, or at all. For example, RHCs often have higher proportions of Medicare patients, which mirrors the relatively older communities they serve. SBHCs and some CSNCs, which serve children, have higher proportions of Medicaid and CHP+ coverage and no Medicare patients. And some CSNCs only serve people without insurance.

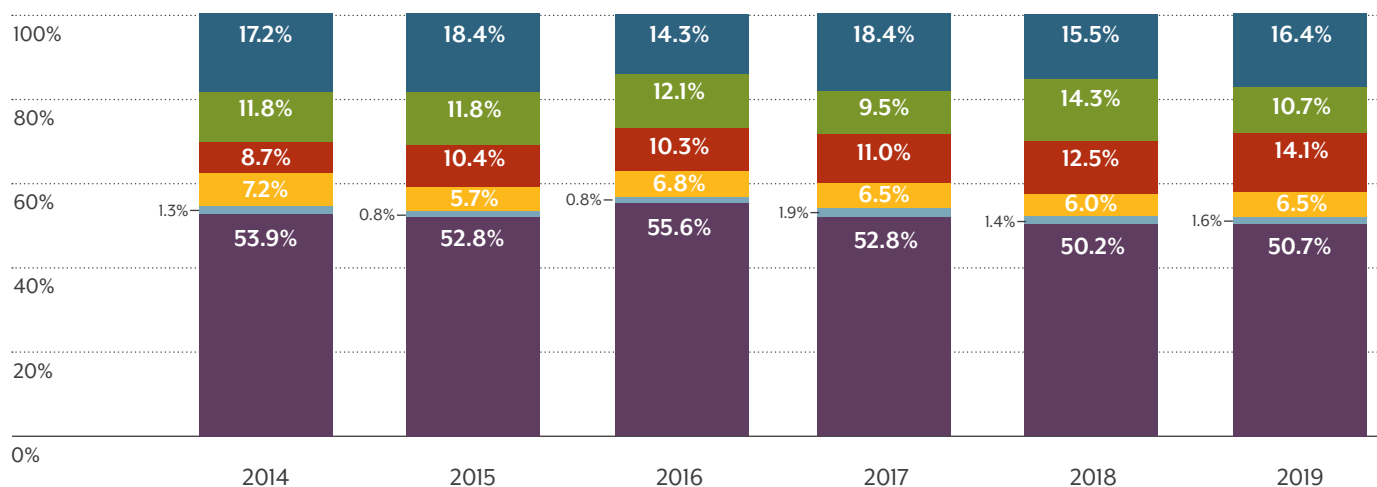


Figure 6. Different Types of Safety Net Clinics Experienced Similar Payer Mix Changes

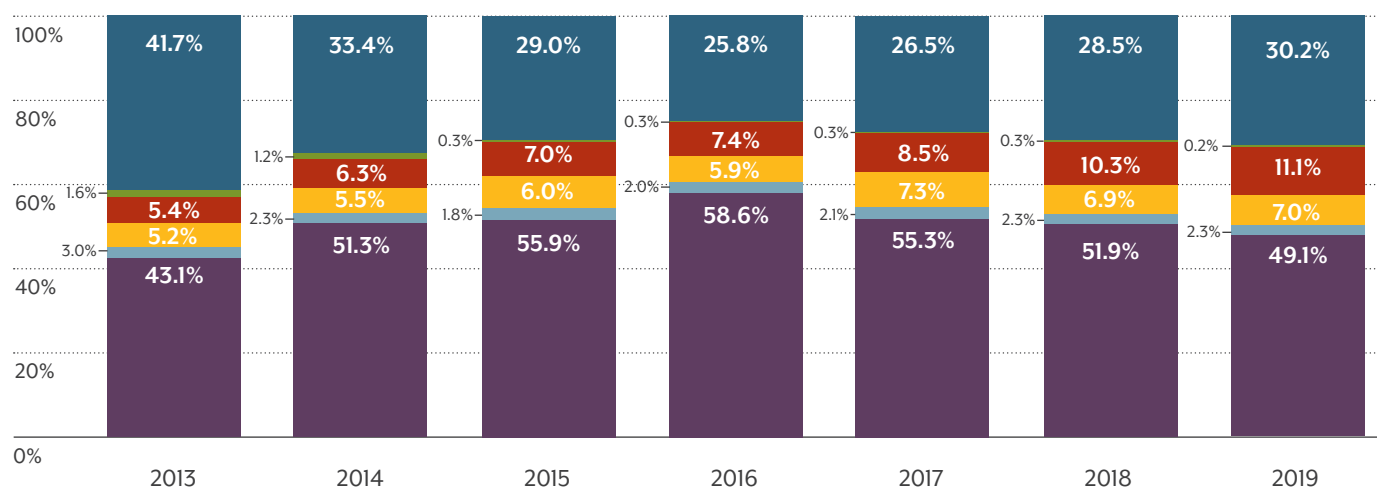
Payer Mix by Type of Safety Net Clinic, Colorado, 2013-2019

Medicaid CHP+ Medicare Private Insurance Other Insurance/Missing Uninsured/Self-Pay

Community Mental Health Centers*



Community Safety Net Clinics**



*2013 data unavailable for CMHCs. See the endnotes for further information about how CMHC categories were grouped.³²

