Colorado Commission on Medicaid

Record of decisions – November 10th, 2026 meeting

Prepared by SHG Advisors · Updated November 17

At a glance

The Commission took up 50 docket lines: all 38 long-term lines and 12 short-term lines in the Who is covered bucket. Seven of ten votes make a recommendation. 78 short-term lines remain for November 18.

Outcome	Lines	Docket lines
ADOPTED	**22**	96, 115, 14, 112, 85, 16a, 40, 15a, 19, 108, 90, 7a, 18, 31, 11, 56, 32, 109, 13c, 29, 36, 87
REJECTED	**20**	73a, 51, 72a, 72b, 72c, 33, 34, 43, 121, 48, 78, 125, 127, 20, 21, 50, 52, 64, 35, 12
NO AGREEMENT	**1**	107
TABLED · NOV 18	**5**	92, 88, 63, 74, 76
FOLDED INTO LINE 18	**2**	73b, 94

How to read this record

Each line shows the docket proposition as members marked it (docket v4.2), the outcome, and – for adopted lines – the wording as adopted, which is what goes into the report. Vote counts are as announced by the Chair; where the Chair asked only for objections and none were raised, the line is shown as adopted or rejected without objection. Members voted by objection, and dissenting members are named as the Chair announced them. Recording times (hours:minutes) let any item be checked against the recording.

Framing from the opening: the evidence record is closed, and questions that need new analysis are written into recommendations as implementation steps naming who does what by when. Most lines have no cost estimate (13 have a stakeholder estimate and 15 a Department figure), and HCPF flagged eight lines as legally limited. The Commission is working under current federal law, including H.R. 1, and does not assume Amendment 87 closes the gap. Several members put on the record their frustration at voting without cost information; further data will come in waves over the coming months rather than before the report.

Long-term · Consensus items

Line 96 Re-evaluate the Behavioral Health Ombudsman Office	ADOPTED
Docket proposition	Re-evaluate the Behavioral Health Ombudsman Office: redirect its resources to proactive accountability by the agencies, BHASOs and RAEs, with consumer protections strengthened so that people can still raise concerns and get help.
Vote	Adopted without objection
As adopted	**Re-evaluate the Behavioral Health Ombudsman Office: redirect its resources to proactive accountability by the agencies, BHASOs, and RAEs, with a simultaneous emphasis on strengthening consumer protections so that people can still raise concerns and get help in a timely manner.**
Notes	The Chair stated for the record that the intent is to strengthen the office, not to eliminate or weaken it.

Recording	0:54

Line 115 Evaluate a single state-directed Pharmacy Benefit Administrator	**ADOPTED**
Docket proposition	Commission an independent evaluation of moving Medicaid pharmacy administration to a single state-directed Pharmacy Benefit Administrator, as Ohio has, covering implementation cost, net General Fund savings, effects on pharmacies and members, and changes to managed care financing. Relates to line 24.
Vote	Adopted without objection
As adopted	**Commission an independent evaluation of moving Medicaid pharmacy administration to a single state-directed Pharmacy Benefit Administrator, drawing on other states' experience, including Ohio's.**
Recording	0:56

Line 14 Reconcile fiscal-note savings with actual results	**ADOPTED**
Docket proposition	Require a reconciliation of every major Medicaid policy change's fiscal-note savings claim against actual results, transmitted to the JBC annually, beginning with Community First Choice, HB21-1021 peer services, Cover All Coloradans and the nurse assessor program that sunset December 2025; count downstream appeal, administrative and workforce costs in every savings estimate, and present each reduction in state-share and total-funds terms. Require every major administrative-efficiency proposal to show current spending, implementation cost, projected savings and actual results, separating General Fund, total funds, additional federal revenue and costs shifted to counties or providers, so the same saving is not counted twice across lines.
Vote	Adopted without objection
As adopted	**Require a quarterly reconciliation of each major Medicaid policy change's projected savings against actual results, with the emphasis on outliers (programs running well beyond their projections) and an annual summary; count downstream appeal, administrative, and workforce costs and show state-share and total-funds effects; break major programs out of the Medical Services Premiums line (combined with short-term line 110); report to the JBC, the health committees of both chambers (including at SMART Act hearings), and any continuing Commission. HCPF and JBC staff publish the method before the first report.**
Notes	"Every" becomes "major". Members want this to surface utilization trends and outliers early, not to add another report the Department must produce.
Recording	1:07

Line 73a Consider merging CDHS and HCPF	**REJECTED**
Docket proposition	Consider merging CDHS and HCPF. See line 78 for the LTSS-only version and line 73b for moving BHA block-grant dollars.
Outcome	**Rejected without objection**

