Commission on Medicaid

Wednesday, November 18th, 2026 · The remaining short-term docket

TODAY

Finishing the docket

9:00	Open: where we landed November 10th, and today's work
9:45	Lines November 10th already answers; consent calendar
10:05	Long-term services and supports, with HCPF
12:15	Who is covered; How the program is run
1:15	Managed care and the ACC
2:30	Behavioral health
3:40	Financing
4:00	The December 11th report
4:15	Public comment

TODAY'S GOAL

Every remaining docket line decided, so the draft report reaches members a week before December 9th.

HCPF joins for the long-term services and supports block.

WHAT WE SAID ON NOVEMBER 10TH

Every line on the docket lands on someone

“Every line on the docket lands on someone: a Medicaid member, a caregiver, a provider, a county worker, a person. Our job is to make sure that whatever we recommend, we’ve looked at the people on the other end of it.”

The direction the long-term votes set

1 Information before decisions

Reconcile savings quarterly, publish forecast assumptions, measure outcomes, add an oversight committee.

Docket lines: 14 · 16a · 15a · 40

2 Benefits reviewed one by one

Review post-2019 changes individually. Hard caps and growth limits were rejected.

Docket lines: 112 · 32 · rejected 72a–c, 34

3 Simpler for Medicaid members

Simpler coordination and enrollment, a smoother cliff, appeals capacity.

Docket lines: 7a · 109 · 85 · 13c

4 Accountable delivery

Common RAE and BHASO standards, value-based payment, a BHA focused on high acuity.

Docket lines: 19 · 90 · 108 · 18 · 96

5 LTSS families can navigate

Toward individual budgets and fewer waivers. Community First Choice is discussed today.

Docket lines: 31 · 88 today

6 Financing in partnership

A CHASE reform process and rural global budgets. New revenue ideas were set aside.

Docket lines: 11 · 56 · rejected 20, 21, 50, 52

A tool to measure whether a program is working

Part of the tool	What it shows	Illustration: peer services
Purpose	What the program is meant to change, in one sentence	Help people stay in recovery and out of crisis care
Outcome measure	One or two results members would notice, not just activity	Share still engaged 90 days after first peer contact; crisis and ER visits
Baseline and target	Where it starts and where it should be in two years	Year one sets the baseline from claims; then a target
Cost	Total spending, cost per member served, and the trend	$293M total funds; no published outcome today
Published	Once a year, by program and by contractor	On the standing dashboard from line 16a
If it misses	Returns to the JBC or the oversight committee to fix, change or end	Required benefits such as EPSDT are reported, not wound down

WHAT IT COULD LOOK LIKE · LINE 15A · A SAMPLE SCORECARD

One page per program, published every year

FOR ILLUSTRATIVE PURPOSES ONLY

Peer services

Purpose: help people stay in recovery and out of crisis care

WATCH

OUTCOME · STILL ENGAGED 90 DAYS AFTER FIRST PEER CONTACT

54%

Target: 65% by year three

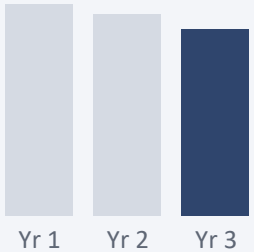
target

RESULT · CRISIS AND ER VISITS PER 1,000 MEMBERS

412

▼ down from 448

lower is better



COST · TOTAL SPENDING, ALL FUNDS

$293M

Cost per member served and the trend come from claims each year

Shown next to the outcome, so cost and results are read together

IF IT MISSES ITS TARGET

On track

Meets its target

Watch

Misses once: the agency publishes a plan to improve

Returns to the JBC

Misses again: the JBC or oversight committee decides to fix, change or end it

HOW IT IS PUBLISHED

- Once a year, on the line 16a dashboard
- By program and by contractor
- Required benefits such as EPSDT are reported, not wound down

Sample scorecard. The 54%, 65%, 412 and 448 figures are made up to show the layout, not HCPF data; $293M total funds is from the record.

A framework to review benefits one by one

Step	Question	Where the answer comes from
1 What changed	What was added or changed since 2019, when, and by what (statute, budget, rule)?	HCPF's list of benefit expansions, 2017–2026
2 Authority	Is it required by federal law, optional, or a state choice?	HCPF legal review
3 Cost against projection	What did the fiscal note expect, and what does it cost now?	Line 14 reconciliation; line 16a forecast
4 Use and results	How many members use it, who, and with what outcome?	Claims data; line 15a outcome measure
5 What a change would do	Would cost shift elsewhere, such as to emergency rooms, or care be lost?	HCPF analysis of cost shifts
6 Options	Keep, modify, limit or repeal – one benefit at a time	Recommendation to the JBC

NOVEMBER 10TH BY THE NUMBERS

50 lines decided; the handout has every vote

22	20	5	2	1
adopted	rejected	held for today	folded into line 18	no agreement (line 107)

Seven of ten votes make a recommendation. Any decision can be revisited before the report is final, and significant changes to the draft come back to the full Commission.

Line 107: no agreement. Line 12: rejected.

Line 107

Guiding principle on coverage

Cover as many people as possible: narrower coverage for more people is generally preferable to more robust coverage for fewer people.

6 support · 4 object

Agreement not reached, so it is not a recommendation. The report describes the views.

Line 12

Member cost sharing

Use member cost sharing as an alternative to coverage reduction if the CHASE trigger hits.

Motion to reject. Announced 9–1; four members then asked to be recorded as objecting.

6 reject · 4 object

Recorded as rejected, as confirmed by Legislative Council Staff.

THE COMMISSION'S CHARGE · SB 26-187

A sustainable Medicaid program

The law asks the Commission to identify and evaluate legislative and executive branch options to implement a sustainable Medicaid program: understanding H.R. 1, administrative structures, eligibility, benefits, delivery and rates, and financing and federal funds. It must weigh member access, quality, and equity, and report short- and long-term recommendations by December 11th.

What the system is managing at the same time

Pressure	Where it stands	What it means for Medicaid
H.R. 1	Six-month redeterminations and work requirements; qualified immigrants lost federal match October 1st	More renewals and appeals: about 1,200 so far this year, against about 500 last year
State budget	The Governor's request names $173.5M GF in cuts and leaves $344.3M unidentified; supplemental due January 2nd	HCPF intends to use Commission recommendations to fill the gap
Cost growth	The FY 2026-27 forecast was revised up $703M GF; community-based long-term care is $244.6M GF over appropriation	Community First Choice is the largest driver on the docket
Hospital provider fee	The CHASE statutory trigger is expected in FY 2027-28	Coverage and hospital payments may have to share a reduction
Change already under way	County transition report due November 30th; CBMS replacement; ACC Phase III in its second year	Savings are sought while systems change
Revenue and Congress	Amendment 87 revenue from January 1st, 2027, shared three ways; a new Congress in January	Neither changes how fast Medicaid costs grow

How the work to date answers the law

1 H.R. 1 changes

Appeals capacity, easier enrollment and renewal, the eligibility cliff. Today: tracking coverage loss.

Adopted 13c · 109 · 85 | Today 122 · 65 · 13a

2 Administrative structures

A BHA focused on high acuity, simpler coordination, reconciled fiscal notes, an oversight committee.

Adopted 18 · 7a · 14 · 16a · 40 | Today 2 · 47

3 Eligibility, benefits, rates

Benefits reviewed one by one, RAE standards, individual LTSS budgets. Today: CFC.

Adopted 112 · 32 · 19 · 31 | Today 88 · 23 · 28

4 Financing and federal funds

A CHASE reform process, rural global budgets, a pharmacy evaluation. New revenue set aside.

Adopted 11 · 56 · 115 | Today 1 · 4 · 24 · 10

5 Input, access, quality, equity

1,196 survey responses, 76 written submissions, 6 member community meetings; outcome measures.

Adopted 15a | Today 69 · 70 · 80

6 The report

Process, who gave input, and short- and long-term recommendations.

Due December 11th

How the Commission has taken up each part of the law

What the law asks	How the Commission took it up	Decided November 10th	Before the Commission today
Understand the H.R. 1 changes and prepare for 2026 to 2028	HCPF and OSPB briefings on coverage loss, work requirements, and the provider-fee step-down; HCPF's October 2nd package on appeals; the October 7th county administration panel with HCPF, CDHS, and counties.	Adopted: appeals capacity (13c), easier enrollment and renewal (109), costing options for the eligibility cliff (85). Rejected: work-requirement safeguards (35); the Department is already doing what federal rules allow.	Coverage-loss dashboard (122); qualified immigrants losing federal match (65); the county transition (13a).
Review how administrative structures have changed over ten years, and where they create friction	August 5th review of HCPF's structure and offices; August 27th behavioral health structure and the Milbank managed care review; HCPF and the BHA together on October 7th.	Adopted: a BHA focused on high acuity (18), simpler care coordination (7a), the ombudsman office (96), fiscal-note reconciliation (14), published forecasts (16a), an oversight committee (40). Rejected: merging CDHS and HCPF (73a); an LTSS office in the Governor's office (78).	HCPF administration (2), IT systems (47), and contracts and memos (8), all on the consent calendar.
Evaluate eligibility, benefits, delivery systems, contracting, rates, and quality for efficacy and value	September 17th LTSS meeting with the case management panel; October 7th behavioral health and provider panels; HCPF cost growth fact sheets.	Adopted: post-2019 benefit review (112), optional benefits (32), RAE and BHASO standards (19), care management (90), value-based payment (108), individual LTSS budgets (31), buy-in premiums (29). Rejected: benefit caps at the federal minimum (34); hard growth limits (72a–c).	Community First Choice (88, 23, and related lines); pediatric behavioral therapy (28); peer services (22, 81); managed care and fee-for-service (92).

How the Commission has taken up each part of the law

What the law asks	How the Commission took it up	Decided November 10th	Before the Commission today
Examine financing, and how Colorado can make the most of federal funds	September 2nd financing and program integrity meeting: CHASE, the upper payment limit, intergovernmental transfers, and rural hospitals.	Adopted: a CHASE reform process (11), a rural hospital global budget (56), a pharmacy benefit evaluation (115). Rejected: five new revenue ideas (20, 21, 50, 51, 52), shown on a later slide.	Medicare enrollment (1), federal match on state-only spending (4), pharmacy (24), program integrity (10), local public health claiming (49), behavioral health match (82).
Seek input, and weigh effects on access, quality, and equity, including for people with disabilities and rural residents	1,196 survey responses; 76 written submissions; office hours in August, September, and October; six member-hosted community meetings; a provider and advocate session; public comment at every meeting.	Adopted: outcome measures (15a), fiscal-note reconciliation (14). The report format states what must be true before any change reaches a member's care.	Member statement of services (69), piloting changes (70), notice before benefit or eligibility changes (80).
Report the process, short- and long-term recommendations, and who gave input, by December 11th	Long-term direction decided November 10th; short-term lines today; draft to members at least a week before December 9th.	22 adopted, 20 rejected, 5 held for today, 1 without agreement (line 107).	How the report is built and its priority tiers (end of day).

What the 22 adopted lines would do to cost

1	10	5	3	3
change cost directly	study or plan a possible saving	build the ability to control cost	protect access	administrative or neutral

SB 26-187 asks for sustainability recommendations. Most of what was adopted asks for a study, a plan, or a report, and none has a Department-costed saving yet. For each line today: does it save money, avoid cost growth, or cost money – and when?

Which adopted lines change cost, and which study a saving

Line	As adopted November 10th (short form)	What is at stake in the record
CHANGES COST DIRECTLY ONCE CARRIED OUT (1)		
18	Right-size the BHA around high-acuity patients; move low-acuity coordination out; avoid duplication	Not costed; Efficiencies are anticipated
STUDIES OR PLANS A POSSIBLE SAVING (10)		
112	Review each benefit, coverage, and utilization change since 2019; repeal or change one by one	Not costed
115	Independent evaluation of a single state-directed pharmacy benefit administrator	Drug spend ~$2.1B against ~$1.0B in rebates
90	Standardize RAE care management; evaluate limiting case management payments to adults	Proceed only where it saves money
108	Extend value-based payment where it lowers cost or improves outcomes	Not costed
31	Plan individual LTSS budgets and fewer waivers, with stakeholders and CMS	Not costed
11	CHASE reform process on how provider-fee reductions are shared	First step: ~$121M in fees, ~$1.1B federal
56	Explore a rural hospital global budget, beginning with obstetrics	Not costed
32	Compare Colorado's optional benefits with other states'	Adult dental: $75M state share
29	Investigate phasing in higher disability buy-in premiums	$6M–$15M a year more, gross (stakeholder)
87	Report the cost sharing federal rules allow for families of children on waivers	Not costed

Which adopted lines build cost control, protect access, or are neutral

Line	As adopted November 10th (short form)	What is at stake in the record
BUILDS THE STATE'S ABILITY TO CONTROL COST (5)		
14	Reconcile fiscal-note savings with actual results quarterly; flag outliers	CFC: a multi-million dollar swing from its fiscal note
16a	Publish forecast assumptions and confidence intervals on a standing dashboard	FY 2026-27 forecast revised +$703M GF
15a	An outcome measure for significant programs; programs that miss return to the JBC	Peer services: $293M TF, no published outcome
40	Interim legislative Medicaid oversight committee to carry work past December 11th	Cost neutral
19	Performance standards for every RAE and BHASO, published by entity	Behavioral health capitation
PROTECTS ACCESS – MAY COST MONEY (3)		
85	Cost options to smooth the eligibility cliff, with a payment source named first	Not costed
109	Make enrolling and renewing easy; build it into the CBMS replacement	System changes draw 90% federal match
36	Evaluate rural and frontier NEMT rates, with anti-fraud controls	Cost neutral to low
ADMINISTRATIVE OR COST NEUTRAL (3)		
96	Redirect the Behavioral Health Ombudsman Office to proactive accountability	Not costed
7a	Simplify care coordination at the member level	Care coordination
13c	Prepare appeals capacity, reassigning existing staff first	Appeals: ~500 last year, 1,200 so far this year

Five revenue ideas were set aside, and why

Line	Idea	Vote	Why it was set aside, and any minority view
20	Employer contribution to Medicaid	Rejected 7–3	Concern about the effect on employers. Minority view: Nevada, New Jersey, and Washington do this, and Medicaid coverage of working people subsidizes their employers.
21	Commercial payment corridor	Rejected 7–3	Beyond the Commission's scope; it acts on commercial plans and has no Medicaid General Fund effect.
50	Local public funds and dedicated taxes as federal match	Rejected unanimously	Uncertain return for the effort, and risk to local governments.
51	Unclaimed property funds as an offset to the provider-fee ratchet	Rejected without objection	An offset, not a saving.
52	Raise alcohol excise taxes for treatment and Medicaid	Rejected unanimously	A revenue question for the General Assembly. A member noted it was one of the few revenue items on the docket.

Still open today: federal match and recovery lines (1, 4, 10, 24, 49, 82). Adopted November 10th: the CHASE reform process (11). The Commission is not assuming Amendment 87 closes the gap.

