Joint Budget Committee

Supplemental Budget Requests
FY 2025-26

Health Care Policy and Financing
All except Behavioral Health and Community Living

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January 27, 2026

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Overview of Health Care Policy and Financing

The Department helps cover health and long-term care costs for low-income and vulnerable people. Federal matching funds assist with most of these costs. In return for the federal funds, the Department must follow federal rules governing eligibility, benefits, and other features. Major programs administered by the Department include:

- Medicaid, which serves people with low income and people needing long-term care
- Child Health Plan Plus (CHP+), which provides low-cost insurance for children and pregnant women with income slightly higher than Medicaid allows
- Health services for children lacking access due to immigration status, which is a new state-funded program that mirrors Medicaid and CHP+

In addition, the Department works to improve the health care delivery system by advising the General Assembly and the Governor, administering grants, and overseeing the Commission on Family Medicine Residency Training Programs.

Summary of Staff Recommendations

Department of Health Care Policy and Financing: Recommended Changes for FY 2025-26

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Current FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Recommended Changes						
Current FY 2025-26 Appropriation	$18,217,290,946	5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Medical forecast	1,059,238,670	221,838,902	186,618,296	-28,263	650,809,735	0.0
Eligibility & benefit changes	-48,043,750	-15,734,057	-2,093,340	0	-30,216,353	0.8
Provider rates	-186,968,474	-69,334,875	2,199,240	0	-119,832,839	0.0
Administration	14,938,658	-3,017,353	222,229	16,583,747	1,150,035	4.3
Impacts driven by other agencies	-549,868	337,803	-125,021	0	-762,650	0.0
Recommended FY 2025-26 Appropriation	$19,055,906,182	$5,688,406,442	$2,217,100,981	$160,576,367	$10,989,822,392	848.3
Recommended Increase/ -Decrease from 2025-26	$838,615,236	$134,090,420	$186,821,404	$16,555,484	$501,147,928	5.1
Percentage Change	4.6%	2.4%	9.2%	11.5%	4.8%	0.6%
FY 2025-26 Executive Request	$18,993,825,568	$5,661,816,757	$2,210,006,381	$165,818,038	$10,956,184,392	854.7
Staff Rec. Above/-Below Request	$62,080,614	$26,589,685	$7,094,600	-$5,241,671	$33,638,000	-6.4

Medical forecast

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
S1 Medical Services Premiums	$903,506,547	$169,695,381	$190,137,305	$0	$543,673,861	0.0	EK
S2 Behavioral health	129,809,174	18,580,986	6,635,629	0	104,592,559	0.0	EP
S5 OCL caseload	59,301,174	32,293,538	-116,084	0	27,123,720	0.0	TD
S4 Other programs & services	16,707,669	16,707,669	0	0	0	0.0	EK
S7g Fed match supplemental payments	0	-3,633,121	0	-28,263	3,661,384	0.0	EK
S6.05 Immigrant family planning	0	0	0	0	0	0.0	EK
S3 Child Health Plan Plus	-21,325,620	-6,530,017	-933,950	0	-13,861,653	0.0	EK
S7d NEMT corrective plan	-17,647,557	-5,275,534	-3,548,245	0	-8,823,778	0.0	EK
S15 Public school health services	-11,112,717	0	-5,556,359	0	-5,556,358	0.0	EK
Total	$1,059,238,670	$221,838,902	$186,618,296	-$28,263	$650,809,735	0.0	

→ S1 Medical Services Premiums

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$903,506,546	$169,695,380	$190,137,305	$0	$543,673,861	0.0
Recommendation	903,506,546	169,695,380	190,137,305	0	543,673,861	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