Recording	1:09

Line 51 Planned use of unclaimed property funds	**REJECTED**
Docket proposition	A permanent, planned use of long-unclaimed Unclaimed Property Trust Fund balances as an offset to the provider-fee ratchet, instead of ad hoc annual draws.
Outcome	**Rejected without objection**
Recording	1:10

Line 72a Hard growth limit on the state Medicaid contribution	**REJECTED**
Docket proposition	A hard growth limit: the state Medicaid contribution grows at inflation only, within TABOR's band. Parts of the earlier line are now lines 72b and 72c. Opposed (October 20): a behavioral health provider association, because health costs outpace inflation and triggers could delay responses to emerging needs.
Outcome	**Rejected 8–1 (Senator Bridges objecting)**
Recording	1:11

Line 72b Apply reductions to new enrollees only	**REJECTED**
Docket proposition	Grandfather current rates and apply any reductions to new enrollees only. Split from line 72.
Outcome	**Rejected unanimously**
Recording	1:11

Line 72c Utilization trigger requiring legislative approval	**REJECTED**
Docket proposition	Require legislative approval when a service category grows more than a set percentage in a year (Idaho HB 345). Split from line 72.
Outcome	**Rejected; Senators Bridges and Frizell objecting**
Notes	Minority view for the report: the fastest-growing part of the budget should face the same hard limits as the rest, and the legislature needs to know during the year when spending is running over. A member asked for a one-page summary of Idaho's cap and may reconsider; the Chair said the Commission can revisit once it has that.
Recording	1:12

Long-term · Who is covered

Line 107 Guiding principle: cover as many people as possible	**NO AGREEMENT**

Docket proposition	As a guiding principle for the Department and the Commission's recommendations, cover as many people as possible: narrower coverage for more people is generally preferable to more robust coverage for fewer people.
Outcome	**Agreement not reached. Six members supported the wording and four objected (Representative Barron, Senator Kirkmeyer, Representative Taggart, and Senator Frizell), short of the seven votes needed, so it is not a recommendation.**
Wording voted	Wording put to the vote: the Commission's goal is that everyone eligible for Medicaid should be covered, and where possible benefits should be narrowed rather than covering fewer people.
Notes	Supporters wanted the Commission's recommendations to protect coverage for everyone eligible and, where savings are needed, to narrow benefits rather than cover fewer people. Other members said Medicaid should first serve people who are low-income and medically fragile within fiscal limits; that a principle is unnecessary when each line is decided on its own; and that any principle should state that it operates within federal authority and fiscal constraints. The report will describe these views.
Recording	1:40

Line 112 Repeal post-2019 benefit additions and utilization-management limits	**ADOPTED**
Docket proposition	Where federal law and rules allow, repeal legislation and rules adopted since 2019 that added benefits or coverage, or that removed utilization-management tools from HCPF or the RAEs. Read with lines 24, 33 and 34.
Vote	Adopted without objection
As adopted	**Review each benefit, coverage, or utilization-management change adopted since 2019 for its cost and effect, including potential cost savings, and recommend repeal or change one by one where federal law allows.**
Recording	1:43

Line 85 Smooth the eligibility cliff for people leaving Medicaid	**ADOPTED**
Docket proposition	Replace the eligibility cliff for people leaving Medicaid: 12-month transitional medical assistance, premium assistance, or a Basic Health Program for 133–200% FPL, with graduated cost sharing above the limit so a dollar more in earnings does not end coverage. Relates to 12 and 29 but for the expansion population.
Vote	Adopted unanimously
As adopted	**Have HCPF cost options for smoothing the eligibility cliff – 12-month transitional medical assistance, premium assistance, or a Basic Health Program – including effects on reinsurance and Connect for Health Colorado; identify the costs, the source of payment, and whether federal match is available before any option is adopted.**
Notes	The analysis should also consider whether a smoother transition increases workforce participation. Members agreed the state should not create a state-only entitlement with over expenditure authority.

Recording	1:48

Line 33 Put CHIP, Cover All Coloradans and eligibility levels on the docket by name	**REJECTED**
Docket proposition	Put CHIP, Cover All Coloradans, optional benefit levels and eligibility thresholds on the docket by name, so the Commission decides whether to decide rather than leaving them to the JBC; include the income level at which HCBS waivers and targeted case management are available.
Outcome	**Rejected without objection**
Notes	Members noted this is already the JBC's role.
Recording	1:51