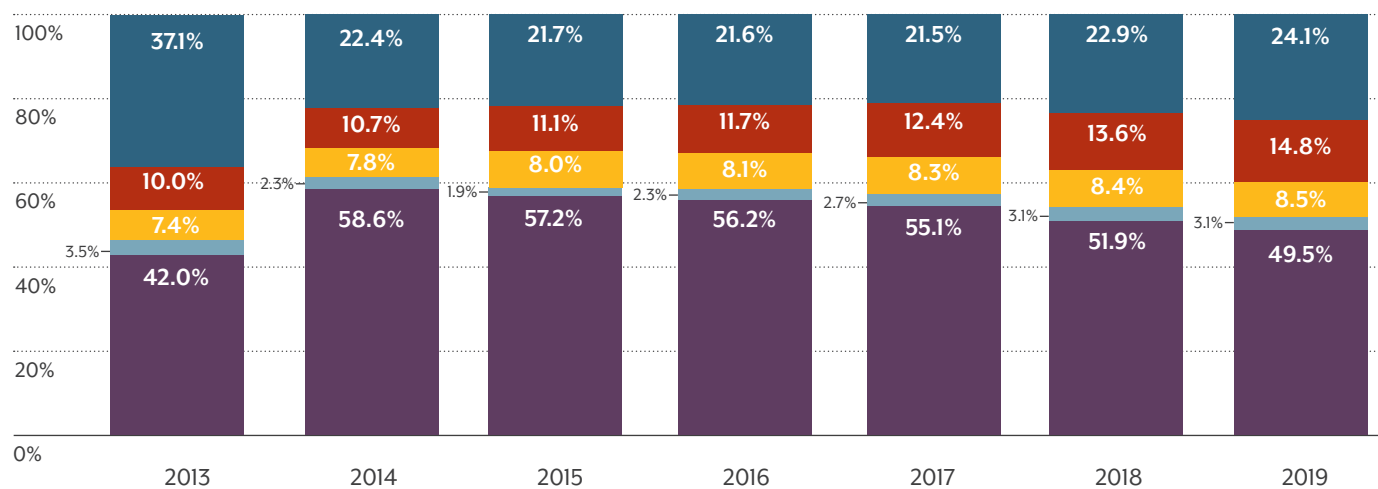
**Graph reflects the 11 CSNCs for which data were available. Most CSNCs only serve patients without coverage or who are enrolled in Medicaid. The proportion of privately insured patients is attributable to two larger CSNCs that accept private coverage.

***Graph reflects the seven RHCs for which data were available. Medicaid and CHP+ were combined in RHC reporting.

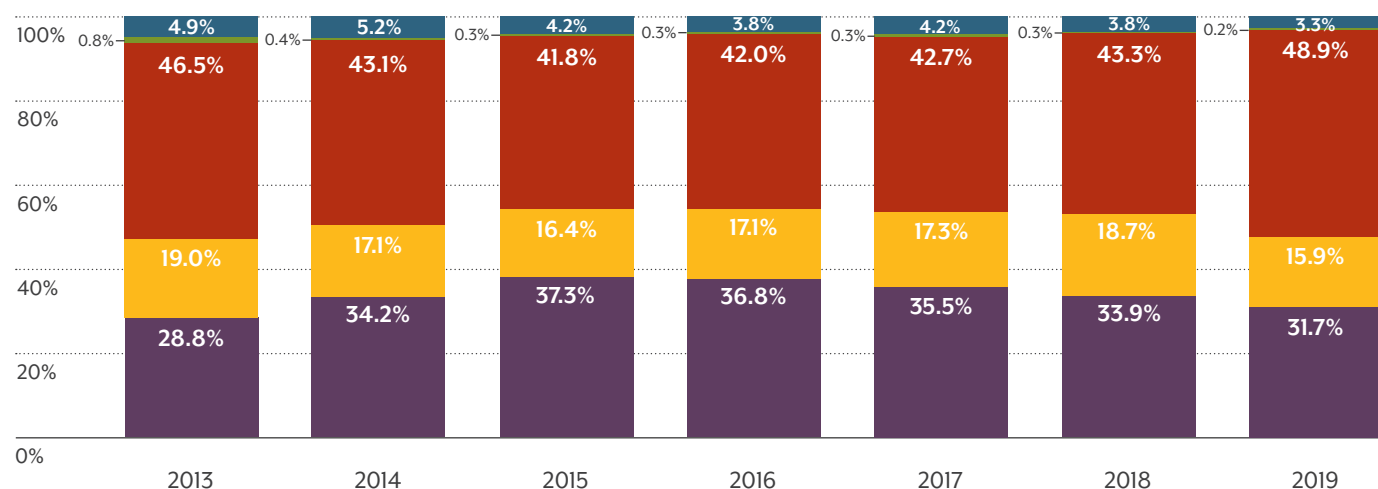
****Graph reflects 17 SBHCs that are not sponsored by a FQHC. FQHC-sponsored SBHCs are included in the FQHC graph. Data were not available for five SBHCs. The large proportion of "Other/Missing" in 2017 is likely due to changes in data collection and reporting that year.

● Medicaid
 ● CHP+
 ● Medicare
 ● Private Insurance
 ● Other Insurance/Missing
 ● Uninsured/Self-Pay

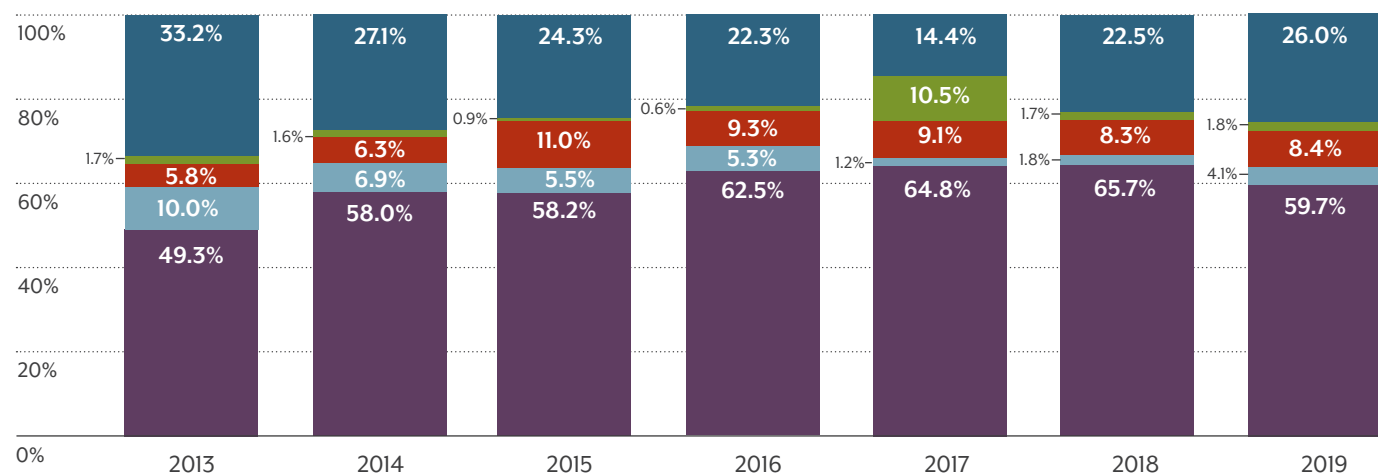
Federally Qualified Health Centers



Rural Health Clinics***



School-Based Health Centers****



Key Questions:

- Where do patients seek care if they are not connected to a medical home?
- To what extent did hospital emergency departments (EDs) experience similar or related changes in payer mix?
- What revenue sources exist to support CSNCs, RHCs, and other safety net clinics that serve patients without insurance but do not have the benefit of federal grants?