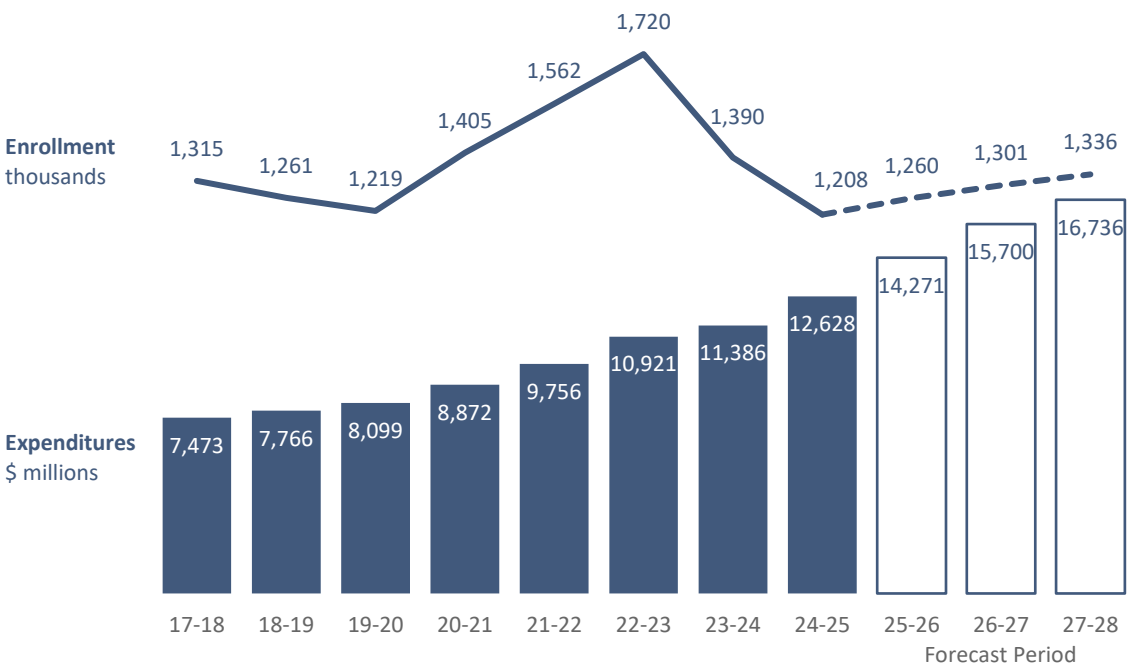
Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

Request

The Department requests funding for a new projection of enrollment and expenditures for Medical Services Premiums under current law and policy.

The request is for an increase of $903.5 million total funds, including $169.7 million General Fund.

The Medical Services Premiums line item pays for physical health care and most long-term services and supports for clients eligible for Medicaid.



Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. The forecast used for the original FY 2025-26 appropriation incorporated data through December 2024. This supplemental request incorporates data through June 2025. The Department will submit a new forecast in February that uses data through December 2025. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill. All of the expenditures contained in the supplemental are for programs authorized in current law.

The projection for FY 2025-26 is up $903.5 million total funds or 7.5 percent, including an increase in General Fund of $169.7 million or 4.7 percent. The table below shows the major contributors to the change from the FY 2025-26 appropriation to the Department's November 2025 forecast for FY 2025-26. It does not show differences from FY 2024-25 expenditures.

FY 2025-26 Medical Services Premiums Enrollment/Utilization Trends

Item	Total Funds	General Fund	Other State	Federal Funds
FY 2025-26 Appropriation	$12,086,735,818	$3,625,759,766	$1,519,647,523	$6,941,328,529
Acute care				
Enrollment	-248,336,409	-26,940,192	-27,845,808	-193,550,409
Per capita	290,920,955	110,876,847	10,887,662	169,156,446
Subtotal - Acute Care	*42,584,546*	*83,936,655*	*-16,958,146*	*-24,393,963*
Long-term care programs				
Home- and community-based services	117,336,291	24,739,258	20,720,505	71,876,528
Long-Term Home Health/PDN/Hospice	12,218,453	6,109,226	0	6,109,227

Item	Total Funds	General Fund	Other State	Federal Funds
Nursing homes	86,515,860	42,931,202	180,793	43,403,865
PACE	5,475,328	2,737,664	0	2,737,664
Subtotal - Long-term Care Programs	*221,545,932*	*76,517,350*	*20,901,298*	*124,127,284*
Federal match changes				
Non-citizen emergency services	0	-28,019,225	6,049,794	21,969,431
Non-emergency medical transport - error	0	0	-46,118,977	46,118,977
Pregnant 134%-185% FPL	0	10,754,619	0	-10,754,619
Subtotal - federal match changes	*0*	*-17,264,606*	*-40,069,183*	*57,333,789*
Medicare & private premiums	16,732,068	7,533,859	0	9,198,209
Service management	29,784,574	13,017,572	1,520,155	15,246,847
Hospital supplemental payments	549,465,215	0	199,922,150	349,543,065
Recoveries	0	-12,998,165	25,996,330	-12,998,165
Community First Choice	46,459,584	20,442,217	0	26,017,367
Other financing	-3,065,373	-1,489,502	-1,175,299	-400,572
Total	$12,990,242,364	$3,795,455,146	$1,709,784,828	$7,485,002,390
Increase/(Decrease)	$903,506,546	$169,695,380	$190,137,305	$543,673,861
Percentage Change	*7.5%*	*4.7%*	*12.5%*	*7.8%*

Acute care

Increased expenditures per capita are the primary cause for the change in the FY 2025-26 forecast. People are using more services than the Department expected, particularly people with disabilities under the age of 59. This population is large and uses a lot of services, so variations in per capita expenditures drive significant dollar changes. A lot of the increase in the FY 2025-26 forecast is due to the actual expenditures for this eligibility category coming in higher in FY 2024-25 than expected. Utilization of physician services by people with disabilities increased 5 percent from FY 2023-24 to FY 2024-25.