What the November 10th decisions already set in motion

Line	What it does	Why it is a better business practice for the State
14	Reconcile fiscal-note savings with actual results each quarter; flag outliers	Shows during the year when a program runs over its projection (CFC: a multi-million dollar swing from its fiscal note)
16a	Publish forecast assumptions and confidence intervals on a standing dashboard	Separates forecast error from real growth (the FY 2026-27 forecast was revised up $703M GF)
15a	An outcome measure for significant programs; programs that miss return to the JBC	Funding decisions follow results
19	Performance standards for every RAE and BHASO, published by entity	Contractors are compared on the same measures; the regional briefing shows the consequences other states attach
90	One standard for RAE care management	One way of working for members and providers in every region
108	A Department plan for value-based payment: programs, measures and timeline	Pays for results where it lowers cost; the briefing shows which designs have saved money
115	Independent evaluation of a single state-directed pharmacy benefit administrator	Tests whether one state-run system would cost less; the briefing sets out the questions

What today's docket could add

Practice	Lines before you today	When
Run leaner	**Docket Line 2:** Restructure HCPF to cut administrative cost · **13b** Draw the enhanced federal match for technology · **47** Consolidate IT systems · **8** Streamline contracts and memos	Consent calendar
Pay right the first time	**Docket Line 113:** Stop improper payments before they go out · **114** Check for other insurance first · **79** Link case management to claims · **9** Recovery audits · **69** Member statements of services billed · **10** Extrapolation and prepayment review	Consent calendar; LTSS; How the program is run; Financing
Hold managed care to account	**Docket Lines 5 and 83:** Validate RAE loss ratios; reinvest or remit surplus · **44** Payments for avoidable events · **45** Audit whether capitation transfers risk	Managed care block
Buy smarter	**Docket Line 24** Pharmacy cost measures · **126** Durable medical equipment purchasing	Consent calendar; Financing

Amendment 87 passed. It adds revenue; it does not change Medicaid's cost growth.

When

Takes effect January 1st, 2027. Legislative Council Staff estimates $958M in FY 2026-27 (half a year), $1.97B in FY 2027-28 and $2.09B in FY 2028-29.

Where it can go

Only K-12 education, health care, and early childhood, in a separate fund with annual reporting and an independent audit. No split among the three is set.

Allowed health care uses

Affordability; replacing federal Medicaid funds cut by H.R. 1 and implementing its requirements; primary care, behavioral health and rural care; older adults and people with disabilities; nutritious food; the health care workforce.

What it means here

Medicaid uses are allowed, but no amount is reserved for them, and the fund is shared three ways. It does not change how fast Medicaid costs grow; the Commission's charge is sustainability.

Sources: Amendment 87 text; Colorado Fiscal Institute (citing Legislative Council Staff estimates).

Congress changes hands in January. The Commission plans to current law.

What changed

Democrats are projected to control both chambers of the 120th Congress, which convenes in January 2027.

What keeps moving

Under current law: work requirements from 2027, the provider-fee step-down from October 2027, cost sharing from October 2028.

How the Commission plans

To current law. A federal change is taken into account if and when it is enacted.

Sources: ABC News projections (Nov 4th, 2026); K&L Gates, Guide to the 120th Congress (Nov 4th, 2026); Commission record.

Follow-ups and where they stand

Request	Who	Status
Five briefings: Idaho and Arizona (72c), Connecticut (92), regional structures (19), value-based payment (108), pharmacy administrator (115)	SHG	In packet; next slide
Better mechanism for surfacing programs not working (line 15a)	SHG with HCPF	To be addressed in report
Community First Choice plan and savings (line 88)	HCPF	Today, LTSS block

Five briefings answer questions members raised on November 10th

Briefing · line	What it found	What it means today
Idaho and Arizona · line 72c	Idaho requires a law before any new coverage or new state cost; it is not a growth cap. The 10% trigger is Arizona's, and covers new waiver changes only.	Revisited only if a member moves to. Neither state lets an interim body approve.
Connecticut · line 92	All of Medicaid on an administrative-services model since 2012. Per-member costs fell, but other reforms came at the same time.	Informs line 92 in Block E. Colorado would lose state-directed payments.
Regional structures · line 19	No evidence that a set number of regions saves money. What counts is what entities answer for, and what happens when they miss.	For the report: outcome measures that count, published by entity, with escalating consequences.
Value-based payment · line 108	Most models have not saved money. Those that do put total cost under one budget, with real risk and fair benchmarks.	For the report: questions the Department plan should answer. PRIME has not been independently analyzed.
Pharmacy administrator · line 115	Colorado already pays most pharmacy through one state system; the open question is two health plans. Ohio's savings are contested.	For the report: the evaluation's questions, including Denver Health's 340B savings.

HCPF materials are in the public folder, by meeting

July 28th	H.R. 1 eligibility, outreach, and hospital provider fee fact sheets; HCPF written responses of July 2nd and July 22nd
Aug 5th	Org chart and FTE, state-only spending, program budget crosswalk, spending by member experience, contractor systems
Aug 28th	Assessment of the ACC; fact sheets on the RAEs, behavioral health, PBMs, fee-for-service benefits and CHP+
Sept 2nd	Money map, program integrity, how rates are set, MPRRAC, rural health transformation, H.R. 1 immigrant changes, federal funding options
Sept 17th	Cost growth trends presentation and fact sheets, benefit expansions since 2017, LTSS fact sheets (services, eligibility, caregiver cap, due process, case management, PETI)
Oct 7th	HCPF & BHA behavioral health presentation, capitated behavioral health, care coordination, appeals backlog, program integrity recovery, HB26-1429, county administration, 1115 waivers, Medicare eligibility, action plan

TODAY'S WORK

78 short-term lines remain, plus five held from November 10th

8

already answered by November 10th decisions

Confirm as a group

1

proposed to set aside

Seven or more Reject

11

consent calendar

Seven or more Proceed

58 + 5

for discussion, by bucket

Including the five held lines

Each line slide explains what the line would do in plain terms, what we know, and suggested wording where members' notes pointed to one. Any member may pull any line from a group vote. For every line, one question: does it save money, avoid cost growth, or cost money – and when?

LINES 9:45 – 9:50

Short-term lines November 10th already answers

Eight short-term lines ask for something the Commission's November 10th decisions already cover. SHG proposes confirming them as a group, so each is noted in the report as covered by the decision that answers it.

Disaggregate the Medical Services Premiums line

DOCKET LINE 110 PROPOSITION · AS MEMBERS MARKED IT · 8 PROCEED · 0 CAUTION · 0 REJECT

Work with JBC staff and HCPF to further disaggregate the Medical Services Premiums line in the Long Bill so the JBC receives regularly updated trends by program and service line, including the LTSS waivers now inside it.

COVERED BY LINE 14 · AS ADOPTED NOVEMBER 10TH

Line 14 – Reconcile fiscal-note savings with actual results. 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.

Why it is covered: Members merged it into line 14 on November 10th.

ANSWERED BY NOVEMBER 10TH · 2 OF 8 · LINE 16B

Outlier list of service lines where dollars and users diverge

DOCKET LINE 16B PROPOSITION · AS MEMBERS MARKED IT · 6 PROCEED · 1 CAUTION · 0 REJECT

Produce a normalized outlier list of service lines where spending and the number of members using them diverge, updated regularly for the JBC.

Related lines: Split from line 16 (an earlier docket line, since split).

COVERED BY LINE 14 AND 16a · AS ADOPTED NOVEMBER 10TH

Line 14 – Reconcile fiscal-note savings with actual results. 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.

Line 16a – Publish forecast assumptions. 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.

Why it is covered: Line 14 now reconciles quarterly with the emphasis on outliers and utilization trends.

Dynamic budgeting: track how cuts shift costs elsewhere

DOCKET LINE 16C PROPOSITION · AS MEMBERS MARKED IT · 5 PROCEED · 3 CAUTION · 0 REJECT

Show how proposed lines compound or offset one another and who carries each; track how a cut or limit in one benefit shifts cost to another, using 12 months of claims data.

Related lines: Split from line 16 (an earlier docket line, since split).

COVERED BY LINE 16a AND 14 · AS ADOPTED NOVEMBER 10TH

Line 16a – Publish forecast assumptions. 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.

Line 14 – Reconcile fiscal-note savings with actual results. 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.

Why it is covered: Members removed “dynamic budgeting” from 16a and asked for a view that counts savings and downstream costs; line 14 counts downstream costs.

One or two statewide RAE quality priorities

DOCKET LINE 15B PROPOSITION · AS MEMBERS MARKED IT · 0 PROCEED · 5 CAUTION · 3 REJECT

Replace the multi-measure RAE quality program with one or two statewide priorities sustained for several years.

Related lines: Split from line 15 (an earlier docket line, since split).

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 15B · WHO PROPOSED WHAT

A perinatal quality collaborative (October 20th): Make perinatal health one of the statewide priorities.

COVERED BY LINE 19 · AS ADOPTED NOVEMBER 10TH

Line 19 – RAE and BHASO performance standards. 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.

Why it is covered: Line 19 sets performance standards for every RAE and BHASO, published by entity; which measures to use is an implementation choice.

ANSWERED BY NOVEMBER 10TH · 5 OF 8 · LINE 6

One set of processes across the RAEs and BHASOs

DOCKET LINE 6 PROPOSITION · AS MEMBERS MARKED IT · 4 PROCEED · 4 CAUTION · 0 REJECT

Standardize what providers and members touch across the four RAEs and the BHASOs: one enrollment and credentialing process and portal, one verified provider directory, one prior-authorization standard, shared call centers and complaint lines, single case agreements and continuity of care when a member's RAE changes or a contract ends, notice to members and providers before any reassignment, and a recoupment look-back no longer than the window in which a provider can still bill the other payer.

COVERED BY LINE 19 · AS ADOPTED NOVEMBER 10TH

Line 19 – RAE and BHASO performance standards. 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.

Why it is covered: Line 19 examines how the entities interact with providers, with a view to standardization.

Standardize RAE care coordination and member tiering

DOCKET LINE 111 PROPOSITION · AS MEMBERS MARKED IT · 3 PROCEED · 5 CAUTION · 0 REJECT

Standardize care coordination across the RAEs on the practices of the most successful RAEs, including one method for tiering members by need.

Related lines: Relates to line 6 (one set of processes across the RAEs and BHASOs); line 7 (an earlier docket line, since split).

COVERED BY LINE 90 AND 7a · AS ADOPTED NOVEMBER 10TH

Line 90 – ACC care management. 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.

Line 7a – Care coordination. Simplify care coordination at the member level.

Why it is covered: Line 90 standardizes care management practice across the RAEs; line 7a simplifies coordination for members.

Expand shared savings and alternative payment models

DOCKET LINE 71 PROPOSITION · AS MEMBERS MARKED IT · 2 PROCEED · 4 CAUTION · 2 REJECT

Expand shared-savings and alternative payment models (maternity bundle, chronic conditions) statewide and report savings annually; pay against an absolute benchmark, not only year-over-year improvement, and release savings to providers; extend value-based purchasing to hospitals and specialists.

Also proposed: A safety-net reinvestment version (written submission, October 5th): qualifying safety-net providers keep a defined share of verified efficiency savings, only where quality, access and outcomes hold, most of the people served have significant needs, the savings are measurable and attributable to better operations, part is reinvested in care, and the use is publicly reported.

COVERED BY LINE 108 · AS ADOPTED NOVEMBER 10TH

Line 108 – Value-based payment. 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.

Why it is covered: Line 108 extends value-based payment where it achieves lower cost or better outcomes.

ANSWERED BY NOVEMBER 10TH · 8 OF 8 · LINE 3

Preserve the hospital upper payment limit federal draw

DOCKET LINE 3 PROPOSITION · AS MEMBERS MARKED IT · 9 PROCEED · 0 CAUTION · 0 REJECT

Preserve the higher federal draw under the hospital upper payment limit: file the per-diem demonstration the hospitals describe (a templated worksheet, no statute or CHASE Board notice, retroactive to October 1st, 2025), or, if the Department's reading is right that a larger UPL triggers the provider-fee hierarchy, amend the hierarchy so UPL room does not pull fee revenue from coverage (line 11).

ADDED TO THE PROPOSITION · LINE 3 · WHO PROPOSED WHAT

HCPF update: HCPF is working with a hospital association on a new upper payment limit methodology for hospital supplemental payments, to be explored prospectively (October 7th meeting).

COVERED BY LINE 11 · AS ADOPTED NOVEMBER 10TH

Line 11 – CHASE reform process. 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.

Why it is covered: Members folded the upper payment limit into the CHASE reform process in line 11.

CONSENT CALENDAR · 9:50 – 10:05

The consent calendar

Eleven lines that seven or more members marked Proceed, voted as a group. Any member may pull a line for discussion. One line with seven or more Reject marks, line 41, is proposed to be set aside. Lines 1, 2, 4 and 24 are ones the docket ranks as acting soonest on the General Fund under existing authority, and line 28 is one of three with a five-year costing.

How the program is run

2 Restructure HCPF to cut administrative cost

Consolidate HCPF's ten offices, publish each office's dollars and staff, and use up administrative savings before cutting coverage.

8 Proceed · 1 Caution · 0 Reject

Previously provided: Aug 5th: HCPF Org Chart and FTE; Oct 7th: Executive Director directive on administration

13b Plan technology to draw the enhanced federal match

Name which systems qualify for 90% federal match to build and 75% to run, and the federal dollars and savings.

7 Proceed · 1 Caution · 0 Reject

Previously provided: Oct 7th: County Administration and Eligibility Systems fact sheet

How the program is run

47 Consolidate HCPF IT systems

Move HCPF's separate systems onto shared, modular platforms that work together.

8 Proceed · 1 Caution · 0 Reject

Previously provided: Aug 5th: HCPF Contractor Systems List

113 Prevent improper payments before payment

Shift program integrity from “pay and recover” to “identify, prevent and act”: Catch improper claims before payment instead of recovering later; pay vendors on validated savings.

8 Proceed · 1 Caution · 0 Reject

Previously provided: Sept 2nd: Detection to Recovery; FWA Road Map

How the program is run

114 Find other insurance before Medicaid pays

Improve how Medicaid identifies other responsible payers before claims are paid; report how much is caught before payment and how much is recovered after.

9 Proceed · 0 Caution · 0 Reject

Previously provided: Oct 7th: Program Integrity Recovery Data

8 Streamline contracts, policy memos and rulemaking

Consolidate contract terms, cut policy memos, and require rulemaking – not a memo – to remove or reprice a benefit.

7 Proceed · 2 Caution · 0 Reject

Behavioral health

15d Review behavioral health pilots and small grants

Review pilots and small grants on outcomes and duplication; wind down those not delivering.

7 Proceed · 1 Caution · 0 Reject

28 Set outcome standards for pediatric behavioral therapy

A standard outcome assessment, tighter qualifications, and high-hour authorizations tied to improvement.

