Memorandum

To: Joint Budget Committee
From: Eric Kurtz, JBC Staff (303-866-4952)
Date: November 13, 2026
Subject: Medicaid provider rate review schedule

Pursuant to statute[1], the Joint Budget Committee (JBC) must decide by December 1 each year whether to direct the Department of Health Care Policy and Financing to review a Medicaid rate outside of the established rate review schedule or include an exempted rate in the review. If the Department receives any petitions for out-of-cycle rate reviews, it must forward them to the JBC. This memo provides background information to help the JBC decide whether to make any modifications to the rate review schedule. Analysis of the Department's provider rate recommendations for FY 2027-28 will be provided at the briefing for the Department of Health Care Policy and Financing.

If the JBC directs a change in the review schedule, the Department must begin the rate review or notify the JBC within 30 days of any obstacles to conducting the review. This notification could include the Department requesting additional funds to complete the review or explaining why the review cannot be completed in the available time.

Recommendation

Staff recommends directing the Department to add nursing facility rates to the review cycle and remove them from the exempt services. A statutory formula that annually adjusted nursing facility per diem rates was phased out by HB 23-1228. Beginning in FY 2026-27, nursing facility rates adjust through the annual budget process. Therefore, the nursing facility rates should get reviewed for adequacy and access to care like other rates that adjust through the annual budget process. The JBC staff defers to the Department to decide what year in the cycle to review the nursing facility rates. Other than the nursing facility rates, the current exemptions appear reasonable for rates that are adjusted or reviewed periodically as a result of another state or federal law or regulation.

Staff does not recommend any modifications to the rate review schedule. This recommendation allows the executive branch to proceed with the reviews in the order deemed most administratively feasible. The Department's decisions appear reasonable to group similar services, align the schedule with the public release of key benchmarks, and synchronize the schedule with key Department deadlines.

[1] Section 25.5-4-401.5 (1), C.R.S.

Rate review process

The Department reviews provider rates on a three-year cycle. The rate reviews are intended to inform the Governor's annual budget request and the General Assembly's deliberations about funding for the Department. As part of the review, the Department must:

- Compare Medicaid rates to available benchmarks
- Use metrics to assess whether payments are sufficient to:
  - allow provider retention and client access; and
  - support appropriate reimbursement of high-value services.

The rate reviews are conducted with input from the Medicaid Provider Rate Review Advisory Committee (MPRRAC). The Department and MPRRAC meet at least quarterly to discuss provider rates and receive public input. In addition to the JBC, the MPRRAC can direct a change to the rate review schedule.

The Department must submit a report by November 1 each year summarizing:

- their analysis of the provider rates under review;
- the public input received and the Department's response;
- how the public input informed the Department's recommendations; and
- the Department's rate recommendations.

The 2026 Medicaid Provider Rate Review Analysis and Recommendation Report is available through the Department's web site.

By December 1 each year, the MPRRAC must present to the JBC an overview of the rate review process, a summary of the rates reviewed, and the strategies for responding to the findings of the review. The discussion of strategies includes any fiscal or non-fiscal approaches or rebalancing of rates, any advisory committee recommendations for rate adjustments, and any recommendations for improving capacity and access to services.

Review schedule

The table below summarizes the Department's published rate review schedule.

Rate Review Schedule

2026 Review (complete)	2027 Review	2028 Review
Abortion	Community First Choice	Dental
Ambulatory Surgical Centers	Emergency Medical Transportation	Dialysis and Nephrology Services
Anesthesia	Home- and Community-Based Services	Durable Medical Equipment
Behavioral Health (fee-for-service)	Home Health Services	Eyeglasses and Vision
Dental	Non-emergent Medical Transportation	Laboratory and Pathology Services
Maternity Services	Pediatric Personal Care	Physical, Occupational, and Speech Therapy
Non-emergent Medical Transport	Private Duty Nursing	Physician Services
Pediatric Behavioral Therapy	Psychiatric Residential Treatment Facilities	Prosthetics, Orthotics, Disposable Supplies
Surgeries	Qualified Residential Treatment Programs	Specialty Care Services

The 2026 review of Non-emergent Medical Transport (NEMT) was an out-of-cycle review that was limited to a rate comparison and did not include claims data, because the Department viewed the available claims data as contaminated by fraudulent activity. For 2027 the Department plans a more standard review of NEMT that will include claims data from after the known fraud period.

The Department's published schedule for 2027 includes reviews of Community First Choice and Home- and Community-Based Services rates in 2027, but a pending proposal would exempt certain direct care service codes in these categories from the MPRRAC review process. Instead, the Department would review these rates biennially through the federal process required by 42 CFR 447.203(b)(6). The federal regulation requires the Department to convene an Interested Parties Advisory Group that includes direct care workers, beneficiaries, authorized representatives of beneficiaries, and other parties impacted by the service rates, as determined by the state. The group will provide feedback on payment adequacy and access to care by region. In addition, the Department is collecting data from these providers for a report on the direct care service cost to administrative cost ratio that is due by December 31, 2027, pursuant to HB 26-1235[2].

Exempt services

The rates reviewed by the MPRRAC represent a subset of the Department's service expenditures. The Department may exempt rates from review because the rates are adjusted or reviewed periodically based on another state or federal law or regulation. A little over half of the Department's appropriations for services are exempted from the rate review process. For rates exempt from the MPRRAC review, any required annual adjustments get included in the forecast requests (R1-R5). The exempted rates include:

- Hospital rates
- Hospital supplemental payments and other financing
- Behavioral health managed care
- Pharmaceuticals
- Nursing facilities
- HMOs
- PACE managed care
- Insurance (Medicare premiums & buy in)
- CHP+ managed care
- Medicare Modernization Act
- FQHCs and RHCs
- Accountable Care Collaborative & disease management
- Hospice
- Administrative case management contracts
- Office of Community Living State-only Program
- Health benefits for children lacking access due to immigration status
- Reproductive health care for individuals not eligible for Medicaid

[2] Section 25.5-6-120, C.R.S.