Enrollment is trending slightly less than one percent below the assumption in the appropriation. The enrollment for children is up slightly due to shifts from CHP+ to Medicaid.

Long-term care programs

The biggest change is an increase in nursing home bed days. The Department attributes this to a rebound from COVID. Use of health services decreased during COVID, but the trends for most services recovered quickly. Use of nursing home services remained low for several years after COVID, leading to speculation that this was a lasting cultural shift. Cost reports submitted to the Department show that nursing homes experienced acute labor shortages that constrained capacity. The Department believes a combination of increased capacity from nursing homes filling positions and an aging population with increased acuity caused nursing bed days to start increasing again after several years of almost flat growth. The state demographer projects the 75+ population will grow from around 330,000 to over 500,000 before 2030, a 28.5% increase over 5 years. Similarly, the demographer projects the 85+ community to grow from 100,000 in 2025 to almost 130,000 by 2030, or a 28% increase. These populations have increasingly high levels of care as people live longer with chronic conditions, mobility limitations, and cognitive impairments.

In addition, the Department under forecasted home- and community-based services (HCBS). These services assist the elderly and people with disabilities with activities of daily living, so that they can live in the community instead of an institutional setting. The services are either non-medical services or routine and repetitive health

maintenance services that do not require clinical judgement or assessment. Examples of the services include assistance with bathing, meals, or cleaning.

Federal match changes

The forecast uses new federal match rates for some services.

Federal law requires states to cover emergency services for people who would otherwise qualify for Medicaid except for their citizenship status. When Colorado expanded Medicaid eligibility, there was a secondary impact that more noncitizens became eligible for these limited emergency services. Some states were interpreting the additional noncitizens as "newly eligible" pursuant to the Affordable Care Act (ACA), and claiming the 90 percent federal match for "newly eligible" populations. Colorado did not realize there was an opportunity to claim a 90 percent federal match until H.R. 1 included a provision ending the enhanced match for noncitizens. The Department submitted a retroactive claim for the 90 percent for the last two years (the maximum time for a retroactive claim) and was able to increase the federal funds and decrease the General Fund at the end of FY 2024-25. The November forecast reflects the projected additional General Fund savings for claims in FY 2025-26. The Department will continue drawing the enhanced federal match until October 2026 when H.R. 1 reduces the match to 50 percent.

The Department went a step further and used the hospital provider fee, rather than the General Fund, as the state match for the "newly eligible" noncitizens who get the 90 percent federal match. This further increased the General Fund savings at the expense of hospitals. Using the hospital provider fee for emergency services to noncitizens may not align with the allowable uses of the hospital provider fee in statute. The JBC staff has asked Legislative Legal Services for feedback.

For non-emergency medical transportation (NEMT), the Department's November forecast shifted $46.1 million in expected costs from the hospital provider fee to federal funds. A subset of NEMT services are to expansion populations that earn a 90 percent federal match. However, this was an error. The NEMT services are defined in federal statute as an administrative service and get a 50 percent federal match, regardless of the population served. The Department will correct the error in the February forecast. It does not change the projected General Fund, but it is a significant error in the projection of hospital provider fee expenditures.

For pregnant women with income from 134 percent to 185 percent of the federal poverty guidelines, the Department changed the projected federal match from 65 percent to 50 percent. Colorado originally covered this population on CHP+ and earned a 65 percent federal match. Senate Bill 11-250 moved the population from CHP+ to Medicaid. The federal government continued to provide a 65 percent federal match. Recently, the federal government informed the Department that they would no longer provide a 65 percent federal match. There are some differences in coverage between Medicaid and CHP+. The JBC staff has asked the Department if it is possible and makes sense to move the population back to CHP+ to earn a higher federal match.

Other noteworthy changes

The Department increased the projection for service management in FY 2025-26. Through the Accountable Care Collaborative (ACC), the Department pays Regional Accountable Entities (RAEs) to manage services for Medicaid members. Part of the payment is built into the managed care contracts for behavioral health but the part for managing physical health is paid from Medical Services Premiums. The Department pays the RAEs per member per month, so the service management costs usually change in unison with changes in enrollment. However, the Department says that during the transition from Phase II to Phase III of the ACC, some unanticipated technical

issues are causing the timing of incentive payments to shift between fiscal years. The combined change over FY 2025-26 and FY 2026-27 is still aligned with enrollment.

Most of the large increase in hospital supplemental payments is due to the Department implementing new state directed payments pursuant to H.B. 25-1213. The Department's previous method for calculating supplemental payments to hospitals was limited by the amount of fee-for-service activity of the hospitals. The state directed payments allow the Department to include managed care activities by hospitals. Also, federal limits on state directed payments are temporarily higher until provisions in H.R. 1 ratchet them down. The state directed payments are increasing hospital supplemental payments by $389.6 million total funds in FY 2025-26.