7 Proceed · 2 Caution · 0 Reject

Previously provided: Sept 2nd: July 1st Rate Reductions fact sheet

Financing

1 Enroll eligible members in Medicare

Enroll members already eligible for Medicare so it pays first; track net savings.

9 Proceed · 0 Caution · 0 Reject

Previously provided: Oct 7th: Medicare Eligibility Analysis

4 Claim federal match on state-only spending

Draw federal match on General Fund spending that could qualify, starting with ten state-only programs.

9 Proceed · 0 Caution · 0 Reject

Previously provided: Aug 5th: HCPF State-Only Expenditure

Financing

24 Adopt pharmacy cost measures

Prefer generics where cheaper after rebates, report 340B's cost, and restore step therapy when the ban sunsets in 2027.

8 Proceed · 0 Caution · 0 Reject

Previously provided: Aug 28th: Partner Fact Sheet: PBMs

PROPOSED TO SET ASIDE

One line seven or more members marked Reject

Line 41

Admit any qualified provider to RAE networks; disclose rates

Admit every enrolled behavioral health provider to every RAE network within 60 days, and require RAEs to disclose how they set rates.

0 Proceed · 1 Caution · 7 Reject

10:05 – 12:00

Long-term services and supports, with HCPF

Hear the Department's plan for Community First Choice

1. What is driving CFC growth, by population and service
2. The changes being made with stakeholders for April
3. Guardrails that keep the enhanced federal match
4. What families can expect, and the savings

ON THE RECORD

- CFC began July 2025.
- Fiscal-note savings have not been realized.
- Provider moratorium from November 1st.
- It cannot simply be paused.

Keep and change Community First Choice, or sunset it

WHAT THIS WOULD DO

- Community First Choice (CFC) is a state plan benefit, begun July 2025, that pays for personal care, homemaker and health maintenance services at home, with an enhanced federal match.
- Line 88 proposed sunsetting CFC and returning those services to the waivers. On November 10th a motion to keep CFC but change it was withdrawn, pending HCPF's plan.

WHAT MEMBERS WROTE

- Change CFC rather than end it; some members prefer a pause.
- Understand what is driving its growth – unclear guidelines, misuse, or both.
- The extra 6% federal match helps only if the program is well managed.

MEMBER MARKS · 9 RETURNED



3 Proceed · 3 Caution · 3 Reject

WHAT WE KNOW

- Fiscal-note savings not realized. Provider moratorium since November 1st.
- Cannot simply be paused.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package and Cost Growth Trends fact sheets; Growth Trends presentation

Keep and change Community First Choice, or sunset it

DOCKET LINE 88 PROPOSITION · AS MEMBERS MARKED IT

Sunset Community First Choice and return personal care, homemaker and health maintenance services to the HCBS waivers, phased over more than one year.

Department context: 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 20th).

Related lines: The larger alternative to the CFC package in line 23 (ITSS program-integrity package for CFC); read with line 57 (evaluate CFC net of shifted services before further cuts).

SUGGESTED WORDING · FOR DECISION

Keep Community First Choice but change it: identify what is driving its growth by population and service, then set guardrails – including the integrity package in line 23 – that keep the enhanced federal match; revisit a sunset only if growth is not controlled; with a transition plan for each family, basic needs met, care in the least restrictive setting, and measurable outcomes.

Adopt a program-integrity package for Community First Choice

WHAT THIS WOULD DO

- Hold CFC personal care and homemaker agencies accountable: limits on enrollment growth or a financial-strength test, rules on advertising and inducements to switch agencies, and stronger authorization and monitoring by case management agencies.
- Guard against remote supports approaching a residential rate. If a reduction is made, make it once rather than in annual steps.
- A pediatric nurse also proposed barring parents from owning an agency that bills for their own children's care without independent oversight.

MEMBER MARKS · 9 RETURNED



7 Proceed · 2 Caution · 0 Reject

WHAT WE KNOW

- HCPF is evaluating a lower personal care cap (48 to about 40 hours) and further limits on how providers market to members.

WHAT MEMBERS WROTE

- Much of this is necessary; the details matter.
- Some members would pause the program until changes are made.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package and Cost Growth Trends fact sheets

Adopt a program-integrity package for Community First Choice

DOCKET LINE 23 PROPOSITION · AS MEMBERS MARKED IT

LTSS program-integrity package: provider accountability for CFC homemaker and personal care agencies – enrollment growth caps or a financial-strength threshold for enrollment, regulation of direct-to-consumer advertising and of inducements to switch agencies, stronger CMA authorization and monitoring, a guardrail so remote supports cannot approach a residential rate – short of pausing CFC; if a reduction is made, make it once rather than in annual steps.

Related lines: Lines 79 and 84 carry the related visibility and benefit-design items.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Evaluate CFC net of services that shifted into it

WHAT THIS WOULD DO

- Test whether CFC's growth is new spending or services that moved over from the waivers and long-term home health, before any further reductions.
- Before any pause, name which program will carry each member's existing hours so no one has a gap.

WHAT MEMBERS WROTE

- Some members would pause the program until changes are made.

MEMBER MARKS · 9 RETURNED



3 Proceed · 1 Caution · 3 Reject

WHAT WE KNOW

- No cost estimate.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package and Cost Growth Trends fact sheets

Evaluate CFC net of services that shifted into it

DOCKET LINE 57 PROPOSITION · AS MEMBERS MARKED IT

Test whether Community First Choice can be evaluated net of services that shifted from waivers and long-term home health, before further reductions; before any pause, name the authority that will carry each member’s existing hours so there is no gap.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Limit homemaker hours; pause the children's Community Connector

WHAT THIS WOULD DO

- Cap homemaker services at 5–7 hours a week for all home and community-based services members, with higher needs met through long-term home health.
- Pause the children's Community Connector benefit for two to three years while it is redesigned. Community Connectors help children with disabilities take part in community activities.

WHAT MEMBERS WROTE

- Consider the effect on families and on care.

MEMBER MARKS · 9 RETURNED



4 Proceed · 5 Caution · 0 Reject

WHAT WE KNOW

- HCPF is evaluating lowering the homemaker cap from 21 to about 7 hours a week.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Growth Trends presentation; LTSS Service Package

Limit homemaker hours; pause the children's Community Connector

DOCKET LINE 84 PROPOSITION · AS MEMBERS MARKED IT

Benefit design within CFC and the children's waivers: cap homemaker services at 5–7 hours a week for all HCBS members, with needs above that met through long-term home health; pause the children's Community Connector benefit for two to three years while its structure is re-examined.

Proposed by: a client-led disability organization.

Concerns raised (October 20th): a member of the public holds that high Community Connector use in a highly screened population is not evidence of overuse and asks that inappropriate billing, provider rates, administrative layers, program design and duplication be examined before access is reduced.

Department context: In its September 30th stakeholder roundtable proposals, HCPF is considering limiting paid personal care provided by parents of minor children from 48 to 7 hours a week. This is a proposal for public input, not a decision, and it is not in the Governor's budget request.

Related lines: Builds on line 23 (lTSS program-integrity package for CFC).

SUGGESTED WORDING · FOR DECISION

Consider limits on homemaker services and a pause of the children's Community Connector benefit only after reviewing the effect on families and on care.

Limit paid parent hours per child

WHAT THIS WOULD DO

- Cap total paid hours from all parents and legally responsible caregivers at 56 a week per child, rather than per caregiver, so a two-parent household is not paid for more parent hours than a single-parent household.
- Adults are unaffected.

WHAT MEMBERS WROTE

- Open to discussion.

MEMBER MARKS · 9 RETURNED



1 Proceed · 6 Caution · 1 Reject

DATA PREVIOUSLY PROVIDED:

Sept 17th: Cost Growth Trends fact sheets

Limit paid parent hours per child

DOCKET LINE 89 PROPOSITION · AS MEMBERS MARKED IT

Cap the total paid hours from all legally responsible persons for a child at 56 a week per member, not per caregiver, so a two-parent household cannot be paid for more parent hours than a single-parent household. Adults are unaffected (at most one legally responsible person).

Department context: HCPF is evaluating limiting paid homemaker by any family caregiver to 7 hours a week, extending the limit for legally responsible persons to all relatives, and limiting paid personal care by parents and legal guardians of children from 48 to 7 hours a week (HCPF roundtable proposals, September 30th). If HCPF adopts its 7-hour proposal, this cap would rarely apply; it matters mainly if HCPF does not.

Related lines: Read with line 39 (hold the weekly caregiver-hour cap until failures are measured).

SUGGESTED WORDING · FOR DECISION

Discuss capping total paid hours from legally responsible persons at 56 a week per child, read with line 39.

Hold the weekly caregiver-hour cap until failures are measured

WHAT THIS WOULD DO

- Do not tighten the weekly cap on caregiver hours further until the state measures how often care arrangements break down because of it.
- Correct how the cap is applied (it applies to the caregiver, not the member), say who finds a second worker when needed, and track nursing facility admissions among members whose hours were cut.

MEMBER MARKS · 9 RETURNED



2 Proceed · 4 Caution · 3 Reject

WHAT WE KNOW

- Costs money, because it holds off a reduction.
- Enacted savings: $0.5M ($0.3M GF) in year one; $2.8M ($1.4M GF) in year two.
- Cap: 84 hours now, 70 in January 2027, 56 in July 2027.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Weekly Caregiver Cap fact sheet

Hold the weekly caregiver-hour cap until failures are measured

DOCKET LINE 39 PROPOSITION · AS MEMBERS MARKED IT

Do not advance the weekly caregiver cap further until arrangement failure is measured; correct the field application (it applies to the caregiver, not the member); define who finds the second worker when authorized hours exceed the cap; track nursing-facility admissions among members whose paid hours were reduced.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Drop the Class B license for non-medical CFC services

WHAT THIS WOULD DO

- Agencies providing non-medical CFC personal care and homemaker services must hold a Class B home care agency license, built for medical settings.
- This line would remove that requirement for non-medical services, and write rules for IDD and TBI group homes that fit their residents.

MEMBER MARKS · 9 RETURNED



2 Proceed · 4 Caution · 1 Reject

WHAT WE KNOW

- No cost estimate.

Drop the Class B license for non-medical CFC services

DOCKET LINE 77 PROPOSITION · AS MEMBERS MARKED IT

Remove the Class B home care agency license requirement for non-medical CFC personal care and homemaker services, and write a regulatory subset for IDD and TBI group homes that fits their residents rather than a medical setting.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Fix authorization before cutting long-term services

WHAT THIS WOULD DO

- Set performance standards for the vendors that authorize private duty nursing, long-term home health and other LTSS, and measure how often their decisions are changed on appeal.
- Hold further across-the-board LTSS limits until that error rate is known.
- Separately, a pediatric nurse also proposed a faster hospital-to-home pathway for children with complex medical needs.

MEMBER MARKS · 9 RETURNED



2 Proceed · 3 Caution · 2 Reject

WHAT WE KNOW

- About 25% of benefit appeals go the member's way.
- HCPF does not track LTSS appeal outcomes.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Due Process for LTSS; Oct 7th: HCPF Appeals Backlog

Fix authorization before cutting long-term services

DOCKET LINE 91 PROPOSITION · AS MEMBERS MARKED IT

Fix authorization before cutting: set performance standards and strengthen contract oversight for the prior-authorization and utilization-review vendors for private duty nursing, long-term home health and LTSS; measure how often authorizations are changed on appeal or exception; hold further across-the-board LTSS limits until that error rate is known. The JBC's lever is declining reductions and conditioning funding on authorization accuracy.

Related lines: Relates to line 23 (lTSS program-integrity package for CFC); line 39 (hold the weekly caregiver-hour cap until failures are measured); line 61 (lTSS exception and appeal reform); line 79 (connect case management to claims to see total hours); line 80 (notice and justification before benefit or eligibility changes).

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 91 · WHO PROPOSED WHAT

A pediatric nurse: A hospital-to-home pathway for children with complex medical needs – expedited or provisional PDN authorization, discharge planning before the expected discharge date, prioritized equipment approval, and tracking of hospital days caused by authorization, equipment or nursing delays.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Restore LTSS access and rates before further cuts

WHAT THIS WOULD DO

- Reverse several recent Community First Choice changes.
- Restore access to private duty nursing and long-term home health under the state plan, and restore direct-care rates that attract and keep a workforce.
- The premise: avoided hospital and institutional care offsets the cost.

MEMBER MARKS · 9 RETURNED



0 Proceed · 0 Caution · 9 Reject

WHAT WE KNOW

- Costs money: a protection, not a saving.
- It is the reverse of lines 23, 84 and 89.

Restore LTSS access and rates before further cuts

DOCKET LINE 93 PROPOSITION · AS MEMBERS MARKED IT

Restore before cutting in LTSS: reverse several recent CFC changes, restore access to private duty nursing and long-term home health under the state plan, and restore direct-care rates that attract and keep a workforce, on the premise that hospital and institutional diversion offsets the cost. A protection, not a saving.

Also proposed (October 20th): raise PDN reimbursement to reflect competitive nursing wages, with enhanced rates for high-acuity children on objective clinical criteria rather than cutting hours for all (a pediatric nurse).

Related lines: The reverse of line 23 (ITSS program-integrity package for CFC); line 84 (cap homemaker hours; pause the children's Community Connector); line 89 (cap paid parent hours per child); read with line 58 (expand family CNA tasks; a state pathway for pediatric PDN); line 91 (fix authorization before cutting LTSS).

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Raise the $2,000 long-term care asset limit

WHAT THIS WOULD DO

- To qualify for Medicaid long-term care, a person may have no more than $2,000 in assets, a limit unchanged for about 30 years.
- This line would raise it with a cost-of-living adjustment, and fix how the limit interacts with the disability buy-in so people are not wrongly terminated.

WHAT MEMBERS WROTE

- Concern about the cost.

MEMBER MARKS · 9 RETURNED



1 Proceed · 7 Caution · 1 Reject

WHAT WE KNOW

- Costs money. HCPF staff share earlier costing today.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Eligibility & Enrollment fact sheet

Raise the $2,000 long-term care asset limit

DOCKET LINE 63 PROPOSITION · AS MEMBERS MARKED IT

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.

SUGGESTED WORDING · FOR DECISION

Have HCPF cost raising the $2,000 LTC asset limit with a COLA, and fix the asset-limit and buy-in interaction that causes wrongful terminations.

Align waiver redeterminations so members face one a year

WHAT THIS WOULD DO

- Waiver members go through two reviews: functional eligibility (do they need this level of care) and financial eligibility, often on different dates – so two redeterminations a year.
- Align the dates so each person faces one. No denial before the review period closes; six months' notice; no suspension when SSI or SSDI is lost but the disability certification stands.

WHAT MEMBERS WROTE

- Should be cost-neutral.
- Don't make redetermination burdensome, but clarify what happens when SSI or SSDI is lost.

MEMBER MARKS · 9 RETURNED



4 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.
- HCPF was asked what federal rules allow.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Case Management fact sheet

Align waiver redeterminations so members face one a year

DOCKET LINE 76 PROPOSITION · AS MEMBERS MARKED IT

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.