Line 34 Cap expansion-population benefits at the federal minimum	**REJECTED**
Docket proposition	Cap benefits for the expansion population: set the alternative benefit plan at the federal minimum essential health benefits with annual limits on optional services (adult dental, vision, non-emergency transportation where permitted), rather than reducing eligibility, if the CHASE trigger hits. Opposed (October 20): a behavioral health provider association, because the cap would fall disproportionately on people with mental health and substance use conditions; a dental association opposes further limiting the adult dental benefit, citing recent rate cuts, the reinstated annual cap and emergency department cost shifts in other states.
Outcome	**Rejected without objection**
Notes	HCPF advised a different alternative benefit plan is possible but administratively difficult, and that removing dental, the main cost driver in that population, may raise emergency and other costs.
Recording	1:55

Long-term · How the program is run

Line 16a Publish forecast assumptions; dynamic budgeting	**ADOPTED**
Docket proposition	Publish the actuarial assumptions and confidence intervals behind every Medicaid forecast and fiscal note on a standing dashboard, and build service-category forecasting with the all-payer claims database as an independent check. Parts of the earlier line are now lines 16b and 16c. HCPF will refine the fund-source part of the forecast after the FY 2025-26 General Fund over expenditure and will revise the FY 2026-27 General Fund estimate in its November 1, 2026 budget submission (HCPF and OSPB, October 20).
Vote	Adopted unanimously
As adopted	**Publish the actuarial assumptions and confidence intervals behind every quarterly Medicaid forecast and every fiscal note on a standing dashboard, and report the cost, benefit, and method of service-category forecasting before building it.**

Notes	"Dynamic budgeting" is removed. The intent is a fiscal impact view that counts savings as well as costs and separates the causes of variance (utilization, assumptions, revenue, policy decisions). Members noted the reliance on the all-payer claims database.
Recording	2:08

Line 40 Standing legislative Medicaid oversight body	**ADOPTED**
Docket proposition	A standing legislative Medicaid oversight body to carry unresolved items past December 11 (Connecticut, Kentucky, North Carolina); sequence LTSS structural recommendations with the externally convened LTSS Work Group reporting September 2027. Opposed in part (October 20): a behavioral health provider association, citing risk of political influence and frequent policy shifts and a preference for a stable, evidence-informed policy environment.
Vote	Adopted unanimously
As adopted	**Create an interim, time-limited Medicaid oversight committee of legislators only to carry unresolved items past December 11 without duplicating the JBC, and explore what authority the committee needs to obtain the information it requires to make policy decisions.**
Notes	The reference to members from outside the legislature is struck; stakeholder input, including from hospitals on CHASE, continues without seats on the body. Purpose: keep the legislature accountable for structural change regardless of Amendment 87. Cadence, term, and facilitation to be settled in the bill.
Recording	2:18

Line 15a An outcome measure for every program, with a wind-down rule	**ADOPTED**
Docket proposition	A defined outcome measure for every Medicaid program and contract, published annually, with a rule that a program the data show is not delivering is wound down. Parts of the earlier line are now lines 15b, 15c and 15d. Also proposed (October 20): rural-appropriate measures using multi-year trends and regional benchmarks where annual facility rates are unreliable (a rural health advocacy group). A peer-support organization proposes measuring peer support by progress toward the person's self-identified recovery and wellness goals.
Vote	Adopted 9–1 (Representative Sirota objecting). An earlier motion to reject failed 4–6.
As adopted	**Require a defined outcome measure for significant Medicaid programs and contracts, published annually; programs that miss their measures come back to the JBC, the Medicaid Commission, or both, for review.**
Notes	The automatic wind-down is removed. Members want a mechanism that surfaces programs that are not working so the legislature can fix or end them; SHG will work with HCPF to determine if a better mechanism exists. HCPF advised that required benefits such as EPSDT cannot be wound down on outcome scores and that not every benefit suits a single measure.
Recording	2:33–2:37

Long-term · Managed care and the ACC

Line 19 Reduce the number of RAEs and BHASOs	ADOPTED
Docket proposition	Reduce the number of RAEs and BHASOs – to two, or one with regions – or, in the alternative, standardize them (line 6); a further alternative heard: bar for-profit entities from behavioral health managed care contracts, as Minnesota does. Alternatives proposed (October 20): prioritize Colorado-based companies for behavioral health managed care contracts while keeping federal consumer-choice compliance, and pilot two or more MCOs for physical health managed care in one county to test payer choice (a behavioral health provider association); consider approaches other states use to preserve community-rooted nonprofit plans and local accountability (a RAE). A behavioral health provider asks whether a for-profit managed care organization that cannot administer Medicaid responsibly should continue to do so; BHA lists targeted regional contracting among its focus areas.
Vote	Adopted 8–1 (Representative Taggart objecting; Senator Frizell excused)
As adopted	**Set performance standards for every RAE and BHASO and publish results by entity; examine the regional structure, how it works in other states, and how the entities interact with providers, with a view to standardization.**
Notes	The clause reducing the number of entities at the next procurement is dropped. One member may object on November 18 if the language does not develop further. Concern for the report: rural economies of scale and regional entities' relationships with providers.
Recording	3:10