How Drops in Medicaid Enrollment Affected Safety Net Patients and Clinics

The combination of conditions outlined previously — including immigration policy, administrative changes, economic factors, lack of affordable insurance, and growing uninsurance — create challenges for safety net patients and clinics in accessing and providing needed care. Most of these factors are still at work in 2020.

When Patients Lose Coverage: Why it Matters

Patients of Colorado's health care safety net disproportionately live in households with low incomes and experience inequities in accessing needed services. When patients lose Medicaid coverage or cannot afford care, both patients and clinics have to make difficult decisions.

Patients may decide to delay or forgo needed care. If patients “churn” between being insured and uninsured — or between types of insurance — they may have to find a new provider who takes their insurance or accepts self-pay patients. One community organization reported that some patients may start seeking care from unlicensed providers. Others may start visiting EDs to seek routine services or because they have delayed care to the point that a health condition has worsened. In CHI's research, clinics did not observe an increase in ED use among patients without insurance, though many do not



have a way to track this. One clinic anticipated increased ED use if its uninsured waiting list grew. Additional research is needed to assess whether ED use grew during this period.

Another consequence of changing providers is an interruption in the continuity of the patient's care. Delaying, forgoing, or interrupting needed care is likely to have negative health impacts.^{33,34} In addition, many clinics serve as a connection point to resources outside of health care but which still contribute to a person's overall health, such as housing, food, and energy assistance programs.

Community Voices and Voices of the Safety Net:

- *“Uninsured patients wait longer to come for services, so they end up having higher severity of illness or more complicated situations when they eventually do come in. Also, generally clinics end up seeing patients less frequently, which prevents clinics from providing the type of medical home they would like. Now, during the COVID-19 pandemic, patients wait longer to come for services because they are scared of catching COVID-19. That means when they come in, their acuity level is higher. Clinics also have to see fewer patients because of the cleaning routines that have been built into the day. All of this contributes to a potentially weaker medical home model. Perhaps telehealth will provide that stronger bond, but that will depend on the decisions regulators make on how to keep telehealth going.”* — Colorado Safety Net Collaborative, an association representing CSNCs
- *“Underground pharmacies exist in immigrant communities. Many people get their health care from unqualified folks. What's common in developing countries is that you go to the doctor,*

and they give you a shot or pills to get better — a shot of antibiotics is very common. You see this in backroom markets here — they give you a shot of antibiotics, but you don't know the quality or whether it's an infected needle. [Underground providers] are probably more prevalent than we think they are. They are filling a demand.” — Latino Community Foundation of Colorado

- *“When people go without health insurance, preventive health care goes away. They pay out of pocket for only the medications they can afford.” — Kids First Health Care, a SBHC and CSNC serving Adams County and northeast Denver*

The Patient Perspective: Experiences in Colorado's Safety Net

CHI interviewed patients and patient advocates to understand the impact of these dynamics on Coloradans. The range of experiences shared in these interviews reflects just how widely interactions within the state's safety net vary. The patients expressed neither wholly positive nor wholly negative experiences with safety net clinics, though they unanimously highlighted the clinics' accessibility and affordability. While patients receiving care in non-safety net clinics might have similar experiences, these interviews were conducted with the objective of highlighting common patient perspectives and potential improvement opportunities within the safety net specifically.

The interviews are not intended to be representative of all of the more than 1 million patients served by Colorado's safety net, but to illustrate the complexity and challenges that individual patients face. A few of the themes from these conversations include:

Navigating payments for care is often much easier in safety net clinics. Clinics tend to be more flexible and offer more alternative payment options than larger hospital systems. There are few, if any, surprise charges.

- *“Two years ago, I was very sick and had to go to a hospital emergency room. I was concerned*

because I found out the cost would be \$20,000, which I had to pay off in installments, which was hard. Now, with the clinic, most of my care is free or more affordable.” — Patient (Uninsured)

Customer service is often better in safety net clinic settings, regardless of insurance status.

Providers in clinics take more time to explain conditions and/or treatment courses than in hospitals. One patient shared that she noticed a difference in care and patient navigation in the hospital when she switched from private insurance to Medicaid.

- *“In the hospital, there have been frustrating experiences when it felt like the medical staff wasn't listening to me or taking the time to talk about what I needed ... but at the clinic, I've interacted with some really great people. I like most of the people and doctors at the clinic.” — Patient (Uninsured)*
- *“When I had Anthem and had to go to the [hospital] campus for a mini stroke, all of my requests were filled quicker, and they would explain things to me in depth. When I went back to [the same hospital] to have my daughter and I had Medicaid, there were a lot more hoops to jump through to get my pain medication, and they wouldn't take as much time to make sure I understood what was going on or happening to me.” — Patient (Medicaid member)*

Differences in care experiences may be related to language.

A patient's needs and requests may be taken more seriously if he or she speaks English, or providers may use language barriers as justification for not explaining as fully as they might to an English speaker.

- *“My niece, who lives in Mexico, can provide better answers for me ... I don't like being told essentially that nothing is really wrong [when I try to voice a health concern].” — Patient (Uninsured)*

Navigating the insurance process can be complicated for non-English speakers.

While the English-speaking patients interviewed described the Medicaid enrollment process as straightforward and quick, a Spanish-speaking patient described a much more tedious process with multiple checkpoints and additional requirements.

- *“I enrolled for Medicaid online primarily because the physical office in Leadville was not super friendly, particularly service-wise. Online enrollment was relatively straightforward and easy. Only one additional follow-up call to verify income.” — Patient (English speaker)*
- *“The last time I tried to apply for myself and my daughter, they asked for a check [proof of income] and a letter. Then another letter and another letter, and it made me mad because it seemed like there was always another thing to do ... another check, another letter. Eventually, I just told them I couldn’t do anymore because I don’t drive, and I can’t keep going to the office all of the time.” — Patient (Spanish speaker)*

Navigating Medicaid disenrollment can be just as frustrating. The patients CHI interviewed all brought up surprise disenrollment — an issue

many of the clinic representatives also discussed. Patients shared experiences of their own and of family members being unaware that their coverage had lapsed due to missed notifications or lack of clarity. Typically, an updated income disclosure would rectify enrollment concerns, but patients were often unaware of this solution until they sought care and were told that their coverage had lapsed. (Clinics will typically help patients figure out what needs to be submitted.)