SUGGESTED WORDING · FOR DECISION

Align functional and financial eligibility dates for waiver members so each faces one redetermination a year, at no added cost, and clarify what happens when SSI or SSDI is lost but disability certification stands.

Re-examine eligibility for the children's CES waiver

WHAT THIS WOULD DO

- The Children's Extensive Support (CES) waiver serves children with developmental disabilities and high needs. Enrollment roughly doubled from 2023 to 2025.
- This line would re-examine eligibility, including whether the evaluation tool is valid, and consider a waitlist or acuity gate.
- It would also give aging caregivers priority for adult developmental disability waiver slots.

WHAT MEMBERS WROTE

- Growth justifies a review; wants detail on how it would be carried out.

MEMBER MARKS · 9 RETURNED



4 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Growth Trends presentation; LTSS Service Package

Re-examine eligibility for the children's CES waiver

DOCKET LINE 60 PROPOSITION · AS MEMBERS MARKED IT

Re-examine CES waiver eligibility – the evaluator tool’s validity, a waitlist or acuity gate – given enrollment roughly doubled 2023–25; give aging caregivers priority for adult DD waiver slots.

SUGGESTED WORDING · FOR DECISION

Re-examine CES waiver eligibility, including the validity of the evaluator tool, and give aging caregivers priority for adult DD waiver slots, with implementation details worked out by HCPF and stakeholders.

Limit what agencies keep; protect caregiver pay

WHAT THIS WOULD DO

- When an agency employs a caregiver, it keeps part of the Medicaid payment. This line would set a standard for how much an agency may keep versus what reaches the worker, by provider type.
- Enforce that family caregivers are W-2 employees, and require any rate cut to come out of the agency's share rather than the caregiver's.
- Use new HB26-1235 cost reports as the first hard data on overhead.

MEMBER MARKS · 9 RETURNED



6 Proceed · 3 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.
- HB26-1235 requires HCPF to collect agency cost data by September 30, 2027 – the first hard data on overhead, but not available before the 2027 session.
- A home care association (November 11th) opposes a fixed pass-through share; it asks that costs be analyzed by service, provider size, and region first.

Limit what agencies keep; protect caregiver pay

DOCKET LINE 30 PROPOSITION · AS MEMBERS MARKED IT

Set a standard for the share of reimbursement an intermediary agency may retain against what reaches the direct-care worker, by provider type; differentiate rates for agencies that pay full benefits; enforce that family caregivers are W-2 employees under the IRS and DOL tests already in force; require any rate reduction to be absorbed by the agency rather than passed to the caregiver; use HB26-1235 cost reporting as the first hard data on overhead.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 30 · WHO PROPOSED WHAT

A pediatric nurse (October 20th): Require that a portion of targeted PDN reimbursement increases reach direct-care nurses as wages, benefits and retention incentives.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Develop a plan to support family caregivers

WHAT THIS WOULD DO

- Develop a plan for family caregivers, including whether structured family caregiving, used in ten states, fits Colorado. It pays a family caregiver a daily rate with professional support.
- Add a consumer-directed option for the developmental disability waiver family caregiver rate, so caregivers can be W-2 employees without an agency taking a share.

WHAT MEMBERS WROTE

- Flesh out both approaches.
- Concern about W-2 status for family caregivers outside agencies; support consumer direction.

MEMBER MARKS · 9 RETURNED



5 Proceed · 2 Caution · 1 Reject

WHAT WE KNOW

- Stakeholder estimate only.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package

Develop a plan to support family caregivers

DOCKET LINE 37 PROPOSITION · AS MEMBERS MARKED IT

A comprehensive family-caregiver plan, including whether structured family caregiving as used in ten states fits Colorado, and a consumer-directed option for the DD-waiver family caregiver rate so caregivers can be W-2 without agency retention.

Also proposed (October 20th): that the next administration evaluate family caregiving models used in other states but not available in Colorado – with predictable payment, professional supports and a difficulty-of-care payment – for their effect on nursing facility placement, personal care and homemaker use, caregiver finances and oversight (a family caregiving organization).

SUGGESTED WORDING · FOR DECISION

Develop a family-caregiver plan that compares structured family caregiving and a consumer-directed W-2 option for family caregivers outside agencies, with costs and supports for consumer direction.

Redesign the income contribution (PETI) on the DD waiver

WHAT THIS WOULD DO

- Post-eligibility treatment of income (PETI) is the amount of a waiver member's own income they must contribute toward their care.
- This line would redesign it on the DD waiver: a sliding scale by income, exemptions for members with no earnings or living at home, and a cap at the buy-in maximum ($200) so a non-working member never pays more than a working one.

WHAT MEMBERS WROTE

- Redesign PETI across all waivers, not only DD, and apply it equitably.
- Use other states' best practices to get it right.

MEMBER MARKS · 9 RETURNED



3 Proceed · 5 Caution · 1 Reject

WHAT WE KNOW

- Costs money, because it reduces contributions.

DATA PREVIOUSLY PROVIDED:

Sept 17th: DD PETI fact sheet

Redesign the income contribution (PETI) on the DD waiver

DOCKET LINE 38 PROPOSITION · AS MEMBERS MARKED IT

Redesign or reverse PETI on the DD waiver: replace the flowchart with an income sliding scale; exempt members with no earned income and members living in their own or a family home; widen the employment exemption beyond job coaching; cap the contribution at the buy-in maximum ($200) so a non-working member does not pay more than a working one; correct the locked worksheet; require the savings figure to be recalculated net of exemptions.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 38 · WHO PROPOSED WHAT

A member of the public: Replace PETI with sliding-scale premiums for all members – nothing at or below FPL, a nominal fee near 300% FPL.

A disability advocate: Repeal PETI by rule on civil rights and Olmstead grounds, and stop counting court-ordered child support for an unemancipated adult child as the member's income.

SUGGESTED WORDING · FOR DECISION

Redesign PETI across all waivers, not only the DD waiver, so it is applied equitably, using other states' practice and an income-based sliding scale.

Expand family CNA tasks; create a state path for pediatric nursing

WHAT THIS WOULD DO

- Allow family members who are certified nursing assistants to perform more skilled tasks, such as tracheostomy and ventilator care.
- Create a Colorado-specific pathway for agencies providing private duty nursing to children, instead of federal home health rules designed for other services.

MEMBER MARKS · 9 RETURNED



0 Proceed · 8 Caution · 1 Reject

WHAT WE KNOW

- No cost estimate.

WHAT MEMBERS WROTE

- Wants the fiscal impact and other states' experience.
- Concern about the safety of expanding unsupervised CNA tasks.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package (private duty nursing)

Expand family CNA tasks; create a state path for pediatric nursing

DOCKET LINE 58 PROPOSITION · AS MEMBERS MARKED IT

Expand delegable skilled tasks (tracheostomy, ventilator) for family CNAs; replace the federal home-health conditions of participation for pediatric PDN agencies with a PDN-specific state pathway by State Plan Amendment and rule.

SUGGESTED WORDING · FOR DECISION

Evaluate expanding delegable skilled tasks for family CNAs and a PDN-specific state pathway, with a fiscal estimate, safety safeguards for unsupervised tasks and other states' experience, before adoption.

Publish the Colorado Single Assessment before it goes live

WHAT THIS WOULD DO

- The Colorado Single Assessment is the new tool for assessing what LTSS members need, which then feeds an algorithm that sets their support level.
- This line would publish the tool and its pilot results before it goes live, or drop resource-allocation tools in favor of a case-manager guide (19 states use none).
- Use the funded acuity tools before any reduction based on acuity.

WHAT MEMBERS WROTE

- Support for parts of the line; more information wanted.

MEMBER MARKS · 9 RETURNED



2 Proceed · 5 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Case Management fact sheet

Publish the Colorado Single Assessment before it goes live

DOCKET LINE 59 PROPOSITION · AS MEMBERS MARKED IT

Decide the Colorado Single Assessment and support-level algorithm: publish the instrument and pilot results before go-live, or discontinue resource-allocation tools in favor of a case-manager services guide (19 states use none); deploy the funded acuity tools before any acuity-premised reduction; account for the nurse assessor program that sunset December 15th, 2025.

SUGGESTED WORDING · FOR DECISION

Publish the Colorado Single Assessment instrument and pilot results before go-live, and report options – including a case-manager services guide – before any acuity-based reduction.

Reform LTSS exceptions and appeals

WHAT THIS WOULD DO

- Use credentialed reviewers; do not widen a review beyond what was requested; publish how often assessments differ from what is authorized.
- Separate utilization review from case management, and count appeal costs against savings.
- A pediatric nurse also proposed independent pediatric review before major service cuts for high-acuity children.

WHAT MEMBERS WROTE

- More information needed.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 0 Reject

WHAT WE KNOW

- About 25% of benefit appeals go the member's way; LTSS outcomes are not tracked.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Due Process for LTSS; Oct 7th: HCPF Appeals Backlog

Reform LTSS exceptions and appeals

DOCKET LINE 61 PROPOSITION · AS MEMBERS MARKED IT

LTSS exception and appeal reform: credentialed reviewers, no expansion of a review beyond what was requested, resolve the CMA conflict at hearing, publish how often assessments differ from authorizations; separate utilization review from case management; report CMA appeal units paid so appeal costs are netted against savings.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 61 · WHO PROPOSED WHAT

A pediatric nurse: Independent review by professionals with pediatric clinical expertise before significant service reductions for high-acuity children, with clear information on appeal rights and continuation of services.

HCPF update: HCPF reports an internal sprint to clear its appeals backlog.

SUGGESTED WORDING · FOR DECISION

Ask HCPF to report how LTSS exceptions and appeals work today, how often assessments differ from authorizations and what appeals cost, before recommending specific reforms.

Let members choose their case management agency

WHAT THIS WOULD DO

- Let members choose their case management agency, or hold agencies to performance-based contracts with consequences for missed authorizations.
- Remove agencies that keep failing after state intervention, and publish the time study behind their rates.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.

WHAT MEMBERS WROTE

- More information needed.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Case Management fact sheet

Let members choose their case management agency

DOCKET LINE 62 PROPOSITION · AS MEMBERS MARKED IT

Member choice of case management agency or performance-based CMA contracts with accountability for missed PARs; remove CMAs that fail after state intervention, with enforcement shared with the Attorney General; publish the time study behind CMA rates.

SUGGESTED WORDING · FOR DECISION

Ask HCPF to report on case management agency performance and the time study behind CMA rates, then recommend member choice or performance-based contracts based on what it shows.

Use housing as a Medicaid cost lever

WHAT THIS WOULD DO

- Fund supportive housing and housing supports for members who use the most care and for home and community-based services members.
- Restore an "SLS-plus" step, with a housing voucher, as an alternative to the more costly developmental disability waiver.

WHAT MEMBERS WROTE

- Could be costly.
- Unclear whether this extends the demonstration or plans for its end.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 0 Reject

WHAT WE KNOW

- At CMS's request, Medicaid will stop paying short-term rental assistance after December 31st. Other Medicaid housing supports continue.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Growth in 1115 Waivers fact sheet

Use housing as a Medicaid cost lever

DOCKET LINE 66 PROPOSITION · AS MEMBERS MARKED IT

Housing as a Medicaid cost lever: supportive housing and housing supports for high utilizers and HCBS members; restore an "SLS-plus" step with a housing voucher as the alternative to the DD waiver.

Department context: At CMS's request, HCPF will end Medicaid payment for short-term rental assistance (housing interventions with room and board) after December 31st, 2026. This is the up-to-six-month bridge for members matched with a housing voucher. Existing vouchers and other housing supports – navigation, tenancy-sustaining services, moving costs, and utility assistance – continue (per a public notice via HCPF, August 2026).

SUGGESTED WORDING · FOR DECISION

Restore an 'SLS-plus' path – extra SLS services plus a prioritized housing voucher – as a lower-cost alternative to DD waiver residential care.

Connect case management to claims

WHAT THIS WOULD DO

- Link the case management system to claims, so a member's total authorized and billed hours across CFC, the waivers, long-term home health and private duty nursing are visible before services are authorized.
- Flag overlapping service days before payment rather than recovering money a year later, and publish total LTSS use and cost.

WHAT MEMBERS WROTE

- Good idea; can the state's IT systems support it?

MEMBER MARKS · 9 RETURNED



6 Proceed · 2 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Case Management fact sheet

Connect case management to claims

DOCKET LINE 79 PROPOSITION · AS MEMBERS MARKED IT

Connect the case management system to claims so a member's total authorized and billed hours across CFC, waiver, long-term home health and PDN are visible before authorization and overlapping service days are flagged before payment, not recouped a year later; publish cross-program LTSS utilization and total cost of care.

Related lines: Builds on line 23 (lTSS program-integrity package for CFC); line 59 (decide the Colorado Single Assessment and support-level algorithm).

SUGGESTED WORDING · FOR DECISION

Connect case management and claims systems so overlapping LTSS hours are flagged before payment, as IT systems can support it, with HCPF reporting the systems changes and timeline needed.

Limit home health episodes; report on pending R-15 changes

WHAT THIS WOULD DO – Two separate items:

- Reinstate a withdrawn rule limiting back-to-back 60-day acute home health episodes.
- Require HCPF to report to the JBC before January 2027 on the pending R-15 home-care changes: federal approval status, any changes from the approved concept, and whether the savings still hold.

WHAT MEMBERS WROTE

- Asked why the earlier rule was withdrawn.

MEMBER MARKS · 9 RETURNED



2 Proceed · 5 Caution · 0 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- Emergency rule on home health units December 11th.
- Emergency rule on home health units December 11th.

DATA PREVIOUSLY PROVIDED:

Sept 17th: LTSS Service Package

Limit home health episodes; report on pending R-15 changes

DOCKET LINE 86 PROPOSITION · AS MEMBERS MARKED IT

Home health: reinstate the withdrawn rule limiting back-to-back 60-day acute home health episodes; require the Department to return to the JBC before January 2027 on the pending R-15 home-care changes (blended PDN/CNA per diem, unit changes, PSN acute care period, which allows nursing to start before authorization) with federal approval status, deviations from the approved concept and whether the savings remain valid.

Related lines: Builds on line 58 (expand family CNA tasks; a state pathway for pediatric PDN).

SUGGESTED WORDING · FOR DECISION

Ask HCPF why the earlier rule on back-to-back home health episodes was withdrawn, and require a JBC update before January 2027 on the pending R-15 home-care changes.

Set standards for group care of medically fragile children

WHAT THIS WOULD DO

- Require an HCPF evaluation when five or more unrelated medically fragile children routinely receive Medicaid-funded care in one home.
- Develop licensing standards and group rates for those settings, without treating biological, adoptive, or foster families as group homes.

WHAT MEMBERS WROTE

- Concern about the cost.

MEMBER MARKS · 9 RETURNED



4 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.

Set standards for group care of medically fragile children

DOCKET LINE 124 PROPOSITION · AS MEMBERS MARKED IT

Require an HCPF evaluation when five or more unrelated medically fragile children routinely receive Medicaid-funded care in one residence, with pediatric medical group-home licensing standards and group reimbursement rates for congregate settings, without classifying biological, adoptive or foster families as group homes.