Line 108 Pay for outcomes: more value-based purchasing	ADOPTED
Docket proposition	Tie a larger share of Medicaid payments to value and outcomes rather than units of service, across programs, wherever possible. Relates to lines 15, 27, 44, 71, 95 and 15b.
Vote	Adopted without objection
As adopted	**Explore where value-based payment is working in Colorado, including PRIME on the Western Slope, against the national evidence, and how to extend it where it achieves lower cost or better outcomes, starting with a Department plan that names the programs, measures, and timeline.**
Notes	HCPF noted national evidence does not show value-based payment reliably reduces cost, and providers must agree to take on risk.
Recording	3:27

Line 90 End or limit ACC primary care case management payments	ADOPTED
Docket proposition	End the Accountable Care Collaborative's primary care case management and care coordination payments, or limit them to adults and fund a pediatric primary care payment model from the children's share – care coordination, team-based care and preventive care, paid when delivered rather than on outcome metrics, with the AAP PACK report and

	Commission testimony on pediatric payment as the reference – keeping a per-member payment for pediatric primary care practices. Relates to 7, 15, 19 and 71. Opposed (October 20): a RAE. HCPF reports it will reduce provider incentive payments, not yet specified (HCPF, October 20).
Vote	Adopted 10–0
As adopted	**Standardize care management practice (not payment) across the RAEs, and evaluate in the next ACC procurement whether primary care case management payments should be limited to adults, with a pediatric primary care payment model funded from the children's share; proceed only where there are cost savings.**
Notes	Members asked that children be considered on their own terms as the ACC is evaluated.
Recording	3:37

Line 43 Shared claims payment for behavioral health	**REJECTED**
Docket proposition	Move behavioral health claims payment onto shared or state-administered infrastructure, keeping RAEs for network and coordination; standardize prior authorization statewide and integrate with provider records. Opposed (October 20): a RAE. HCPF reports strengthened monitoring and retroactive review of outpatient psychotherapy, with RAEs directed to explore utilization management for outlier billing and to apply targeted prior authorization in FY 2026-27; prior authorization for outpatient psychotherapy is constrained by SB22-156 (HCPF, October 20).
Outcome	**Rejected unanimously**
Notes	HCPF advised that interoperability across the RAEs' proprietary systems is likely not feasible.
Recording	3:42

Line 92 End capitated managed care for behavioral health	**TABLED · NOV 18**
Docket proposition	End capitated managed care for behavioral health: pay behavioral health services fee-for-service or through an administrative-services contract, keeping network and care-coordination functions where they add value; first, have HCPF cost the administrative saving at constant utilization. Relates to 5, 19, 43 and 45; line 18 asks the agency question with and without it. Opposed (October 20): a behavioral health provider association, which asks that any move proceed through analysis, stakeholder engagement and targeted pilots, and a RAE. Another behavioral health provider association is neutral on managed-care structure (lines 19 and 92) provided cost-based safety-net payment first has a defined home and high-acuity and no-refusal responsibility is assigned.
Outcome	**Tabled**
Notes	To be taken up with a discussion of managed care and fee-for-service across the whole program, so behavioral and physical health are weighed together. Any evaluation should not presume a pilot. Members are divided; parity between behavioral and physical health was raised.
Recording	3:57

Long-term · Behavioral health

Line 7a Consolidate care coordination	ADOPTED
Docket proposition	Consolidate care coordination – including the care coordination now run through BHA and the BHASOs – into HCPF's structure on a shared risk-stratification platform, so one entity coordinates for the same member; stop paying for coordination HCBS providers already carry in their rate; give providers a channel into RAE care coordination; publish cost per engaged member against other states. Alternative proposed (written submission, October 5): complete the 2020 Blueprint's transfer of individualized care coordination from the BHA to the BHASOs, scaled to need, and return funding not needed for an essential function to the general fund. Also proposed (October 20): comprehensive safety net providers and CCBHCs coordinate care for the highest-need people they serve, under managed-care oversight and without financial risk, with duplicative RAE and BHASO coordination reduced and records matched against provider rosters to find duplication (a behavioral health provider association); supporters of the BHASO transfer add that the State define who does what (another behavioral health provider association). The pay-for-complexity part of the earlier line is now line 7b.
Vote	Adopted 10–0
As adopted	**Simplify care coordination at the member level.**
Notes	HCBS case management is out of scope. As few coordinators per member as possible, coordinated across HCPF and the BHA and close to the member's provider, recognizing high-acuity patients may need more than one.
Recording	4:09