- *“My family members have had pretty similar experiences. Most of them go to the same clinic as me ... We only hear we were dropped when we try to use it at the clinic and then realize it’s been cancelled. I think they just need to check my income. I am looking forward to getting it again.” — Patient (former Medicaid member with plans to re-enroll)*

Figure 7. Patients Are Affected by Changes in Coverage in Different Ways

Population Identified	How They Are Affected
Patients Who Are Immigrants or Have Immigrant Family Members	Fear of public charge and other immigration policies may drive people to avoid seeking care or avoid enrolling in benefits for which they are eligible. In particular, children who are eligible for public coverage programs may remain uninsured because families are fearful about enrolling them.
Non-English Speakers	Language barriers create difficulty navigating insurance requirements and seeking care.
Seasonal Workers	Companies are unlikely to offer seasonal employees health insurance, and seasonal employees may only be eligible for Medicaid part of the year. They remain uninsured.
People Who Have Lost Jobs	A sudden loss of employment may mean a loss of employer-sponsored coverage without affordable alternatives, especially if the person receives unemployment insurance, which counts against Medicaid eligibility.
People Experiencing Food and Housing Insecurity	People may prioritize housing, food, and other basic needs above enrolling in coverage or seeking care. In addition, lack of a consistent mailing address makes it more likely that Medicaid members will miss a letter from HCPF and be disenrolled.
Rural Residents	Rural residents may be geographically isolated and have to travel far to find a provider who accepts their coverage or serves those without coverage.
Patients With Incomes Over Medicaid Eligibility	Some people, especially those living in areas with a high cost of living, may be ineligible for Medicaid and financial assistance through the health insurance marketplace, yet unable to afford private insurance due to the high cost of housing, food, and other basic needs.

Source: CHI’s key informant interviews with safety net stakeholders, conducted between March–April 2020.

Which Patients Were Most Affected by Adjustments in Safety Net Resources?

CHI asked safety net clinics which patients are most likely to be affected when clinics adjust to declining Medicaid enrollment or other changes.

Interviewees provided a range of responses to this question — seasonal workers, older adults, and immigrant families to name a few (see Figure 7). People may be represented in more than one group and therefore may face compounded barriers to care.

Pre-COVID-19 Safety Net Provider Adaptation Strategies

Prior to the COVID-19 pandemic, safety net clinics were taking steps to adapt to the changes around them. While both urban and rural safety net clinics faced financial hardship, those serving rural communities were particularly vulnerable.

And not all safety net clinics experienced the changes — declining Medicaid volume and increasing uninsurance — in the same way or to the same extent. This variation is reflected in the range of ways safety net clinics adapted.

Three key types of actions emerged from CHI's research, summarized in Figure 8.

Making budget cuts, especially in rural areas:

Before COVID-19, many safety net clinics were making hard decisions to preserve their financial viability while trying to maintain care for their patients. Layoffs of staff — including a few clinicians — were perhaps the most drastic measure taken by a handful of FQHCs and CMHCs. At least one FQHC had to limit the number of new patients without insurance it could take on and created a waiting list. And some clinics instituted furloughs and were planning to downsize staff prior to the pandemic.

Layoffs, wait lists, and furloughs, however, were the exception and not the rule among the clinics CHI interviewed. Much more common were measures to belt-tighten and adapt to a constrained budget. Safety net clinics made budget modifications and

dipped into financial reserves. A few FQHCs had to put capital projects on hold, while others froze hiring. And small rural hospitals that own and operate RHCs — a number of which are operating in the red themselves — have absorbed their RHCs' administrative costs.

The effect of budget or staffing cuts for clinics in rural areas is compounded by the fact that health professionals are often in short supply and recruitment to rural areas can be difficult. The federal government has designated most of Colorado's rural counties as having shortages of professionals providing primary care, mental health care, and oral health care.³⁵ Budget cuts impair a rural clinic's ability to offer competitive salaries and retain staff. Layoffs mean that rural clinics may have to invest more resources in recruiting clinicians when the budget improves.

Community Voices and Voices of the Safety Net:

- *“There were others that were hit harder than us because of the amount of COVID testing and telehealth visits, but we definitely had to make significant budget modifications and reduce costs.”* — STRIDE Community Health Center, an FQHC serving the east and west metro Denver areas
- *“Many Community Health Centers are having to make tough decisions to ‘pull things in.’ One Western Slope [Community Health Center] had to lay off two medical providers, and a large northeast Community Health Center had to remove 47 staff positions for patient services.”* — Colorado Community Health Network, an association representing FQHCs
- *“It’s heartbreaking. We call it the deal with the devil. As the uninsured have grown dramatically, we’re faced with choosing between delivering the best care possible to some or providing unlimited basic services to the many.”* — Mountain Family Health Centers, Glenwood Springs-based FQHC

Diversifying and increasing sources of revenue:

Many safety net providers increased their fundraising and grant-writing efforts. As nonprofits, most safety net providers — especially those serving large populations of patients lacking insurance — fundraise by appealing to foundations and private donors and hosting fundraising events.

The budget shortfalls prior to COVID-19 meant ramping these efforts up even more.

Fundraising and applying for grants are not without drawbacks. Some clinics are concerned that philanthropic support for safety net services has decreased over time. As economic conditions improved and coverage increased since ACA expansions, philanthropic resources became more limited as the financial stability of a number of clinics improved. Over the past decade, foundations and many others in the health policy community have expanded their focus to include other factors that contribute to health beyond health care — such as a safe environment, stable housing, and food security. When grants are available to clinics, they are often restricted to a specific project or program rather than being general operating grants that support a nonprofit's overall mission. And some clinic interviewees said that managing multiple grants requires a significant investment of staff resources and support.