Related lines: Relates to line 58 (expand family CNA tasks; a state pathway for pediatric PDN); line 86 (home health episode limits and an R-15 report-back).

SUGGESTED WORDING · FOR DECISION

Require an HCPF evaluation, including cost, when five or more unrelated medically fragile children routinely receive care in one residence, without classifying biological, adoptive or foster families as group homes.

12:15 – 12:35

Who is covered

Four lines, including line 74, held from November 10th. Lines 63 and 76 were decided this morning in the LTSS block. For each line: does it save money, avoid cost growth, or cost money – and when?

Fix gaps when children move from CHP+ to Medicaid

WHAT THIS WOULD DO

- When a child moves from CHP+ to Medicaid, the two coverage start dates often do not line up, leaving gaps and denied claims for families and providers.
- For members who have commercial insurance first and Medicaid second, Medicaid would again accept claims when the commercial plan treats the provider as out of network.
- A dental association and a behavioral health provider also proposed: Medicaid payment for in-office dental anesthesia in that situation, and prompt RAE disenrollment when a member moves to other coverage.

WHAT MEMBERS WROTE

- Asked for more information.

MEMBER MARKS · 9 RETURNED



3 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- Operational fixes; no cost estimate or legal concern.
- Held from November 10th without discussion.

DATA PREVIOUSLY PROVIDED:

Oct 7th: County Administration and Eligibility Systems fact sheet

Fix gaps when children move from CHP+ to Medicaid

DOCKET LINE 74 PROPOSITION · AS MEMBERS MARKED IT

Fix the CHP+-to-Medicaid transition so effective dates align; reinstate acceptance of out-of-network commercial status for Medicaid-secondary members.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 74 · WHO PROPOSED WHAT

A dental association (October 20th): 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 behavioral health provider (October 20th): Prompt RAE disenrollment when a member moves to other coverage, with payment for services delivered while the member remained enrolled.

SUGGESTED WORDING · FOR DECISION

Ask HCPF for more information on the CHP+-to-Medicaid transition and out-of-network commercial coverage for Medicaid-secondary members, then recommend fixes to align effective dates.

Cover qualified immigrants who lost federal match with state funds

WHAT THIS WOULD DO

- On October 1st, H.R. 1 ended federal Medicaid match for about 7,000 lawfully present (qualified) immigrants in Colorado.
- This line would use state dollars to keep covering them – or, as a narrower version, the roughly 250 of them who receive long-term services and supports.
- It would also stabilize Cover All Coloradans and OmniSalud as the place people land.

WHAT MEMBERS WROTE

- Concern about the loss of coverage, weighed against what the state can afford.
- Concern that the state cannot take on new state-only coverage.

MEMBER MARKS · 9 RETURNED



0 Proceed · 4 Caution · 4 Reject

WHAT WE KNOW

- Costs money; no estimate. About 7,000 people lost federal match on October 1st.
- State-only eligibility and funding sit with the JBC.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: H.R. 1 Qualified Immigrant Changes and Cover All Coloradans fact sheets

Cover qualified immigrants who lost federal match with state funds

DOCKET LINE 65 PROPOSITION · AS MEMBERS MARKED IT

State-only coverage for the ~7,000 qualified immigrants losing federal match October 1st, or the ~250 receiving LTSS; stabilize Cover All Coloradans and OmniSalud as the landing place – a protection, not a saving.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Review how estate recovery affects use of home care

WHAT THIS WOULD DO

- Federal law requires Medicaid to seek repayment from the estates of members who received long-term care at age 55 or older, after they die – usually from the home – unless a spouse or a minor or disabled child survives them.
- This line asks for a review of whether Colorado's rules, and how families learn about them, discourage people from accepting home care they need, so they end up in a more costly crisis later.
- A review could look at what Colorado recovers beyond the federal minimum, hardship waivers, and how notice is given.

MEMBER MARKS · 9 RETURNED



2 Proceed · 4 Caution · 2 Reject

WHAT WE KNOW

- No cost estimate. Narrowing recovery could cost money.
- [Confirm with HCPF: annual recoveries and scope.]

Review how estate recovery affects use of home care

DOCKET LINE 75 PROPOSITION · AS MEMBERS MARKED IT

Estate recovery review: whether rules deter people from accepting home care they need.

SUGGESTED WORDING · FOR DECISION

Ask HCPF to report what Colorado's estate recovery program recovers each year and for which services, how often hardship waivers are granted, and whether there is evidence that recovery deters people from accepting home care, before recommending any change.

Track H.R. 1 coverage loss and access on one dashboard

WHAT THIS WOULD DO

- A public dashboard, built with private partners, that tracks how many people lose coverage and whether they can still get care as H.R. 1 takes effect.
- It would use data that already exists – HB26-1429 eligibility data, HCPF monthly enrollment, hospital emergency department data and periodic samples of clinic volume – with no new state data collection.

WHAT MEMBERS WROTE

- Concern about the cost.

MEMBER MARKS · 9 RETURNED



4 Proceed · 2 Caution · 3 Reject

WHAT WE KNOW

- No cost estimate.
- HB26-1429 already calls for a public dashboard from January 1st, 2027.

DATA PREVIOUSLY PROVIDED:

Oct 7th: HB26-1429 Overview presentation

Track H.R. 1 coverage loss and access on one dashboard

DOCKET LINE 122 PROPOSITION · AS MEMBERS MARKED IT

Set up a shared public-private dashboard that tracks coverage losses and access to care as H.R. 1 is implemented, using existing data – HB26-1429 eligibility and enrollment data, HCPF monthly enrollment, hospital emergency department and coverage data, and periodic samples of clinic and behavioral health provider volume – without new state data collection.

SUGGESTED WORDING · FOR DECISION

Ask HCPF and its partners whether the HB26-1429 public dashboard can carry these coverage and access measures, using existing data, rather than building a separate dashboard.

12:35 – 1:15

How the program is run

Eight lines for discussion. Six more were on the consent calendar and three are answered by November 10th decisions. For each line: does it save money, avoid cost growth, or cost money – and when?

Report and reform recovery audits

WHAT THIS WOULD DO

- Recovery audits are contractors who review paid claims and recover overpayments. This line would send the JBC and the Commission the recovery forecast and five years of actual recoveries on a standing basis.
- Pay the audit contractor on findings that hold up, not on claims flagged; have the State Auditor review the largest vendor contracts; publish what detection costs against what it recovers.
- A coalition of providers and advocates also proposed a public list of HCPF contracts over $5 million a year with performance reporting.

MEMBER MARKS · 9 RETURNED



5 Proceed · 2 Caution · 0 Reject

WHAT WE KNOW

- Cost neutral.
- Recoveries came in below what the budget assumed; HCPF cites SB 25-314's audit changes and lower third-party recoveries. The bill's fiscal note flagged the risk but did not estimate it.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: Program Integrity – Detection to Recovery; Oct 7th: Program Integrity Recovery Data

Report and reform recovery audits

DOCKET LINE 9 PROPOSITION · AS MEMBERS MARKED IT

Transmit the recovery forecast and five years of recoveries by category to the JBC and the Commission on a standing basis; reform the recovery-audit contract so the contractor is paid on substantiated findings; commission State Auditor performance audits of the Department's largest vendor contracts; publish where recovered dollars go and what detection costs against what it recovers.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 9 · WHO PROPOSED WHAT

A coalition of providers and advocates: A consolidated public inventory of HCPF contracts over $5 million a year, with annual performance reporting and, for recovery or savings contracts, net benefit to the state.

HCPF update: HCPF will adjust Recovery Audit Contract recovery expectations after recoveries fell short of forecast, a shortfall it attributes to changes to the RAC audit process and third-party liability recoveries under SB 25-314, whose fiscal note assumed no change in recoveries.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Replace state quality measures with national CMS measures

WHAT THIS WOULD DO

- Hospitals and providers report national quality measures to CMS. Colorado also asks some of them to report a separate set of state-specific measures.
- This line would replace the state-specific measures with the national ones providers already report, cutting reporting burden and making Colorado comparable with other states.
- A perinatal quality collaborative also proposed keeping the full CMS maternity measures, give critical access hospitals a way to report, and break results out by race, ethnicity and payer.

WHAT MEMBERS WROTE

- Asked how the state-specific measures compare with the national ones, and why they exist.

MEMBER MARKS · 9 RETURNED



5 Proceed · 2 Caution · 1 Reject

WHAT WE KNOW

- No cost estimate or legal concern.

DATA PREVIOUSLY PROVIDED:

Aug 28th: HCPF's Assessment of the ACC

Replace state quality measures with national CMS measures

DOCKET LINE 15C PROPOSITION · AS MEMBERS MARKED IT

Replace state-specific hospital and provider quality measures with national CMS measures providers already report.

Related lines: Split from line 15 (an earlier docket line, since split).

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 15C · WHO PROPOSED WHAT

A perinatal quality collaborative: In moving to national measures, keep the full CMS Maternity Core Set, give critical access hospitals a way to report, and stratify by race, ethnicity and payer.

SUGGESTED WORDING · FOR DECISION

Compare Colorado's state-specific quality measures with national CMS measures, explain why the state measures exist, and move to national measures where they cover the same ground.

Target any reductions by acuity, not across the board

WHAT THIS WOULD DO

- If provider rates must be cut, cut the least-acute services rather than taking the same percentage from everyone.
- Set rates for nursing facilities, PACE and adult day on a multi-year basis so providers can plan.
- Replace the current provider rate review with actuarial rate-setting and "secret shopper" checks of whether members can actually get appointments. A community health center association also proposed excluding primary care from rate cuts.

WHAT MEMBERS WROTE

- The ramifications need more discussion before deciding.

MEMBER MARKS · 9 RETURNED



2 Proceed · 5 Caution · 1 Reject

WHAT WE KNOW

- Changes how cuts are made, not how much.
- HCPF will implement benefit limits, not yet specified.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: How Rates Are Determined; MPRRAC Background and Gap Analysis; July 1st Rate Reductions

Target any reductions by acuity, not across the board

DOCKET LINE 17 PROPOSITION · AS MEMBERS MARKED IT

Structure any reduction so it is not across-the-board: segment services by acuity and apply a budget-neutrality factor to the least-acute tier rather than a uniform percentage; move LTSS facility, PACE and adult-day rate setting to a multi-year basis; replace the provider rate review process with actuarial rate-setting and targeted access surveys (secret-shopper pilots on the MPRRAC cycle) while keeping an independent outside view.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 17 · WHO PROPOSED WHAT

A community health center association: Exclude primary care from provider rate cuts.

HCPF update: HCPF reported on October 7th that it will implement benefit limits, not yet specified.

SUGGESTED WORDING · FOR DECISION

Discuss the ramifications of structuring any reduction by acuity rather than across the board, and of multi-year and actuarial rate setting, before recommending it.

Send members a statement of services billed in their name

WHAT THIS WOULD DO

- Members would receive a statement listing services billed in their name, so they can flag anything they did not receive.
- Service plans would show the full rate and the share the agency keeps.
- Providers could check in real time whether a member has other insurance that should pay first.

WHAT MEMBERS WROTE

- Concern about the cost.

MEMBER MARKS · 9 RETURNED



2 Proceed · 5 Caution · 1 Reject

WHAT WE KNOW

- Members asked for a cost first.
- Public comment on November 10th asked for this.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Program Integrity Recovery Data (other insurance)

Send members a statement of services billed in their name

DOCKET LINE 69 PROPOSITION · AS MEMBERS MARKED IT

A member-facing explanation of benefits so members can dispute what is billed in their name; the service plan shows the full rate and the agency's share; real-time third-party-liability checks for providers.

SUGGESTED WORDING · FOR DECISION

Have HCPF cost a member-facing explanation of benefits and real-time third-party-liability checks before recommending them.

Pilot policy changes before statewide rollout

WHAT THIS WOULD DO

- Test policy changes in a pilot before applying them statewide.
- Publish a calendar of upcoming rule changes, and space changes so providers and families absorb one before the next arrives.
- A pediatric nurse also proposed a two- to three-year pilot for high-acuity children's care, and a behavioral health provider association's October 19th letter proposed implementation dates that give providers time to change staffing, billing systems and contracts after the RAEs issue policy.

WHAT MEMBERS WROTE

- Pilot when possible; immediate budget changes may not allow time for one.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- HCPF legal note: a pilot needs federal waiver authority. Only the pilot part is affected.

Pilot policy changes before statewide rollout

DOCKET LINE 70 PROPOSITION · AS MEMBERS MARKED IT

Pilot policy changes before statewide rollout; publish a rule-change calendar; finish absorbing one change before starting the next.

Related lines: See line 80 (notice and justification before benefit or eligibility changes) for notice.

SUGGESTED WORDING · FOR DECISION

Pilot policy changes where federal authority allows or is obtained, and otherwise phase them in; publish a rule-change calendar; space changes so each is absorbed before the next; and set implementation dates that give providers time to change staffing, billing systems and contracts after the RAEs issue policy, recognizing immediate budget actions may not allow a pilot.

Give notice and reasons before benefit or eligibility changes

WHAT THIS WOULD DO

- Give members 60 to 90 days' notice before any benefit reduction or eligibility change takes effect, and batch service-plan changes rather than sending them one at a time.
- Seek public input before rollout.
- Attach a short statement to every cost-containment proposal: stakeholder work done, federal engagement, effect on members, and why less restrictive options were not enough. A behavioral health provider association's October 19th letter also proposed sharing draft proposals, documenting feedback, and explaining final decisions.

WHAT MEMBERS WROTE

- Some notice may already be required; do this when possible.

MEMBER MARKS · 9 RETURNED



6 Proceed · 3 Caution · 0 Reject

WHAT WE KNOW

- Some notice is already required by law.
- The Medical Services Board takes up emergency rules December 11th.

Give notice and reasons before benefit or eligibility changes

DOCKET LINE 80 PROPOSITION · AS MEMBERS MARKED IT

Before any benefit reduction or eligibility change takes effect: 60–90 days' member notice; service-plan changes batched rather than issued one at a time; public input before rollout; and a four-part statement with every cost-containment proposal – stakeholder work done, federal engagement, member-impact data, and why less restrictive measures were insufficient.

Related lines: Builds on line 8 (streamline contracts, policy memos and rulemaking); line 14 (reconcile fiscal-note savings with actual results); line 70 (pilot policy changes before statewide rollout).

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 80 · WHO PROPOSED WHAT

A hospital association (October 20th): Hold benefit and program design discussions with patient, disability, consumer and provider organizations so affected communities are represented.

A behavioral health provider association (October 20th): Publish payment methodologies in advance with notice before changes.

SUGGESTED WORDING · FOR DECISION

Before benefit reductions or eligibility changes take effect, provide 60–90 days' member notice and public input when possible; share draft funding and structural proposals with stakeholders, document their feedback and explain final decisions; confirming what is already required so the recommendation adds only what is not.