Line 18 Move BHA payment and contracting functions into HCPF	ADOPTED
Docket proposition	Move the Behavioral Health Administration's payment, contracting and care-coordination functions into HCPF, leaving licensing and crisis outside the payer; consolidate the behavioral health programs scattered across nine to twelve departments that contract with the same providers. Opposed (October 20): a behavioral health provider association would keep the BHA as a cabinet-led agency with a streamlined role, review each BHA position's function, workload and statutory or federal basis, and complete the 2020 Blueprint's delegation of roles to BHASOs and providers. Members discussed consolidating administrative costs across behavioral health agencies and asked for an analysis of consolidating the behavioral health programs spread across nine to twelve departments (October 7 meeting).
Vote	Adopted 10–0
As adopted	**Right-size the Behavioral Health Administration so it is focused on serving high-acuity patients; move care coordination for low-acuity patients out of the BHA, closer to the RAEs and providers; keep licensing and the BHA's other functions, including federal block-grant administration, with the BHA; avoid duplication of service delivery.**
Notes	The Commission did not decide whether functions move to HCPF or whether the BHA remains cabinet-level. Members noted the need for a unified strategy across the two agencies.
Recording	4:24

Line 73b Move BHA block-grant dollars into HCPF	FOLDED INTO LINE 18
Docket proposition	Move the Behavioral Health Administration's federal block-grant dollars into HCPF. Split from line 73; read with line 18.
Outcome	**Not taken up; superseded by line 18**
Recording	4:24

Line 94 Target BH safety-net and indigent care funding at highest need	FOLDED INTO LINE 18
Docket proposition	Target behavioral health safety-net and indigent care funding at the highest need: keep the statutory "no refusal" requirement for comprehensive safety net providers but focus it on the highest-acuity people; redefine "priority populations" in statute; let indigent care funding follow the person to any eligible provider – including specialty, essential and substance use treatment providers – through flexible BHASO funding rather than siloed streams. A behavioral health provider association would preserve early intervention while focusing on the highest-need people, have funding follow the obligation by contract to the designated provider, CSNP or ESNP, and, as BHA develops no-refusal enforcement, clarify who follows up after assessment and referral so that a CSNP that is not the primary treating provider does not automatically take on placement responsibility (October 20). Another behavioral health provider association offers statutory language.
Outcome	**Folded into line 18**
Recording	4:25

Line 121 An Office of Recovery and a voice for people in recovery	REJECTED
Docket proposition	Create an Office of Recovery in the next administration to support the peer and recovery workforce, and give people with lived experience and recovery professionals a standing way to be heard on decisions about recovery services. Relates to lines 22 and 81.
Outcome	**Rejected unanimously**
Recording	4:26

Long-term · Long-term services and supports

Line 31 Individual budgets for LTSS; consolidate the waivers	ADOPTED
Docket proposition	Move LTSS toward an individual budget model: each member receives a stated budget derived from assessed need and chooses services from a menu with a support broker – self-direction extended beyond CDASS and beyond the three services now allowed – with a defined "stacking" framework and, over time, the nine waivers consolidated into one. A narrower version (office hours, October 5): one adult waiver and one children's waiver, each with a menu of services subject to authorization; the combining of the CLLI and CHCBS children's waivers is cited as precedent (to confirm).
Vote	Adopted unanimously

As adopted	**Develop, with stakeholders and CMS, a plan to move LTSS toward individual budgets based on assessed need and to consolidate the waivers, and compare it with managed LTSS before choosing a model.**
Recording	4:28

Line 48 Area Agencies on Aging deliver older-adult services	**REJECTED**
Docket proposition	Contract Area Agencies on Aging to deliver community-based services for older adults, as other states do.
Outcome	**Rejected without objection**
Recording	4:29

Line 78 One accountable LTSS structure in the Governor's office	**REJECTED**
Docket proposition	One accountable LTSS structure: a Governor's Office of LTSS or senior advisor with authority across HCPF, CDPHE, CDHS, CDEC and DOLA to set priorities, align or eliminate overlapping offices, hold a single interpretation of the rules across all case management agencies, move surveys from process to outcomes and restore an on-time survey cycle. Extends 73.
Outcome	**Rejected unanimously**
Recording	4:30