Community Voices and Voices of the Safety Net:

- *“We have a huge fundraising operation since we historically served the uninsured. We have over 40 grants that we manage. In the same breath, it sure would be nice if we didn’t have to devote the same amount of attention to these grants.”* — Summit Community Care Clinic, an FQHC serving Summit County and surrounding communities
- *“Clinics are concerned about funding since rates of uninsured patients have been rising and foundations have pivoted away from direct patient care to social determinants. While important, direct patient care is not as sexy as these other areas right now. There has been a slight reprieve during this pandemic as foundations provided great flexibility if you were already a grantee. This was greatly appreciated by safety net clinics. But care needs do not go away when the pandemic does, so clinics are having to get very creative on how to sustain their commitments to marginalized communities.”* — Colorado Safety Net Collaborative, an association representing CSNCs
- *“What we anticipate is a change in demand. We*

are ramping up to meet increased demand from Medicaid eligibles. We were planning for a 15% revenue reduction in 2020-21 due to the decline in Medicaid eligibles; now we are projecting a flat budget moving forward. At one point, we were looking at vacancy savings and non-essential layoffs. Now it’s hold the line. There will be a wave. We don’t want to have to rebuild our workforce to meet the demand.” — Southeast Health Group, a CMHC serving southeastern Colorado

- *“It’s extremely difficult to get grants and nonrestrictive funding to cover medical care for kids. It costs us close to \$1 million to take care of uninsured kids. There’s some money we apply for from the Primary Care Fund, but we still need to raise \$600,000 a year, and so we are trying to apply to foundations and holding fundraising events throughout the year to appeal ... it’s a really hard time making it all work.”* — Every Child Pediatrics, a CSNC operating clinics and SBHCs in metro Denver, Fort Collins, Basalt, Cortez, and Dolores

Increasing community outreach: In light of financial shortfalls prior to COVID-19, safety net providers pursued additional outreach to both patients and other community agencies. On the patient side, some clinics renewed efforts to invest staff resources in enrolling people who are eligible for Medicaid and CHP+. One CMHC, concerned about Medicaid disenrollment due to the returned mail policy, directed staff resources to contact former Medicaid members to verify that they had, in fact, decided to disenroll. These efforts were becoming more and more difficult, however, as families declined to meet with outreach and enrollment staff because of fear around public charge and other immigration policies.

Safety net providers also built partnerships with organizations in the community to generate revenue. Some CSNCs, for example, applied for support for outreach and enrollment efforts from local health departments, partnered with hospitals to build referral relationships, and represented their clinics on local health alliances and RAE advisory councils. Clinics are partnering with community groups that are working to educate immigrant communities about their rights under public charge and other immigration policies. And at least two FQHCs have established “care card”

programs with local businesses to offer a defined set of subsidized primary care services to those businesses' employees.

Finally, some clinics expanded during the years prior to COVID-19. One rural FQHC expanded its school clinic program. Another clinic is focused on expanding the overall proportion of Medicaid patients it serves. And while some clinics needed to make budget cuts and generate new revenue in response to declining Medicaid enrollment starting in 2017, it is important to remember that the overall volume of Coloradans seeking safety net services continued to grow over this period. (See Figure 2.)

Community Voices and Voices of the Safety Net:

- *“Over the past two years we have seen an increased number of people requesting enrollment assistance often because they have not received an eligibility determination by applying on their own or their benefits were terminated due to system issues.”* — ConnectAurora, an organization in Aurora that assists people with enrollment in public and private coverage
- *“Our community has taken on trying to educate people about the public charge — about how it would or wouldn't affect you — to help them*

understand what they qualify for and what they don't qualify for.” — Summit Community Care Clinic, an FQHC serving Summit County and surrounding communities

Key Questions:

- In what ways can state policy account for growing numbers of patients without insurance served at safety net clinics?
- Are there modes of communication other than mail that can be used to reach Medicaid members, such as text?
- Many safety net clinics were already facing workforce shortages. Will clinics be able to hire staff to meet anticipated demand?
- Will clinics be able to meet the needs of the growing number of people who are uninsured in addition to those who were already uninsured? How much will this population grow?
- Will a surge of Coloradans who are newly uninsured or enrolled in public coverage create additional barriers and disparities for people already experiencing inequities? Which population segments are at risk of falling between the cracks and going unserved?

Figure 8. Safety Net Clinics Adapted Using a Range of Pre-COVID-19 and COVID-19-Related Actions

Pre-COVID-19		COVID-19 Related
Budgetary adjustments <ul style="list-style-type: none"> • Layoffs • Furloughs • Hiring freezes • Use of reserves • Budget cuts 	Increasing community reach <ul style="list-style-type: none"> • Partnerships • Advocacy • Outreach and enrollment • Creation of “care card” programs • Expansion 	<ul style="list-style-type: none"> • COVID-19 testing • Telemedicine service expansion • Staff redeployments • Absorbing patients from closed practices
Finding new revenue <ul style="list-style-type: none"> • Increased fundraising • Increased grant writing and management 		

PART 2:

A Weakened Safety Net in the Age of COVID-19

As 2020 began, many of Colorado's safety net clinics were adapting to the effects of depleted revenue streams, preparing to serve a smaller Medicaid population and more people without insurance.

And then a global pandemic hit.

Colorado's first confirmed case of COVID-19 was reported on March 5, 2020.³⁶ That month, the COVID-19 pandemic and the state's Stay-at-Home Order, which shut down large parts of the economy, introduced yet another set of significant new realities. These included hundreds of thousands of Coloradans out of work; the cancellation of many non-emergency in-person medical and dental procedures; patients postponing appointments due to stay-at-home orders; and the need to treat people showing symptoms of the virus.

The previously described pre-COVID-19 factors had the net effect of weakening the state's safety net by limiting who was enrolled and the budgets with which clinics operate. With the advent of COVID-19 in March 2020, postponed or cancelled appointments represented a further hit to revenue. The sidebar on Page 26 summarizes the range of financial impacts of COVID-19 from a variety of safety net perspectives.

As of summer 2020, some providers are caught in a difficult spot because, while they are still struggling due to conditions before the pandemic, they want to keep their staffing levels up to meet an anticipated surge in demand for their services as in-person care resumes.