Exempt high-performing providers from prior authorization

WHAT THIS WOULD DO

- Providers whose prior-authorization requests are almost always approved for a procedure could skip prior authorization for that procedure for a set period.
- This mirrors HB24-1149, which does the same for commercial insurers.
- It could be tested in dental first.

WHAT MEMBERS WROTE

- Align with the state's prior-authorization law for commercial insurers.
- Questioned whether this is a Commission priority.

MEMBER MARKS · 9 RETURNED



3 Proceed · 4 Caution · 1 Reject

WHAT WE KNOW

- No cost estimate. Saves administrative work; risks more unneeded services.

DATA PREVIOUSLY PROVIDED:

Aug 28th: Partner Fact Sheet: FFS Benefits (prior authorization)

Exempt high-performing providers from prior authorization

DOCKET LINE 120 PROPOSITION · AS MEMBERS MARKED IT

Let providers with consistently high prior-authorization approval rates on specific procedures skip prior authorization on those procedures for a set period, as HB24-1149 does for commercial carriers; it could be piloted in dental first.

SUGGESTED WORDING · FOR DECISION

Pilot, in dental first, letting providers with consistently high prior-authorization approval rates skip prior authorization on those procedures, aligned with HB24-1149 for commercial carriers.

State the Commission's position on the county transition

WHAT THIS WOULD DO

- HB26-1429 moves Medicaid eligibility administration from 64 separate counties toward a cohort or shared-services model.
- This line asks the Commission to say what it wants from that plan before it reaches the JBC on January 1st: county readiness and data matching for six-month redeterminations and work requirements, so members are verified without paperwork.

WHAT MEMBERS WROTE

- Wants to see the county proposal soon, to weigh it against a regional approach.

MEMBER MARKS · 9 RETURNED



4 Proceed · 2 Caution · 1 Reject

WHAT WE KNOW

- The plan reaches the JBC January 1st; the transition report is due November 30th.
- The agencies report schedule risk.

DATA PREVIOUSLY PROVIDED:

Oct 7th: HB26-1429 Overview; County Administration and Eligibility Systems fact sheet

State the Commission's position on the county transition

DOCKET LINE 13A PROPOSITION · AS MEMBERS MARKED IT

Take a Commission position on the HB26-1429 county-administration transition before the January 1st, 2027 plan reaches the JBC: county readiness and data-matching for six-month redeterminations and work requirements, so members are verified without paperwork.

Related lines: The technology and appeals parts of this line are now line 13b (technology modernization plan that draws the enhanced federal match); line 13c (fund appeals capacity before H.R. 1 volume arrives).

SUGGESTED WORDING · FOR DECISION

The Commission asks that the HB26-1429 transition plan show each county's readiness and data matching for six-month redeterminations and work requirements, so members can be verified without paperwork, and that the JBC receive the cohort and governance decision with its cost and schedule risk.

1:15 – 2:20

Managed care and the Accountable Care Collaborative

Line 92, held from November 10th, opens the block as one discussion of managed care and fee-for-service across the program. Then eight lines; lines 5 and 83 are decided together. For each line: does it save money, avoid cost growth, or cost money – and when?

Evaluate managed care and fee-for-service across the program

WHAT THIS WOULD DO

- Line 92 proposed ending capitated managed care for behavioral health and paying fee-for-service or through an administrative-services contract.
- On November 10th members tabled it, to take up with the broader question: should Colorado evaluate managed care and fee-for-service for the program as a whole, so physical and behavioral health are weighed together?

WHAT MEMBERS WROTE

- Federal funds are tied to managed care, and fee-for-service could cost more.
- This is a major change; try targeted pilots first.
- Hold the RAEs accountable instead of ending capitation.

MEMBER MARKS · 9 RETURNED



0 Proceed · 2 Caution · 6 Reject

WHAT WE KNOW

- HCPF: ending capitation ends state-directed payments and fee-for-service residential mental health.
- Connecticut: all of Medicaid on an administrative-services model since 2012; costs fell, alongside other reforms (briefing).

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet; Aug 28th: BH RAE fact sheet

Evaluate managed care and fee-for-service across the program

DOCKET LINE 92 PROPOSITION · AS MEMBERS MARKED IT

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.

Concerns raised:

- Requests that any move proceed through analysis, stakeholder engagement and targeted pilots.
- Cost-based safety-net payment first has a defined home and high-acuity and no-refusal responsibility is assigned.

Related lines: Relates to line 5 (validate, then enforce, RAE medical loss ratios); line 19 (reduce the number of RAEs and BHASOs); line 43 (shared claims payment for behavioral health); line 45 (independent audit of behavioral health capitation); line 18 asks the agency question with and without it.

SUGGESTED WORDING · FOR DECISION

Before the next ACC procurement, have HCPF evaluate the costs and trade-offs of capitated managed care, an administrative-services model, and fee-for-service for physical and behavioral health together, without presuming a pilot.

Validate, then enforce, RAE medical loss ratios

WHAT THIS WOULD DO

- A medical loss ratio is the share of a RAE's payment spent on care rather than administration and margin. Colorado sets a floor.
- First, have the State Auditor or an outside actuary independently check the ratios the RAEs report, using one template with fixed definitions.
- Then enforce the floor: a RAE that falls short pays back the difference.

MEMBER MARKS · 9 RETURNED



4 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- RAEs report all exceeded the 85% floor in FY 2024-25 – self-reported, not checked.

WHAT MEMBERS WROTE

- Surprised validation isn't happening already; asked why.
- Wants more discussion, taken together with line 83.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: How Rates Are Determined in Medicaid

Validate, then enforce, RAE medical loss ratios

DOCKET LINE 5 PROPOSITION · AS MEMBERS MARKED IT

Get accurate RAE medical loss ratios, then enforce them. First, independently validate the loss-ratio reports the RAEs have submitted – by the State Auditor or an outside actuary – and set one reporting template with fixed definitions of what counts as care (utilization-management staff, subcontractor and related-party margin, risk-corridor returns), with an officer's attestation and validated results published by entity. Then, on validated figures: remittance with penalty when a RAE misses the floor; hold the floor at 89% unless the quality metrics that lower it to 85% are named and met; score loss ratios by population cohort; spend the SUD risk-corridor allocation rather than return it; tie part of the quality bonus to actual care spend; cap care-management margin and raise the PCMP pass-through floor.

Related lines: Line 83 is the alternative to remittance; line 45 is the related audit of capitation itself.

SUGGESTED WORDING · FOR DECISION

Independently validate RAE medical loss ratio reports with one reporting template and fixed definitions, and report why validation is not happening today; decide with line 83 what happens to recouped funds.

Reinvest RAE surplus instead of remitting it

WHAT THIS WOULD DO

- When a RAE falls below the floor and pays money back, about 90 cents of each dollar recovered on the expansion population goes back to the federal government.
- This line would instead require the surplus to go into a restricted account, spent on care under a plan the Department approves, as Pennsylvania does.

WHAT MEMBERS WROTE

- Take together with line 5, with more discussion.

MEMBER MARKS · 9 RETURNED



1 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- The alternative to line 5's pay-back.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: How Rates Are Determined in Medicaid

Reinvest RAE surplus instead of remitting it

DOCKET LINE 83 PROPOSITION · AS MEMBERS MARKED IT

RAE surplus reinvestment instead of remittance: because about ninety cents of every dollar recouped from a RAE on expansion-population capitation returns to the federal government, require surplus below the MLR floor to go to a restricted account spent under a Department-approved plan (Pennsylvania HealthChoices model).

Related lines: The alternative to the remittance mechanism in line 5 (validate, then enforce, RAE medical loss ratios).

SUGGESTED WORDING · FOR DECISION

Take with line 5: where RAE surplus falls below the MLR floor, consider reinvesting it through a restricted account under a Department-approved plan instead of remitting it, since most recouped expansion funds return to the federal government.

Reward integrated physical and behavioral health care

WHAT THIS WOULD DO

- Encourage community health centers and comprehensive safety net providers that serve the same community to combine.
- Build integrated accountability for physical and behavioral health into RAE contracts.
- Grow the fully capitated PRIME model within its current enrollment cap before deciding on broader capitation.

MEMBER MARKS · 9 RETURNED



5 Proceed · 3 Caution · 0 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- Some want a pilot first; some want combining to be voluntary.

DATA PREVIOUSLY PROVIDED:

Aug 28th: HCPF's Assessment of the ACC (PRIME)

Reward integrated physical and behavioral health care

DOCKET LINE 27 PROPOSITION · AS MEMBERS MARKED IT

Create incentives for integrated physical and behavioral health care: combine FQHCs and comprehensive safety net providers where both operate in the same community; integrated accountability within RAE contracts; expand the existing fully capitated PRIME model within its enrollment cap before deciding on broader capitation.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 27 · WHO PROPOSED WHAT

A behavioral health provider association: Before broader integration, a RAE-administered demonstration pilot integrating physical and behavioral health with set outcome measures.

Another behavioral health provider association: Any organizational combination community-chosen rather than mandated.

A health plan association and a RAE: Expanding fully capitated integrated care with the managed care entity rather than the state holding financial risk.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Audit whether behavioral health capitation transfers risk

WHAT THIS WOULD DO

- Under capitation, the state pays a RAE a fixed amount per member and the RAE takes the risk if care costs more.
- This audit would test whether that risk is real, or whether rates simply reprice last year's costs so the RAE never bears it.
- It would also create a dedicated managed-care oversight unit.

WHAT MEMBERS WROTE

- Asked what the audit would actually test.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 0 Reject

WHAT WE KNOW

- $1.77 billion total, $414.8 million General Fund, FY 2026-27.
- Projected $2.289 billion by 2029 with no action.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet

Audit whether behavioral health capitation transfers risk

DOCKET LINE 45 PROPOSITION · AS MEMBERS MARKED IT

Independent audit of whether behavioral health capitation transfers risk or merely reprices prior-year cost; a dedicated managed-care oversight unit.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 45 · WHO PROPOSED WHAT

A behavioral health provider: Legislative examination of RAE administration before small behavioral health providers leave the network.

A behavioral health provider consultancy: Investigation of RAE and HCPF behavioral health payment reform with restored HCPF oversight of managed care contracts.

HCPF update: HCPF projects behavioral health capitation at $2.289 billion by 2029 with no action, driven mainly by service cost and utilization per person rather than enrollment, and reports RAE FY 2026-27 negotiations producing a 6–10% rate reduction.

SUGGESTED WORDING · FOR DECISION

Commission an independent audit that tests whether behavioral health capitation transfers financial risk to the RAEs or only reprices last year's costs, and report the results to the JBC.

Make community health centers the medical home

WHAT THIS WOULD DO

- Make community health centers the primary-care medical home for more members.
- Use their enrollment staff to help members with redeterminations and work requirements.
- A community health center association also proposed directing new primary-care funding to safety-net clinics and raise RAE primary-care incentive payments.

WHAT MEMBERS WROTE

- Asked whether this is already happening, and for more information.

MEMBER MARKS · 9 RETURNED



1 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- Stakeholder estimate only.

DATA PREVIOUSLY PROVIDED:

Aug 28th: Partner Fact Sheet: RAEs; HCPF's Assessment of the ACC

Make community health centers the medical home

DOCKET LINE 67 PROPOSITION · AS MEMBERS MARKED IT

Community health centers as the primary-care medical home; use their enrollment staff for redeterminations and work-requirement compliance.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 67 · WHO PROPOSED WHAT

A community health center association: Direct state investment, including any newly identified funding, to safety-net primary care through the Provider Stabilization Fund, and work with RAEs to raise primary care incentive payments through per-member-per-month or other methods.

SUGGESTED WORDING · FOR DECISION

Ask HCPF to report how community health centers are used today as medical homes and for enrollment help, then recommend building on what works for redeterminations and work-requirement compliance.

Scale EMS treatment-in-place and community paramedicine

WHAT THIS WOULD DO

- Treatment-in-place pays paramedics to treat someone at the scene rather than taking them to an emergency department.
- Community paramedicine sends paramedics to check on patients at home, for example after a hospital discharge.
- This line would scale both statewide.

WHAT MEMBERS WROTE

- Use the data from last session's EMS changes first, and show the savings.

MEMBER MARKS · 9 RETURNED



2 Proceed · 5 Caution · 0 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- The legislature made EMS changes last session. HB26-1069 (2026) lets Medicaid pay EMS for treatment in place, telehealth-supported care, and alternative destinations; the fiscal note projects savings starting FY 2026-27. Implementation is just beginning

Scale EMS treatment-in-place and community paramedicine

DOCKET LINE 68 PROPOSITION · AS MEMBERS MARKED IT

Scale EMS treatment-in-place and community paramedicine statewide.

SUGGESTED WORDING · FOR DECISION

Using data from last session's EMS changes, report the savings from treatment-in-place and community paramedicine, and scale statewide where savings are shown.

Reduce RAE payments for potentially avoidable events

WHAT THIS WOULD DO

- Lower RAE capitation for potentially avoidable events, such as avoidable emergency department visits and hospital readmissions, as Pennsylvania has done.
- The aim is to give RAEs a financial reason to prevent them.

MEMBER MARKS · 9 RETURNED



0 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- A provider association proposes rewards instead of penalties.

DATA PREVIOUSLY PROVIDED:

Aug 28th: HCPF's Assessment of the ACC

Reduce RAE payments for potentially avoidable events

DOCKET LINE 44 PROPOSITION · AS MEMBERS MARKED IT

Cut RAE capitation for potentially avoidable events (ER visits, readmissions), as Pennsylvania did.

Concerns raised: a behavioral health provider association proposes incentives for RAEs, providers and hospitals, that reduce avoidable events instead.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Seek recommendations on primary care investment

WHAT THIS WOULD DO

- Ask the Colorado Primary Care Payment Reform Collaborative, at the Division of Insurance, and other primary-care stakeholders for recommendations on increasing access to and investment in primary care.

MEMBER MARKS · 9 RETURNED



3 Proceed · 3 Caution · 2 Reject

WHAT WE KNOW

- No cost estimate. Asks an existing state body for recommendations.

DATA PREVIOUSLY PROVIDED:

Aug 28th: Partner Fact Sheet: RAEs; HCPF's Assessment of the ACC

Seek recommendations on primary care investment

DOCKET LINE 119 PROPOSITION · AS MEMBERS MARKED IT

Seek recommendations from the Colorado Primary Care Payment Reform Collaborative (Division of Insurance) and other primary care stakeholders on increasing access to and investment in primary care.
Related lines: Relates to line 67 (community health centers as the medical home); line 108 (pay for outcomes: more value-based purchasing).

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

2:30 – 3:40

Behavioral health

Twelve decisions. Lines 22 and 81 on peer services are taken together, and lines 46, 95 and 118 on safety net payment may be taken as a package. For each line: does it save money, avoid cost growth, or cost money – and when?

Pay for care coordination by member complexity

WHAT THIS WOULD DO

- Today RAEs are paid a set amount per member for care coordination, whether or not a member needs it.
- This line would match the intensity of coordination, and the payment, to each member's complexity, using one tiering method across the RAEs.
- Publish cost per engaged member against other states.