Line 88 Sunset Community First Choice	**TABLED · NOV 18**
Docket proposition	Sunset Community First Choice and return personal care, homemaker and health maintenance services to the HCBS waivers, phased over more than one year. The larger alternative to the CFC package in line 23; read with 57. HCPF is evaluating removing personal care for children from Community First Choice; a forwarder of the proposal asks whether families encouraged to move from CNA services to personal care can return without a reduction in hours or a reassessment (HCPF roundtable proposal, October 20).
Outcome	**Tabled to November 18 (a motion to adopt revised wording was withdrawn)**
Notes	HCPF will present its CFC plan, the changes it is making with stakeholders for April, and the savings. Motion before withdrawal: keep CFC but change it; identify what drives growth; set guardrails, including the line 23 integrity package, that keep the enhanced federal match; revisit a sunset only if growth is not controlled; with a plan for each family, basic needs met, care in the least restrictive setting, and measurable outcomes. HCPF: CFC began July 2025; the fiscal-note savings have not been realized; a provider enrollment moratorium took effect November 1; CFC cannot simply be paused.
Recording	5:00

Line 125 Prescribed pediatric extended care	**REJECTED**

Docket proposition	Create a Medicaid Prescribed Pediatric Extended Care benefit or pilot – day centers providing skilled nursing and therapies for medically complex and technology-dependent children, paid on a shared-care basis – as an added option, not a replacement for one-on-one home nursing.
Outcome	**Rejected unanimously**
Recording	5:02

Line 127 Managed long-term services and supports (MLTSS)	**REJECTED**
Docket proposition	Move long-term services and supports – home and community-based services and, as some states do, nursing facility care – into capitated managed care (managed long-term services and supports, or MLTSS), or pursue another LTSS delivery-system reform, such as a different case management system. 23 states used MLTSS as of 2023 (NCSL), and the Department's Manatt/MISO report listed it among "other potential opportunities." In Colorado today, HCBS is paid fee-for-service (HCPF). Relates to lines 19, 31 and 92.
Outcome	**Rejected without objection**
Recording	5:04

Long-term · Financing

Line 11 Amend the CHASE provider-fee hierarchy	**ADOPTED**
Docket proposition	Amend the CHASE funding hierarchy so the expansion population is not the sole absorber of provider-fee reductions, with rural and frontier hospitals, and Denver Health, held harmless as the fee ratchets down; read with line 3. Alternative proposed (October 20): rather than isolated provider-fee changes, a defined, collaborative CHASE reform initiative with timelines and deliverables, in which key partners evaluate federal funding, expenditure growth, coverage and hospital reimbursement, and the legal, fiscal and access implications of changes before they advance (a hospital association).
Vote	Adopted without objection
As adopted	**Launch a defined CHASE reform process with hospitals, the Colorado Hospital Association, the CHASE Board, legislators, and consumers, with timelines and deliverables, to decide how expansion coverage and supplemental hospital payments share provider-fee reductions, holding rural and frontier hospitals harmless; include a shared financial baseline, a comprehensive evaluation of options and trade-offs, and the upper payment limit.**
Notes	Hospitals to be treated as partners. The process should not foreclose timely federal financing opportunities. HCPF expects the statutory trigger in FY 2027-28; joint modeling with the hospital association is underway.
Recording	5:35

Line 56 Hospital global budgets or an AHEAD-style model	**ADOPTED**

Docket proposition	Hospital global budgets or an AHEAD-style multi-payer model instead of supplemental payments; a rural global budget pilot beginning with obstetrics; a statewide rural clinically integrated network; rural public health districts as special districts operating within a global budget. Also proposed (October 20): voluntary, locally designed regional rural collaboratives under the RHTP that share staff, infrastructure, data and service capacity, piloted and scaled if successful, and alignment of RHTP, the Hospital Improvement Program and CHASE under one rural performance framework within an all-payer strategy (a rural health advocacy group). A perinatal quality collaborative supports the obstetrics pilot, asking how baselines avoid locking in underservice and what happens to HQIP quality funding.
Vote	Adopted unanimously
As adopted	**Explore and potentially pilot a rural hospital global budget, beginning with obstetrics, and evaluate cost, access, and quality before any statewide multi-payer model.**
Notes	The Chair prefers language about rolling out incrementally rather than piloting.
Recording	5:39

Line 20 Employer contribution to Medicaid	**REJECTED**
Docket proposition	An employer contribution to Medicaid: large employers whose workers are enrolled in Health First Colorado pay an assessment toward the cost of their coverage, with the proceeds directed to the Accountable Care Collaborative; as a first step, an annual report naming employers of Medicaid members (Nevada, New Jersey, Washington model).
Outcome	**Rejected 7–3 (Senators Mullica and Bridges and Representative Sirota objecting)**
Notes	Minority view: other states (Nevada, New Jersey, and Washington) do this, and Medicaid coverage for working people subsidizes the employer.
Recording	5:40