The increase in demand is expected due to multiple factors: increased volume of Medicaid enrollment as people lose jobs and benefits; patients putting off other needed services until the pandemic passes; and anticipated behavioral health needs in the wake of prolonged social isolation and the economic downturn. In May 2020, HCPF estimated more than half a million people will enroll in Medicaid and CHP+ before the end of 2020 (see

Figure 1).³⁷ To date, however, the surge has largely yet to be realized, with about 65,000 new enrollees in Medicaid and fewer than 1,000 in CHP+ between March and May 2020.³⁸ This slow growth may be because people are holding out without coverage in anticipation of returning to a job, are ineligible due to unemployment benefits, or may not realize they qualify for public coverage.

There is likely to be a surge in demand for behavioral health services due to stress and anxiety created by COVID-19 and the economic downturn. A recent Colorado Health Foundation/Healthier Colorado survey found that 53% of respondents indicated the stress and worry related the coronavirus had a negative impact on their mental health.³⁹

Safety net providers must consider another set of variables as they plan for the future:

- **A potential surge in the number of patients lacking insurance:** One set of projections estimates up to 126,000 Coloradans will become newly uninsured on top of an estimated 361,000 already lacking coverage.^{40, 41} This number could be even higher since those using unemployment benefits will likely not qualify for Medicaid and will have significant uncertainty regarding their income and expenses.
- **Federal stimulus funding:** Some safety net clinics received direct funding through the Coronavirus Aid, Relief, and Economic Security, or CARES, Act. Approximately \$54 million was granted by the federal government directly to specific FQHCs across the state.⁴² The state legislature allocated approximately \$7.3 million in CARES Act money through the Colorado Department of Human Services to support community mental health and substance use services and \$2 million to support school-based mental health services. Safety net clinics also were eligible for the Paycheck Protection Program, which provided forgivable loans to

businesses as an incentive to keep their workers on payroll. However, these programs do not provide ongoing, sustained resources, and the prospects for continued federal support are uncertain.

- **Federal maintenance of effort requirements:** Another set of factors comes from the federal government. CMS established a “maintenance of effort” requirement that states keep all Medicaid members enrolled during the public emergency period — presumed to end December 31, 2020 — at which point an estimated 332,000 members will be disenrolled due to no longer meeting eligibility requirements.⁴³
- **Increased number of providers:** Providers who currently don’t accept Medicaid may begin doing so to retain patients or meet the demand.
- **Medicaid attribution:** The final consideration is how the Medicaid ACC will attribute or assign new Medicaid enrollees to primary care safety net providers as their medical home. HCPF recently provided guidance that attribution will be prioritized to FQHCs, RHCs, and other safety net providers designated as Essential Community Providers.⁴⁴

Safety net clinics often serve as the medical home for their patients. They aim to be available to patients who are symptomatic or need access to preventive primary care, testing, or behavioral health, all while striving to keep staff and patients safe. Some patients — particularly those from immigrant communities who may not seek care due to fear — run the risk of falling through the cracks amid a surge of newly enrolled and newly uninsured patients.

Figure 8 (see Page 23) displays some of the adaptive actions safety net clinics have taken so far in responding to the pandemic while trying to meet the needs of patients. Not all clinics took — or were able to take — the same actions. While a number of clinics wanted to conduct COVID-19 testing, for example, they lacked the needed supplies. Another important action is that most clinics temporarily shuttered their dental programs for non-emergency procedures during the pandemic due to an Executive Order from Gov. Jared Polis to

curb the risk of infection and conserve personal protective equipment.⁴⁵

One bright spot is that clinics have adapted rapidly to provide telemedicine services. Loosening of state and federal telemedicine restrictions in the wake of COVID-19 means that providers can be reimbursed for telemedicine services in ways not previously covered by payers, such as audio-only phone calls and non-HIPAA compliant platforms like Skype or Facebook Messenger video.⁴⁶ Phone calls, in particular, are a popular telemedicine modality among safety net clinics for delivering primary care services and follow-up visits. Phone calls address many of the technical barriers — such as lacking a device or secure internet connection — that safety net patients experience. Some clinics do question, however, whether the quality of care is as strong on a call as with an in-person or video visit.

The passage of legislation (SB20-212) by the Colorado General Assembly in June 2020 codifies many of the state’s emergency telemedicine provisions — such as requiring Medicaid to reimburse FQHCs, RHCs, and Indian Health Service for telemedicine services or allowing disciplines like physical therapy or pediatric behavioral health care to be delivered by telemedicine.⁴⁷ Despite the passage of legislation, safety net organizations still have questions about whether some telemedicine services may be cut in future budget cycles or whether the federal government will maintain its own telemedicine provisions established during the pandemic.

The safety net’s rapid pivot to telemedicine as well as many examples of creative problem-solving demonstrate the system’s resilience in meeting its mission in challenging times. But not all services can be delivered by phone or online. And not all patients can participate in telemedicine, due to lack of a reliable internet connection, a device, or a private space to share sensitive information. It will take work and investment for clinics to endure and adapt in the coming months and years. The challenges and potential ramifications for Colorado’s health care safety net are significant and complex.

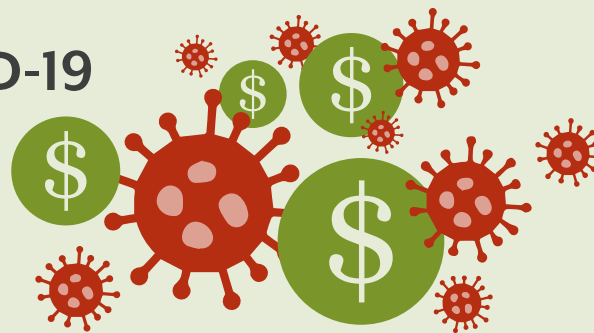
One approach to structuring the discussion of how the safety net can recover is to identify short-term

Financial Impact of COVID-19

COVID-19 hit safety net clinics hard in several places, including their bottom lines. Information available for safety net clinics is uneven by provider types and is limited primarily to April and May. However, the data point to a clear trend of lost revenues.

The number of visits shrunk due to stay-at-home orders as well as the cancellations of elective procedures and other services such as dental. Most CSNCs were operating at 60% capacity during the shutdown, and about half (10) are still at less than 60% capacity. FQHCs' medical visit volume was anywhere between 50% and 75% of usual, with dental visit volumes dropping 75% to 85% of usual volume. Many RHCs experienced visit reductions of 50% to 60%.