WHAT MEMBERS WROTE

- Supports the idea but asked whether it can be administered on time.
- Consider risk adjustment across the RAEs and one standard tiering method.

MEMBER MARKS · 9 RETURNED



3 Proceed · 5 Caution · 1 Reject

WHAT WE KNOW

- RAEs received $236.8 million in care management payments in FY 2025-26.

DATA PREVIOUSLY PROVIDED:

Oct 7th: ACC Care Coordination fact sheet

Pay for care coordination by member complexity

DOCKET LINE 7B PROPOSITION · AS MEMBERS MARKED IT

Match the intensity of RAE care coordination – and what is paid for it – to each member's complexity, rather than paying a per-member amount across the whole population, and publish cost per engaged member against other states.

Related lines: Split from line 7a (consolidate care coordination).

ADDED TO THE PROPOSITION · LINE 7B · WHO PROPOSED WHAT

A perinatal quality collaborative: Count pregnancy through 12 months postpartum as a high-complexity trigger and make the RAE referral channel work for birthing units.

SUGGESTED WORDING · FOR DECISION

Tier RAE care coordination by member complexity using one standard tiering method and risk adjustment across the RAEs, starting only when HCPF confirms it can be administered on time; publish cost per engaged member against other states.

Right-size residential SUD treatment and withdrawal management

WHAT THIS WOULD DO

- Determine how many residential substance use treatment facilities the state needs, and limit participation to that number with quality oversight.
- Align withdrawal management with the national ASAM 4th edition criteria and shift most of it to outpatient care.
- Tie the residential benefit to the evaluation its federal waiver already requires.

WHAT MEMBERS WROTE

- Supports the idea; data are limited and members want more detail.

MEMBER MARKS · 9 RETURNED



5 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- Spending has run about twice its 2018 estimate.
- HCPF ends free-standing withdrawal management July 1st, 2027.

DATA PREVIOUSLY PROVIDED:

Oct 7th: HCPF & BHA behavioral health presentation; Sept 17th: Cost Growth Trends fact sheets

Right-size residential SUD treatment and withdrawal management

DOCKET LINE 25 PROPOSITION · AS MEMBERS MARKED IT

Have BHA or HCPF determine how many residential SUD facilities the state needs and limit participation to that number with quality oversight; align withdrawal management with ASAM 4th edition and shift opioid, stimulant and cannabis withdrawal management to outpatient; condition the residential benefit on the 1115 waiver's own evaluation.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 25 · WHO PROPOSED WHAT

A behavioral health provider association: A behavioral health Certificate of Need process in which BHA establishes need, providers show alignment with it before licensure for public contracts, and providers repeatedly failing quality standards lose contracts, covering residential, crisis, inpatient and withdrawal management services.

Another behavioral health provider association: Placement based on need rather than facility counts, with ambulatory withdrawal management at a sustainable rate.

HCPF update: HCPF is implementing ASAM 4th edition and will end free-standing withdrawal management on July 1st, 2027.

SUGGESTED WORDING · FOR DECISION

Have BHA and HCPF report how many residential SUD beds the state needs, with the data behind it, and align withdrawal management with ASAM 4th edition; consider limiting participation only after that report.

Move safety net providers to CCBHC prospective payment

WHAT THIS WOULD DO

- Comprehensive safety net providers are paid a cost-based daily rate. This line would move those that can meet federal Certified Community Behavioral Health Clinic standards to the CCBHC prospective payment model.
- It would also pause the rule that RAEs pay these providers at least 80% of a set rate until performance metrics are defined.

WHAT MEMBERS WROTE

- Not every community mental health center can become a CCBHC.
- HCPF ended the minimum rate for essential providers' bedded services on July 1st, 2026, but continues the directed rate for comprehensive providers; the CSNP floor is not paused.

MEMBER MARKS · 9 RETURNED



1 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- HCPF secured the federal CCBHC demonstration.
- Any saving from pausing the 80% floor is unestimated.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet

Move safety net providers to CCBHC prospective payment

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 46 · WHO PROPOSED WHAT

A behavioral health provider association: Evaluate CCBHC fit during the demonstration and design prospective payment with temporary innovation rate adjustments and flexible service areas.

Another behavioral health provider association: Keep cost-based payment until CCBHC payment has a permanent home in the state plan and replace the 80–105% corridor that took effect October 1st with a stable, published methodology.

A behavioral health provider consultancy: Reconsider the 80% CSNP payment model in light of the no-refusal obligation.

HCPF update: HCPF secured the CCBHC demonstration and, from July 1st, 2026, no longer sets a minimum rate for essential safety net services in bedded facilities, while continuing directed rates for CSNPs and other named services.

Move safety net providers to CCBHC prospective payment

DOCKET LINE 46 PROPOSITION · AS MEMBERS MARKED IT

Move comprehensive safety net providers to CCBHC prospective payment and pause the 80% state-directed payment floor until metrics are defined.

SUGGESTED WORDING · FOR DECISION

Move comprehensive safety net providers that can meet CCBHC standards to CCBHC prospective payment, with a separate path for those that cannot; confirm whether the 80% state-directed payment floor is already paused before acting on it.

Choose guardrails or billing fixes for peer services

WHAT THIS WOULD DO

- Line 22: limit where and by whom peer and support services can be billed, require clinical oversight, and seek federal approval to pause enrollment of new unlicensed providers.
- Line 81, proposed by peer providers as the alternative: split the single peer billing code by setting and function, set credentialing and supervision standards, and act on fraud reports – "fix the pipes instead of turning off the water".
- An stakeholder suggested adding credentialing, supervision and QBHA proposals, shown after the two proposition slides.

WHAT MEMBERS WROTE

- Members are split on 22 versus 81, and open to either; take them together.
- Agreement with “fixing the pipes instead of turning off the water.”
- Some members would pause peer services first.

MEMBER MARKS · 9 RETURNED



Line 22: 8 P · 1 C · 0 R



Line 81: 6 P · 3 C · 0 R

WHAT WE KNOW

- $293 million in FY 2025; about 3,600 members got peer services with little other care.
- HCPF cannot identify peers in claims.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet; HCPF & BHA presentation

Choose guardrails or billing fixes for peer services

DOCKET LINE 22 PROPOSITION · AS MEMBERS MARKED IT

Limit allowable place of service and provider types for peer and support services, require clinical oversight, and seek CMS approval to pause enrollment of new unlicensed behavioral health providers; test whether peer and support services can be delivered through primary care and integrated settings rather than as standalone billed services.

Also proposed: An aggregate annual limit of 200 hours across 18 support and rehabilitation codes – peer, psychosocial rehabilitation, clubhouse, community psychiatric support, supported employment and targeted case management among them – so that services do not shift from one code to another; and a cap of about eight participants on peer-led groups, or group peer support only within a treatment plan.

Concerns raised: The same coalition opposes removing the peer benefit.

Related lines: Line 81 is the alternative peer providers propose.

Choose guardrails or billing fixes for peer services

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 22 · WHO PROPOSED WHAT

A behavioral health provider association: Disallow peer-led groups in Recovery Community Organizations and Recovery Support Services Organizations while keeping them in treatment and facility-based settings.

A health plan association: Tighten the coding manual for non-clinical skills training.

Opposed by a peer-support organization: The aggregate cap across 18 codes, which would reach case management and rehabilitation that people with serious mental illness depend on (a behavioral health provider association), and clinical oversight and place-of-service limits, in favor of peer-competent supervision under SAMHSA standards and a comparison of delivery models on disaggregated data.

HCPF update: HCPF reports provider, credentialing, group-scope, daily (CO MUE) and same-day billing limits phased in from July 1st, 2025 to October 1st, 2026, with limits on services not connected to clinical care as the next step, and said it found a couple of thousand cases of peer or supportive services with no connected clinical care (October 7th meeting).

Choose guardrails or billing fixes for peer services

DOCKET LINE 81 PROPOSITION · AS MEMBERS MARKED IT

Peer services, the alternative to line 22: break the single peer-services code into codes by setting and function (recovery housing, hospital, justice, harm reduction, community), publish what each may bill, set a credentialing and supervision standard for individual peer providers, add early-warning checkpoints, and act on fraud reports – “fix the pipes instead of turning off the water.”

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 81 · WHO PROPOSED WHAT

A peer-support organization: Disaggregate growth in the H0038, H0023 and H2014 codes by service, provider type and billing entity before attributing it to peer support, and protect role fidelity so peer staff are not required to drug test, conduct room checks or enforce treatment compliance.

Panelists: Warned that limiting peer services alone may shift billing to staff who also hold the qualified behavioral health assistant credential, and that there is no cap on the number of peers billing under one rendering provider (October 7th meeting).

Add credentialing, supervision and QBHA standards for peers

Verified credentials

Pay for peer services only with an active credential, or verified "in process" status with a set end date. No self-attestation. Credentialing bodies keep public registries and share oversight data.

Recovery community organizations

Organizations receiving public funds – directly or through a billing partner – are licensed, approved or certified by the state or an independent body, with standards for staff, supervision and finances.

QBHA standards

HCPF and BHA set common standards for qualified behavioral health assistants – training, competency, scope, supervision, billing – distinct from peer support, with clear enforcement.

Supervision limits

Statewide supervision ratios for rendering providers, counting their combined workload across every organization and billing arrangement, with a way for HCPF and the RAEs to verify it.

Decide lines 22 and 81 together

SUGGESTED WORDING · FOR DECISION

Take lines 22 and 81 together: fix peer services by splitting the billing code by setting and function; require an active or verified in-process credential for payment, with public credential registries shared with the departments; require recovery community organizations receiving public funds to be licensed, approved or certified; set statewide supervision ratios that count a rendering provider's work across all organizations; set HCPF and BHA standards for qualified behavioral health assistants distinct from peer support; and act on fraud reports, with any limits from line 22 applied only where those fixes fall short.

MEMBER MARKS · 9 RETURNED



Line 22: 8 P · 1 C · 0 R



Line 81: 6 P · 3 C · 0 R

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet; HCPF & BHA behavioral health presentation; Sept 17th: Cost Growth Trends fact sheets

Reconcile behavioral health federal match

WHAT THIS WOULD DO

- Make sure the budget's split between federal and state dollars for behavioral health matches what the state actually claims from CMS.
- Claim RAE incentive payments at the match rate of the people they serve, check an estimate that shifts costs into a lower-match category, and seek replacement for an enhanced prenatal match lost in July 2025.
- Show every reduction in both state and total dollars.

MEMBER MARKS · 9 RETURNED



6 Proceed · 2 Caution · 0 Reject

WHAT WE KNOW

- A $1 cut for expansion adults saves about 10 cents of state money; for others, about 48 cents.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Medicaid Fund Source for Every Population; Sept 2nd: Options for Increased Federal Funding

Reconcile behavioral health federal match

DOCKET LINE 82 PROPOSITION · AS MEMBERS MARKED IT

Behavioral health federal match reconciliation: reconcile the budget's fund splits to actual CMS-64 claiming; claim RAE incentive payments at the FMAP of the populations they serve rather than a flat 50%; validate the 75/25 proxy that shifts capitation into the 80% "non newly eligible" cell; seek replacement authority for the enhanced prenatal match lost in July 2025; present every reduction in state-share and total-funds terms.

Also proposed: A perinatal quality collaborative asks HCPF to name the federal authority, expected match rate and services covered for the replacement prenatal behavioral health match.

Related lines: Builds on line 4 (claim federal match on state-only spending).

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Tier payment for comprehensive safety net providers

WHAT THIS WOULD DO

- Replace the single prospective payment rate for comprehensive safety net providers with rates tiered by how complex and intensive the people they serve are – for example people cycling through hospitals, jail or homelessness, or with serious mental illness.
- Keep the obligation to serve everyone, and reward providers that serve the highest-need clients.

WHAT MEMBERS WROTE

- Cost the tiered method before agreeing to it, perhaps as a pilot.
- Protect rural and small providers.

MEMBER MARKS · 9 RETURNED



2 Proceed · 6 Caution · 1 Reject

WHAT WE KNOW

- Indirect cost rates average 30.3% (12.2–46.2%).
- HCPF estimates $155.2 million General Fund in FY 2026-27 goes to comprehensive safety net providers' prospective payment rates. Tiering would redistribute this; any saving depends on the design.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet

Tier payment for comprehensive safety net providers

LINE 95 · OTHER PROPOSALS, CONCERNS AND CONTEXT

Also proposed: A behavioral health provider association is open to paying more for the hardest-to-serve through the federal CCBHC options with special population rates and outlier payments (PPS-2 and PPS-4), which Colorado's daily PPS-1 lacks.

Department context: HCPF reports cost transparency and allowable-cost limits in CSNP prospective payment from July 2025, value-based payments from October 2026 and RAE use of capitated CSNP arrangements; it said CSNP indirect costs are not capped and prospective payment spending is rising significantly

Tier payment for comprehensive safety net providers

DOCKET LINE 95 PROPOSITION · AS MEMBERS MARKED IT

Tiered payment for comprehensive safety net providers: replace the uniform prospective payment rate with rates tiered by the complexity and intensity of the population served (people cycling through hospitals, crisis services, jail or homelessness; serious mental illness; severe substance use disorder; children at risk of out-of-home placement), with an obligation to serve everyone and outcome accountability; correct incentives that spread routine services across several days with lower-cost staff or shift complex clients to other providers; direct RAEs and BHASOs to reward providers that serve the highest-need clients.

Related lines: Relates to line 17 (target reductions by acuity, not across the board); line 26 (review crisis services; site-neutral behavioral health pricing); line 46 (cCBHC prospective payment; pause the 80% payment floor).

SUGGESTED WORDING · FOR DECISION

Have HCPF cost a tiered payment method for comprehensive safety net providers, test it as a pilot, and protect rural and small providers in any design.

Reform BHA licensing and network adequacy checks

WHAT THIS WOULD DO

- BHA licensing site visits would measure quality of care rather than paperwork compliance.
- Network adequacy reports would verify real access: hours, appointment availability for Medicaid members, and after-hours access.
- Before new licensing rules take effect, assess their effect on access and cost, especially in rural areas.

WHAT MEMBERS WROTE

- More information needed.

MEMBER MARKS · 9 RETURNED



3 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- No cost estimate.
- On November 10th members kept licensing with the BHA.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Behavioral Health Accountability Map

Reform BHA licensing and network adequacy checks

DOCKET LINE 116 PROPOSITION · AS MEMBERS MARKED IT

Reform Behavioral Health Administration licensing so site visits measure quality of care rather than process compliance, and require network adequacy reports that verify hours of operation, appointment availability for Medicaid members no less favorable than for other patients, after-hours access and whether quality standards are met. Before BHA licensing and designation rules take effect – including ASAM 4th edition and walk-in crisis center licensure – assess their effects on access, administrative burden, capacity and state cost, especially in rural and frontier areas where one provider may carry the full continuum.

SUGGESTED WORDING · FOR DECISION

Ask the BHA to report how licensing site visits could measure quality of care rather than process, and how network adequacy reports would verify access, before recommending specific licensing changes.