Line 21 Commercial payment corridor (Washington model)	**REJECTED**
Docket proposition	A commercial payment corridor on the Washington model: cap hospital payment in state-regulated plans at a multiple of Medicare and floor primary care and non-facility behavioral health at a multiple of Medicare, starting with the state employee plan.
Outcome	**Rejected 7–3 (Representatives Sirota and Brown and Senator Bridges objecting)**
Recording	5:43

Line 50 Local public funds as federal match; dedicated taxes as match	**REJECTED**
Docket proposition	Certified public expenditures and intergovernmental transfers from counties, public health and government-owned providers as non-federal share; tobacco, nicotine, cannabis or lottery funds as match.
Outcome	**Rejected unanimously**

Recording	5:45

Line 52 Raise alcohol excise taxes for SUD treatment and Medicaid	**REJECTED**
Docket proposition	Raise alcohol excise taxes and dedicate revenue to SUD treatment and Medicaid.
Outcome	**Rejected unanimously**
Notes	A member noted it was one of the few revenue items on the docket.
Recording	5:48

Short-term · Who is covered

Line 12 Member cost sharing instead of coverage reduction	**REJECTED**
Docket proposition	Member cost sharing as an alternative to coverage reduction if the CHASE trigger hits.
Outcome	**Motion to reject, 6–4 (the Chair, Senator Kirkmeyer, Senator Frizell, and Senator Mullica objecting). Announced 9–1 before the objections were added.**
Notes	Legislative Council Staff confirmed on November 16 that it is recorded as rejected, 6–4. From the discussion: other states' collection experience has been poor (Michigan collected 26% of premiums charged; Arizona spent more than $15 million to collect about $5 million); HCPF considers the existing $8 non-emergency ER copay to meet H.R. 1.
Recording	5:54

Line 32 Benchmark optional benefits against the national midline	**ADOPTED**
Docket proposition	Benchmark every optional benefit against the national midline and cost what adjusting to the midline would save, before any benefit decision is taken; model adult dental first, since it is already capped.
Vote	Adopted unanimously
As adopted	**Review where Colorado's optional benefits stand relative to other states, relying on national partners such as NCSL or the least costly reliable source rather than HCPF staff time.**
Recording	5:58

Line 64 Waitlist before new arrivals access HCBS waivers	**REJECTED**
Docket proposition	Waiting period or waitlist before new arrivals access HCBS waivers; track residency of state-only program users (HCPF: waiting periods are not federally allowed; waitlists are).
Outcome	**Rejected without objection**
Notes	HCPF legal note: eligibility cannot turn on length of residence.

Recording	6:03

Line 109 Make enrolling and re-enrolling as easy as possible	**ADOPTED**
Docket proposition	Streamline state eligibility and enrollment IT, rules and processes so members can enroll and keep coverage. Share verified income information both ways between Medicaid and SNAP where federal rules allow; compare Colorado's renewal questionnaire with simpler versions in other states, including Maryland; remove unneeded questions, prepopulate information already on file and offer a short, mobile-friendly renewal; set targets for automatic renewals, processing time and cost.
Vote	Adopted unanimously
As adopted	**Streamline eligibility and enrollment IT, rules, and processes so members can enroll and keep coverage, drawing on best practices in other states such as Maryland's short renewal, and build this into the CBMS replacement.**
Notes	The applicant's experience should be as simple as possible while keeping applications accurate. A member asked whether people with lifelong disabilities can avoid repeated redeterminations (see line 76).
Recording	6:12

Line 13c Fund appeals capacity before H.R. 1 volume arrives	**ADOPTED**
Docket proposition	Fund state appeals capacity before the volume from six-month redeterminations and work requirements arrives. Split from line 13.
Vote	Adopted unanimously
As adopted	**Prepare state appeals capacity for the volume from six-month redeterminations and work requirements, reassigning existing staff first and adding funding only where needed.**
Notes	HCPF: benefit appeals up from about 500 last year to 1,200 so far; Office of Administrative Courts scheduling into October 2027; root-cause review underway. A member asked that lines not be dropped only because they are in the Governor's budget.
Recording	6:20

Line 29 Raise disability buy-in premiums, phased and income-capped	**ADOPTED**
Docket proposition	Raise disability buy-in premiums rather than reduce coverage – phased, protecting the lowest tiers, capped as a share of income, and factoring household wealth – particularly for members on an HCBS waiver who are working. Not a doubling. Also heard: count more of earned income when setting the premium (not eligibility) – about half of earned income is disregarded today, so a member with gross earnings of about $11,000 a month can qualify and pay the $200 top tier. A behavioral health provider association would raise premiums at the highest and lowest levels and hold or modestly raise the middle levels (October 20). HCPF is exploring higher member cost sharing, such as enrollment fees and premiums, where programs allow it (HCPF, October 20).