Reduced volume led to safety net clinics collectively losing millions of dollars in revenue during the first two months of the pandemic. CMHCs across the state experienced an estimated reduction of revenue between January and May 2020 of just over \$14 million compared to the same months in 2019, primarily due to reduced visits by patients. The Colorado Community Health Network estimates that FQHCs collectively will have a revenue shortfall of \$21.5 million in the 2020 calendar year. Most RHCs reported revenue



losses, some losing more than \$100,000 per day. And half of CSNCs are operating at less than 70% of their projected budgets, with 60% having less than three months cash on hand and 47% having less than two months.

Data were not available for SBHCs, though many are included in the figures for FQHCs and CSNCs. School clinics might face unique challenges moving forward, since they have medical sponsorship from FQHCs and CSNCs and also depend upon students attending school — an uncertain prospect.

Not all reduced encounters can be directly attributed to COVID-19. And while in-person visits are down, telehealth allowed providers to replace some of the lost volume. Yet safety net clinics face an uncertain financial future. New financial hurdles, ranging from standing up telemedicine platforms to the ongoing cost increases of purchasing personal protective equipment and other infection control measures, will strain an already struggling safety net.

(within the coming months), medium-term (by this time next year), and long-term (years away) challenges and actions to promote resilience.

The Safety Net Opportunity Matrix on page 28 identifies examples of the pandemic's potential detrimental effects on the health care safety net and short-term, medium-term, and long-term opportunities for funders and policymakers that might mitigate the impact.

Discussion and Conclusion: A New Landscape for the Safety Net

Safety net clinics provide access to high-quality care for their communities, and they have always innovated to find creative solutions to fulfill their mission.

In 2020, Colorado's safety net providers are facing challenges similar to safety net providers across the country.⁴⁸ There are recent signs of

a rebound in ambulatory care nationally after the COVID-19 outbreak due to increases in in-person visits and telemedicine during the pandemic.⁴⁹ Nationally, however, the field of primary care continues to reel from the impact of the pandemic. In the most recent survey from the Primary Care Collaborative, fewer than half of practices that completed the survey indicated they had enough cash on hand to stay open, 37% of clinicians reported new layoffs and furloughs, and 58% are nervous about a new surge in patient health issues from delayed care during the pandemic.⁵⁰

Before COVID-19, providers were adjusting their budgets to deal with declining Medicaid enrollment and worrying about who was being left behind by the booming economy. Since COVID-19, the safety net has experienced a rapid transformation in the delivery of care (to telemedicine and COVID-19 testing) at the same time it is preparing for anticipated increases in Medicaid volume and meeting the demand for services that patients may have postponed during stay-at-home orders. There are concerns about addressing the needs of those who were already losing coverage and access to care as well as new concerns about who will be left behind amid drastic state budget cuts and record-breaking unemployment.

What will a next phase of safety net resilience look like? The answer isn't clear yet, but several factors might inform how Colorado's safety net adapts:

- **All-in with the ACA:** Colorado made policy decisions over the past decade to go all-in with the ACA. The state made a significant expansion of Medicaid, and Colorado has one of the most successful and enduring state-based health insurance marketplaces. Coloradans have better access to coverage amid the economic downturn.
- **State commitments to the safety net:** In the past, Colorado has made a series of policy decisions to allocate resources to the safety net. For example, the legislature approved residential and inpatient substance use disorder benefits under Medicaid in 2018.⁵¹ An adult dental benefit was added to Medicaid in 2014, though it was reduced in 2020. The legislature significantly increased an annual line item for Colorado's SBHC program to \$5.2 million in 2014.⁵² And 2004's Amendment 35 tobacco tax created the Primary Care Fund to support eligible safety net clinics.⁵³ Although the SBHC line item and

Primary Care Fund remained untouched in the FY 2020-21 budget, some worry that they will be on the table for cuts in future budgets given the economic downturn.

- **Philanthropic community:** Compared to other states, Colorado has a strong community of philanthropies that have fostered the growth of the health care safety net and facilitated more equitable access to services. Foundations have established the COVID Relief Fund to help communities responding to the pandemic, among other efforts.⁵⁴
- **Integrated care:** Through Colorado's State Innovation Model (SIM) grant program, many providers have made significant progress in integrating physical and behavioral health care. These innovations endure after SIM. Although barriers to integration remain — especially for many small and rural providers — integration of services continues to be important for facilitating access to behavioral health services. Demand for behavioral health care is expected to increase in the wake of the pandemic.⁵⁵
- **Partnerships:** Some safety net clinics are forging new relationships with local public health agencies to provide COVID-19 testing services. Others are fostering relationships with social services agencies to connect patients with non-medical resources such as food banks and housing programs.
- **Telemedicine:** The governor's office and Colorado's state agencies were quick to respond to make temporary policy changes to facilitate rapid adoption of telemedicine during the pandemic. The Colorado General Assembly recently moved to make most of these changes permanent with the passage of SB20-212.⁵⁶ The legislation — which expands the types of telemedicine services that can be reimbursed — signals that some degree of telemedicine is here to stay. Preliminary evidence suggests that telemedicine will be an important tool for increasing access to certain services.⁵⁷

These factors and the collaborative nature of Colorado communities give reason for optimism during challenging times. Despite an unprecedented public health emergency and shift in the state's economy, Colorado's safety net has opportunities to provide care to those who need it the most.

Supplement: Safety Net Opportunity Matrix

Short-Term, Medium-Term, and Long-Term Opportunities for Safety Net Resilience

This supplement identifies opportunities for policymakers and funders that might mitigate the impact of factors from before and during the COVID-19 pandemic on safety net providers and patients. CHI identified these opportunities through its research and discussions with safety net stakeholders. CHI does not engage in advocacy for any particular policy proposal.

Increased Demand for Behavioral Health Services

The challenge:

Many stakeholders expect a wave of demand for behavioral health care due to COVID-19. This demand will likely be driven by people postponing in-person services during the pandemic, as well as behavioral health challenges driven by the economic downturn, lost jobs, and social isolation. According to a recent Healthier Colorado/Colorado Health Foundation survey, people most likely to report that coronavirus has had a negative impact on their mental health include women (61%), people in households with children (64%), young adults ages 18-29 (69%), Denver residents (62%), people who lack insurance (69%), and people who have lost a job or income (62%).⁵⁸

Short-term strategies:

Address barriers to accessing telebehavioral health. Provide ongoing financial support for technical assistance to patients in using telehealth technology. Support clinics' procurement of equipment necessary to conduct video visits.