Allow review of outpatient therapy after a set number of visits

WHAT THIS WOULD DO

- Allow a clinical check on whether outpatient therapy is still appropriate once a member reaches a set number of visits in a year.
- The number of visits was not specified.

WHAT MEMBERS WROTE

- Who sets the visit threshold, and on what basis?
- Keep to mental health parity and avoid disrupting care.

MEMBER MARKS · 9 RETURNED



2 Proceed · 7 Caution · 0 Reject

WHAT WE KNOW

- The Governor's request lifts the prior-authorization ban outright ($14.5 million General Fund). This is narrower.

DATA PREVIOUSLY PROVIDED:

Sept 17th: Cost Growth Trends fact sheets; Oct 7th: Capitated Behavioral Health fact sheet

Allow review of outpatient therapy after a set number of visits

DOCKET LINE 117 PROPOSITION · AS MEMBERS MARKED IT

Allow clinical-appropriateness review of outpatient therapy once a member reaches a set number of visits in a year; the threshold was not specified.

Related lines: Read with line 41 (any-willing-qualified-provider rule; RAE rate transparency); line 42 (behavioral health rate floor and notice before cuts); line 112 (repeal post-2019 benefit additions and utilization-management limits).

SUGGESTED WORDING · FOR DECISION

Allow clinical-appropriateness review of outpatient therapy above a visit threshold set by HCPF on clinical evidence, confirmed compliant with mental health parity, and designed so current treatment is not interrupted.

Define costs consistently and set safety net rates earlier

WHAT THIS WOULD DO

- Use HCPF's existing Accounting and Auditing Committee to set one definition of overhead for comprehensive safety net providers and publish a stable, multi-year payment method.
- Compare providers on cost per unit of service among similar peers, not on overhead share.
- Set rates early enough for providers to budget. A behavioral health provider association also proposed a published multi-year behavioral health funding plan with spending parameters by sector, outcomes, and priorities for capacity and access.

MEMBER MARKS · 9 RETURNED



4 Proceed · 4 Caution · 0 Reject

WHAT WE KNOW

- Stakeholder estimate only.
- Indirect cost rates average 30.3%.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Capitated Behavioral Health fact sheet

Define costs consistently and set safety net rates earlier

DOCKET LINE 118 PROPOSITION · AS MEMBERS MARKED IT

Use HCPF's existing Accounting and Auditing Committee, with provider cost-reporting experts, to set consistent cost definitions for comprehensive safety net providers and publish a stable, multi-year payment methodology, with decisions made in public with written reasons. Define and report overhead the same way for every provider and compare providers on cost per unit of service and access among peers of similar size, geography and services rather than on overhead share. Set prospective payment rates early enough for providers to budget.

Related lines: Relates to line 46 (cCBHC prospective payment; pause the 80% payment floor); line 95 (tiered payment for comprehensive safety net providers).

SUGGESTED WORDING · FOR DECISION

Use HCPF's Accounting and Auditing Committee to set one definition of overhead and a stable, multi-year payment method for comprehensive safety net providers, and publish a multi-year behavioral health funding plan with spending parameters by service sector, measurable outcomes, and priorities for provider capacity and member access.

Review crisis services and pay the same for the same service

WHAT THIS WOULD DO

- Review walk-in crisis centers and crisis stabilization units: how much they are used, outcomes, and cost against alternatives.
- Pay the same for the same service regardless of setting, tiered by acuity and geography.
- Pay routine children's behavioral health assessments at a community-practice rate wherever they are done.

MEMBER MARKS · 9 RETURNED



6 Proceed · 0 Caution · 3 Reject

WHAT WE KNOW

- HCPF moved crisis units to a fee schedule July 1st, 2026.
- Two provider groups would pay for 24/7 capacity instead.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Behavioral Health Accountability Map; Capitated Behavioral Health fact sheet

Review crisis services and pay the same for the same service

DOCKET LINE 26 PROPOSITION · AS MEMBERS MARKED IT

Review standalone walk-in crisis centers and crisis stabilization units – utilization, outcomes and cost against alternatives – and move to tiered, site-neutral pricing for crisis stabilization, outpatient therapy and inpatient mental health by acuity and geography; pay routine pediatric behavioral health assessments at a community-practice rate wherever they are done.

Concerns raised: two behavioral health provider associations would pay walk-in centers and crisis stabilization units for 24/7 standby capacity rather than per-visit or site-neutral pricing, with CSU payment rewarding overnight referrals and complex clients; one would also fix walk-in center and CSU licensing and service expectations and bring them under a Certificate of Need process.

Department context: HCPF stopped directing cost-based CSU and ATU payments on July 1st, 2026, moving to a fee schedule .

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Set a behavioral health rate floor and notice before cuts

WHAT THIS WOULD DO

- Set a statewide minimum behavioral health rate at the fee-for-service schedule, with a cost-of-living index.
- Require 120 days' notice before rate cuts or billing-manual changes, an annual comparison of rates across RAEs, and a parity check before behavioral-health-only cuts.

WHAT MEMBERS WROTE

- Interest in the alternative: tie payment to quality instead of a flat floor, with notice scaled to the size of the change.
- Caution about added administrative burden on RAEs and providers.

MEMBER MARKS · 9 RETURNED



0 Proceed · 6 Caution · 3 Reject

WHAT WE KNOW

- No estimate; a floor would likely cost money.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: How Rates Are Determined in Medicaid

Set a behavioral health rate floor and notice before cuts

DOCKET LINE 42 PROPOSITION · AS MEMBERS MARKED IT

A statewide behavioral health rate floor at the fee-for-service schedule with a cost-of-living index, 120-day notice before reductions or manual changes, annual cross-RAE rate comparison, parity analysis before BH-only cuts; notice and a dispute process before cost-report audit changes produce retroactive adjustments.

Also proposed: tie payment to quality rather than a uniform floor, with notice periods scaled to the size of the change (a behavioral health provider association).

ADDED TO THE PROPOSITION · LINE 42 · WHO PROPOSED WHAT

A behavioral health provider: An independent parity review of a RAE's behavioral health reimbursement.

A behavioral health provider: Notice before payment-method, claims-rule and enrollment-type changes.

A behavioral health provider consultancy: Treating unit and code limits, including new Medically Unlikely Edits on H0005, H2014 and T1017, as material changes requiring 90-day notice under state law, with parity applied to service limits.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Let behavioral health providers limit their Medicaid caseload

WHAT THIS WOULD DO

- Allow enrolled behavioral health providers to cap how many Medicaid clients or hours they serve, or wind down gradually while keeping current clients, without breaching their RAE contracts.

WHAT MEMBERS WROTE

- Asked what happens to patients who are turned away.

MEMBER MARKS · 9 RETURNED



1 Proceed · 3 Caution · 3 Reject

WHAT WE KNOW

- Cost neutral.
- HCPF will end any-willing-provider contracting for RAEs.

DATA PREVIOUSLY PROVIDED:

Aug 28th: Partner Fact Sheet: BH RAE

Let behavioral health providers limit their Medicaid caseload

DOCKET LINE 123 PROPOSITION · AS MEMBERS MARKED IT

Allow enrolled behavioral health providers to limit the number of Medicaid clients or weekly hours they serve, or wind down Medicaid participation gradually while keeping current clients, without breaching their RAE contracts.
Related lines: Relates to line 6 (one set of processes across the RAEs and BHASOs); line 41 (any-willing-qualified-provider rule; RAE rate transparency).

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

3:40 – 4:00

Financing

Six lines. Lines 1, 4 and 24 were on the consent calendar and line 3 is answered by line 11. For each line: does it save money, avoid cost growth, or cost money – and when?

Loosen state limits on Rural Health Transformation funds

WHAT THIS WOULD DO

- The Rural Health Transformation Program is new federal funding for rural health under H.R. 1.
- This line would use part of it as a revolving loan fund, remove restrictions Colorado added beyond federal law (a five-site cap, a $3 million limit, and a county test that excludes one federally designated critical access hospital), and report outcomes to the JBC.

WHAT MEMBERS WROTE

- Support for parts of the line.
- Rural hospitals in poor financial shape may not be able to repay a revolving loan.

MEMBER MARKS · 9 RETURNED



6 Proceed · 2 Caution · 1 Reject

WHAT WE KNOW

- No cost estimate.

DATA PREVIOUSLY PROVIDED:

Sept 2nd: Rural Health Transformation Program fact sheet

Loosen state limits on Rural Health Transformation funds

DOCKET LINE 55 PROPOSITION · AS MEMBERS MARKED IT

Use RHTP principal as a revolving loan fund; remove state-added RHTP restrictions beyond federal law (five-site cap, $3M limit, a county test that excludes a federally designated CAH); transmit RHTP outcomes and obligation status to the Commission and JBC.

SUGGESTED WORDING · FOR DECISION

Confirm how much RHTP principal the federal government allows to be used as a revolving loan fund, design repayment terms rural hospitals can meet, and remove state-added restrictions beyond federal law.

Expand extrapolation; target prepayment review

WHAT THIS WOULD DO

- Extrapolation: when an audit finds billing errors in a sample of a provider's claims, the error rate is applied to all of that provider's claims to set the recovery. Colorado allows it only for pharmacy, transportation and pediatric behavioral therapy.
- This line would expand it, and replace program-wide limits with prepayment review of the specific providers billing inappropriately.

MEMBER MARKS · 9 RETURNED



2 Proceed · 3 Caution · 3 Reject

WHAT WE KNOW

- Department figure on file.
- HCPF reports new RAE billing controls and claims edits.

WHAT MEMBERS WROTE

- See results in the areas already agreed before expanding.
- Concern about relying on the Department to apply it.

DATA PREVIOUSLY PROVIDED:

Oct 7th: Program Integrity Recovery Data; Sept 2nd: Detection to Recovery

Expand extrapolation; target prepayment review

DOCKET LINE 10 PROPOSITION · AS MEMBERS MARKED IT

Expand program-integrity extrapolation authority beyond pharmacy, non-emergency transportation and pediatric behavioral therapy (HB26-1412), and replace blanket program-wide limits with provider-specific prepayment review when a small number of providers bill inappropriately.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 10 · WHO PROPOSED WHAT

A health plan association: A moratorium on new provider contracts in areas with high fraud, waste and abuse and where billing is materially outside peer norms.

HCPF update: HCPF reports RAE billing controls for FY 2026-27 (procedure-code changes, encounter limits, audits, coding reviews and targeted monitoring), revalidation of high-risk providers and action on enrolled 'ghost providers', and claims-system changes for 'medically unlikely' billing in high-cost growth areas.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Let local public health agencies claim administrative match

WHAT THIS WOULD DO

- Let local public health agencies claim federal Medicaid match for administrative work they do for Medicaid members, and bill as providers through shared billing hubs.
- Create a way to pay them for care coordination they now absorb from the RAEs.

WHAT MEMBERS WROTE

- The write-up was hard to follow; more explanation needed.

MEMBER MARKS · 9 RETURNED



0 Proceed · 4 Caution · 4 Reject

WHAT WE KNOW

- No cost estimate.

Let local public health agencies claim administrative match

DOCKET LINE 49 PROPOSITION · AS MEMBERS MARKED IT

Medicaid administrative claiming, a provider designation and billing hubs for local public health agencies; a payment path for care coordination they absorb from RAEs.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Let ABLE accounts reimburse home care costs

WHAT THIS WOULD DO

- ABLE accounts are tax-advantaged savings accounts for people with disabilities. This line would let account holders voluntarily reimburse the state share of their home and community-based services costs.

MEMBER MARKS · 9 RETURNED



1 Proceed · 5 Caution · 3 Reject

WHAT WE KNOW

- HCPF legal note: not allowed under federal law; Congress would have to act.

Let ABLE accounts reimburse home care costs

DOCKET LINE 53 PROPOSITION · AS MEMBERS MARKED IT

Voluntary ABLE-account reimbursement of the state share of HCBS direct-service costs after a federal amendment.

SUGGESTED WORDING · FOR DECISION

Add to the Commission's requests to Colorado's congressional delegation: amend federal law to allow voluntary ABLE-account reimbursement of HCBS costs, split between the federal and state shares.

Require commercial insurers to cover services shifted to Medicaid

WHAT THIS WOULD DO

- Require commercial health plans to cover private duty nursing, long-term home health and life-sustaining medications and equipment that families now turn to Medicaid for, as Minnesota has since 2010.

MEMBER MARKS · 9 RETURNED



0 Proceed · 4 Caution · 5 Reject

WHAT WE KNOW

- Shifts cost to commercial premiums.
- Self-funded employer plans are federally regulated.

WHAT MEMBERS WROTE

- Would raise commercial premiums for employers and consumers.
- Doubt that a bill like this would pass.

Require commercial insurers to cover services shifted to Medicaid

DOCKET LINE 54 PROPOSITION · AS MEMBERS MARKED IT

Require commercial insurers to cover private duty nursing, long-term home health, and life-sustaining medications and equipment now shifted to Medicaid, as Minnesota has since 2010.

ADDED TO THE PROPOSITION ON OCTOBER 20TH · LINE 54 · WHO PROPOSED WHAT

A peer-led coalition (October 20th): Make commercial coverage of peer recovery support services a priority.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

Reform durable medical equipment purchasing

WHAT THIS WOULD DO

- Reform how Medicaid buys durable medical equipment: a statewide program to recover and refurbish equipment, repair before replacement, competitive and bulk purchasing, separate pricing of communication device hardware and software, and itemized costs for high-cost equipment.

MEMBER MARKS · 9 RETURNED



0 Proceed · 5 Caution · 2 Reject

WHAT WE KNOW

- No cost estimate.

Reform durable medical equipment purchasing

DOCKET LINE 126 PROPOSITION · AS MEMBERS MARKED IT

Reform durable medical equipment purchasing: a statewide recovery and refurbishment program, repair before replacement, competitive and bulk purchasing with price transparency, augmentative communication devices priced with hardware separate from specialized software and services, and itemized costs for high-cost equipment.

NO SUGGESTED WORDING

Members' notes did not point to a revision. Decide on the proposition as written, amend it, or set it aside.

How the report is built

EVERY RECOMMENDATION SHOWS

- The recommendation, as adopted
- Vote and any minority view
- Who acts, and by when
- Conditions before it changes anyone's care
- Information still needed: who, by when
- Effect on cost, and what is at stake
- How it will be tracked
- Considerations

Tier 1 — **Act in the 2027 session**

Oversight, reconciliation, BHA, enrollment, appeals, CHASE

Tier 2 — **Proceed once conditions are met**

Costing, funding or a plan comes first

Tier 3 — **Study and report back**

Questions to answer before deciding

From today to the report



Nov 18th

Remaining docket lines decided

[Dec 2nd]

Draft report to members

[Dec 7th]

Member comments and any minority statements due

Dec 9th

Commission reviews and finalizes the report

Dec 11th

Report to the General Assembly and the Governor

If you expect to write a minority statement, please say so today so it can be included.

4:15 – 5:15

Public comment

Thank you

Next meeting: December 9th, 2026 · Review of the draft report