Vote	Adopted 10–0
As adopted	**Investigate a phase-in of higher disability buy-in premiums, rather than reducing coverage, with realistic income thresholds that protect the lowest tiers and cap premiums as a share of income, including the plan for carrying it out, who is affected, and the savings.**
Recording	6:22

Line 35 Continuous authorization and work-requirement safeguards	**REJECTED**
Docket proposition	Continuous authorization in place of annual redetermination for people with certified non-reversible conditions; a documentation framework and 30-day corrective-action period before disenrollment under the H.R. 1 work requirement (Arizona model); monthly eligibility-status sharing with safety-net systems and the health information exchange so exemptions are found without paperwork; housing and homeless providers as first-line navigators; an optional voluntary workforce-support program for expansion adults (Montana, New Hampshire models). Also proposed (October 20): give RAEs timely member-level renewal and redetermination data, including ex parte verification status for work requirements, for targeted outreach (a RAE); longer service authorization periods and a unified pediatric assessment across PDN, CNA and HCBS for children with permanent conditions (a pediatric nurse). HCPF reports that CMS denied continuous eligibility for youth and reentry populations (HB 23-1300) and has indicated verbally that it will not approve presumptive eligibility for people needing LTSS (HB 24-1229) (HCPF, October 20).
Outcome	**Rejected unanimously**
Notes	If Arizona's approach makes it easier for people to keep coverage, the Department should use it.
Recording	6:26

Line 36 NEMT rural classification and rates	**ADOPTED**
Docket proposition	Classify Montezuma County and the southwest corner as rural for non-emergency medical transportation; publish a dated rollout schedule beyond the nine metro counties; restore the two NEMT rates to a cost-covering level with anti-fraud controls rather than the across-the-board cuts of 2025 and 2026. Also proposed (October 20): extend the rural correction to all rural and frontier counties through a rural modifier on procedure codes or new rural-access codes, paid for from fraud-prevention savings under the NEMT broker (a transportation association).
Vote	Adopted unanimously (a motion to reject was withdrawn)
As adopted	**Evaluate non-emergency medical transportation rates for all rural and frontier counties after reviewing the effect of recent rate changes, with anti-fraud controls and an understanding of the cost.**
Notes	The Chair's view that rate-setting belongs with the JBC is noted.
Recording	6:34

Line 63 Raise the $2,000 long-term care asset limit	TABLED · NOV 18
Docket proposition	Raise the $2,000 LTC asset limit (frozen 30 years) with a COLA; fix the asset-limit and buy-in interaction that produces wrongful terminations.
Outcome	**Tabled to November 18**
Notes	HCPF's LTSS staff will share earlier research; no new modeling.
Recording	6:38

Line 74 Fix CHP+-to-Medicaid transitions	TABLED · NOV 18
Docket proposition	Fix the CHP+-to-Medicaid transition so effective dates align; reinstate acceptance of out-of-network commercial status for Medicaid-secondary members. Also proposed (October 20): Medicaid payment for in-office dental anesthesia when the provider is out of network with a commercial plan that does not cover the service (a dental association), and prompt RAE disenrollment when a member moves to other coverage, with payment for services delivered while the member remained enrolled (a behavioral health provider).
Outcome	**Held for November 18 without discussion**
Recording	6:38

Line 76 One redetermination a year for waiver members	TABLED · NOV 18
Docket proposition	Align functional and financial eligibility dates for waiver members so a person faces one redetermination a year, not two; no denial before the review period closes; six months' notice with case-manager support; no suspension of Medicaid when SSI or SSDI is lost for a member whose disability certification stands.
Outcome	**Tabled to November 18**
Notes	SHG to gather information on what federal rules allow.
Recording	6:39

Line 87 Sliding-scale parental fee for children on waivers or CFC	ADOPTED
Docket proposition	A sliding-scale parental fee for children who receive Medicaid through an HCBS waiver or CFC, where eligibility does not count parental income: no fee for low-income families, rising with family income (the submitter's illustration: about $200 a month at $150,000 a year, about $500 for high-income families). Relates to 29 and 38. Also proposed (October 20): tier pay for paid parental caregivers by household income, resources, the child's medical complexity and the family's ability to stay employed, keeping authorized care based on clinical need, with income verification by participating agencies and random HCPF audits where HCPF cannot verify (a pediatric nurse).
Vote	Adopted unanimously

As adopted	**Do not pursue a parental-income fee, which HCPF reports federal rules do not allow; ask HCPF to report the cost-sharing options federal rules permit for families of children on HCBS waivers.**
Recording	6:41