Medium-term strategies:

Some psychiatrists indicate that a video platform is better for providing telepsychiatry than an audio-only phone call. Since video platforms require greater bandwidth, support technological solutions that optimize video but minimize bandwidth for patients and providers. Increase education of patients about advantages of video, how to use video, and how to ease discomfort with video.

Long-term strategies:

Ensure an adequate behavioral health workforce exists to meet the need. One possible area is addressing policy barriers to allow the practice of and reimbursement for telebehavioral health across state lines, while ensuring patients have access to in-person behavioral health resources when needed. Another is to address bandwidth deficits that continue across the state so that rural providers can provide compliant telehealth services. Use the experience of behavioral health providers during the pandemic to identify best practices for sharing behavioral health information under federal rule 42 CFR Part 2.

Fear and Medical Homelessness

The challenge:

The crackdown on immigration continues despite COVID-19.⁵⁹ Some people in immigrant families continue to disenroll from Medicaid or not seek services due to fear. They run the risk of becoming "medically homeless." It is unclear where they turn for needed care; one interviewee reported some patients may seek services and prescription medication at underground, unregulated providers.

Short-term strategies:

Support promotion of COVIDLine to connect people without insurance to telemedicine visits and local providers for treatment of COVID-19.⁶⁰ Assess whether telehealth addresses some of the concerns of seeking in-person care.

Medium-term strategies:

Survey safety net providers that are trusted sources of health care in immigrant communities to identify their needs. This includes providers who serve immigrants and refugees who speak languages other than English and Spanish. For example, identify educational and consulting needs of safety net clinics to expand capacity and services that are culturally appropriate for immigrant and refugee populations. Advocate at the federal level for more inclusive structures and messages.

Long-term strategies:

Support trusted organizations using effective outreach and education efforts to increase awareness of what immigration rules do and do not apply, and the dangers of using unregulated providers. Explore payment models or additional funding sources to support clinics' ability to serve patients without coverage.

Affordability of Private Coverage

The challenge:

Cost continues to be the reason most Coloradans without insurance cite for lacking coverage.⁶¹ Some policy changes like reinsurance have brought insurance premiums down in the individual market, but people may purchase plans with unaffordable copays and deductibles, or skip coverage altogether.

Short-term strategies:

Provide technical assistance and transitional funding to safety net clinics to scale up solutions like the "Care Card" arrangements some FQHCs have with local businesses. Understand how COVID-19 has impacted local initiatives aimed at reducing the cost of coverage and increasing access, like the Peak Health Alliance in Summit County.

Medium-term strategies:

Support clinics partnering with Connect for Health Colorado for outreach and enrollment, particularly around financial assistance with cost-sharing available with some plans. For example, the Premium Sponsorship Program at Doctors Care — a CSNC in Littleton — pays participants' monthly premium for a silver-level plan purchased through Connect for Health Colorado and provides support with navigating private insurance.⁶²

Long-term strategies:

Assess the feasibility of proposals for a public option or other policies on affordability of coverage, especially under new budget limitations.⁶³

Safety Net Clinic Operations: Keeping the Lights On

The challenges:

Safety net clinics face an array of financial challenges related to COVID-19. For example, federal aid went to health care providers that serve Medicare before those that only serve Medicaid. This meant delayed federal aid for clinics like some SBHCs and CSNCs that don't have Medicare patients.⁶⁴ Not all federal recovery resources are available to all safety net clinics. Some practices might have to close altogether or consolidate with larger health care systems, leading to higher prices.⁶⁵ Some SBHCs can't operate because

of their physical location in closed school buildings. Surveys of primary care practices (not limited to safety net providers) conducted after the COVID-19 outbreak found 84% of clinicians have patients who struggle with digital platforms, 27% of practices report no use of video visits, and 53% do not use e-visits.⁶⁶ Over half (55%) of primary care practices responding to a national survey indicate they are not ready for the next wave of the pandemic.⁶⁷

Short-term strategies:

Assess the need for and allocate philanthropic “bridge funding” to allow clinics to remain adequately staffed and to ramp up for an anticipated surge of patients enrolled in Medicaid or lacking insurance. Make sure clinics have what they need in terms of COVID-19 testing and personal protective equipment. Support clinics like SBHCs with collecting enrollment forms and patient payment virtually. Provide clinics with funding for technologic and capital improvements — new computers, electronic health record (EHR) upgrades, space redesign. Support clinics establishing curbside lab and pharmacy services.

Medium-term strategies:

Provide support to safety net clinics for telemedicine training and navigating different billing rules from different payers.⁶⁸ Explore partnerships with HCPF and RAEs for attribution efforts, care coordination, and onboarding newly enrolled Medicaid members. Support outreach and enrollment efforts for clinic communities. Advocate at the federal level to ensure that recovery funds support a variety of safety net providers.

Long-term strategies:

Support mergers between providers when necessary, while assessing potential effects on patient choice and affordability. Financially support social health information sharing by clinics to connect patients to assistance with social factors such as food, energy assistance, and housing with a warm hand-off. Assess the impact of budget cuts affecting the state’s health care safety net in FY 2021-22. Assess a) opportunities to allocate additional state funding to the Primary Care Fund, and b) the impact of opening the Fund to other providers serving Coloradans who lack insurance, such as oral health providers.

Lost Ground on Oral Health

The challenge:

Safety net oral health programs were abruptly suspended amid safety concerns related to transmission of COVID-19. Colorado may lose ground on its preventive oral health gains over the past decade while also facing pent-up demand for restorative and routine oral health once it is deemed safe.

Short-term strategies:

Increase provider awareness around what oral health services are covered by Medicaid, particularly prevention services. Support creative redeployment of oral health staff. For example, one FQHC trained staff from its shuttered oral health program to assist in the clinic’s COVID-19 testing efforts and reassigned dental hygienists to help with infection control and sterilization in medical areas of the clinic. These approaches allowed the employees to stay on staff until dental programs could reopen.

Medium-term strategies:

Ensure that safety net clinics have a sufficient supply of PPE and adequate physical space/ventilation to safely perform oral health procedures. Explore the benefits and drawbacks of teledentistry and preventive at-home oral health programs.

Long-term strategies:

In future years, work to restore the Medicaid adult dental benefit after reductions made in the FY 2020-21 state budget.⁶⁹

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