The forecast includes $46.5 million total funds for Community First Choice but this is just a shift from the Office of Community Living with no net increase in expenditures across the whole department. Under Community First Choice, certain services are moving from benefits that are available only through a waiver to services that are available to all Medicaid clients through the state plan. Some of the Community First Choice services are provided to people with intellectual and developmental disabilities. The money for those services was appropriated to the Office of Community Living. After the budget was adopted, the Department realized it would need programming changes to the billing and accounting systems to continue paying for these services from the Office of Community Living. All other state plan services are paid from the Medical Services Premiums line item. These system changes would be expensive and necessary only to achieve an administrative goal of conforming with the format of appropriations in the Long Bill. There would be no change in the Department's ability to track and report the expenditures or in the services to members. Rather than incurring these programming costs, the Department decided to bill the services to the Medical Services Premiums line. The forecast reflects this change in procedure and the Department will request the corresponding appropriation change in a supplemental.

The biggest services that are moving are personal care and homemaker services. Clients must still complete assessments to determine the services are necessary, but the Department expects more people will qualify for the services due to the easier eligibility procedures. At the same time, the federal government is paying an additional 6 percentage points federal match for these services. The General Fund savings from the higher federal match more than offsets the expected cost increase from the easier eligibility procedures.

→ S3 Child Health Plan Plus

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$21,325,620	-$6,530,017	-$933,950	$0	-$13,861,653	0.0
Recommendation	-21,325,620	-6,530,017	-933,950	0	-13,861,653	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

Request

The Department requests funding for a new projection of enrollment and expenditures for the Child Health Plan Plus under current law and policy.

The request is for a decrease of $21.3 million total funds, including a decrease of $6.7 million General Fund.

The Child Health Plan Plus (CHP+) compliments the Medicaid program by providing low-cost health insurance for children and pregnant women in families with more income than the Medicaid eligibility criteria allow. CHP+ is the marketing name the Department uses for what state statutes call the Children's Basic Health Plan and federal statutes call the Children's Health Insurance Program. CHP+ covers children and pregnant women to effectively 265 percent of the federal poverty guidelines, or $70,623 annually for a family of three.

Historically, enrollment in CHP+ has been highly changeable, in part because eligibility for the program is sandwiched between an upper income limit and a lower income limit below which an applicant is eligible for Medicaid and not eligible for CHP+. Sometimes when Medicaid enrollment decreases CHP+ enrollment increases, and vice versa, as people transition between the two programs. In addition, CHP+ has experienced frequent adjustments to state and federal eligibility criteria and to administrative procedures for handling eligibility determinations.

Federal funds match state funds for program costs. The federal match rate for CHP+ is derived from the standard match for Medicaid. Federal policies provided a temporary boost to the match rates for federal fiscal years 2015-16 through 2019-20. The federal match for FY 2025-26 is 65 percent

CHP+ typically receives roughly $15 million in revenue from the tobacco master settlement agreement distribution formula and some of the state match for higher income children and pregnant adults comes from the hospital provider fee. Any remaining state match comes from the General Fund.

Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. The forecast used for the original FY 2025-26 appropriation incorporated data through December 2024. This supplemental request incorporates data through June 2025. The Department will submit a new forecast in February that uses data through December 2025. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill. All of the expenditures contained in the supplemental are for programs authorized in current law.

The projection for FY 2025-26 is down $21.3 million total funds, including a decrease of $6.5 million General Fund. The table below shows the major contributors to the change from the FY 2025-26 appropriation to the

Department's November 2025 forecast for FY 2025-26. It does not show differences from FY 2024-25 expenditures.

FY 2025-26 Child Health Plan Plus Enrollment/Utilization Trends

Item	Total Funds	General Fund	Other State	Federal Funds
FY 2025-26 Appropriation	$287,385,214	$49,960,249	$50,689,576	$186,735,389
Enrollment	-56,448,036	-6,530,017	-13,226,795	-36,691,224
Per capita	35,122,416	0	12,292,845	22,829,571
FY 2025-26 Projection	$266,059,594	$43,430,232	$49,755,626	$172,873,736
Increase/(Decrease)	-$21,325,620	-$6,530,017	-$933,950	-$13,861,653
Percentage Change	*-7.4%*	*-13.1%*	*-1.8%*	*-7.4%*

→ S4 Other programs & services

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$16,707,669	$16,707,669	$0	$0	$0	0.0
Recommendation	16,707,669	16,707,669	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of new data that was not available when the original appropriation was made regarding actual enrollment and expenditures.

Request

The Department requests funding for a new projection of enrollment and expenditures for other entitlement programs operated by the Department. The forecast is of expected expenditures under current law and policy.

The request is for an increase of $16.7 million General Fund.

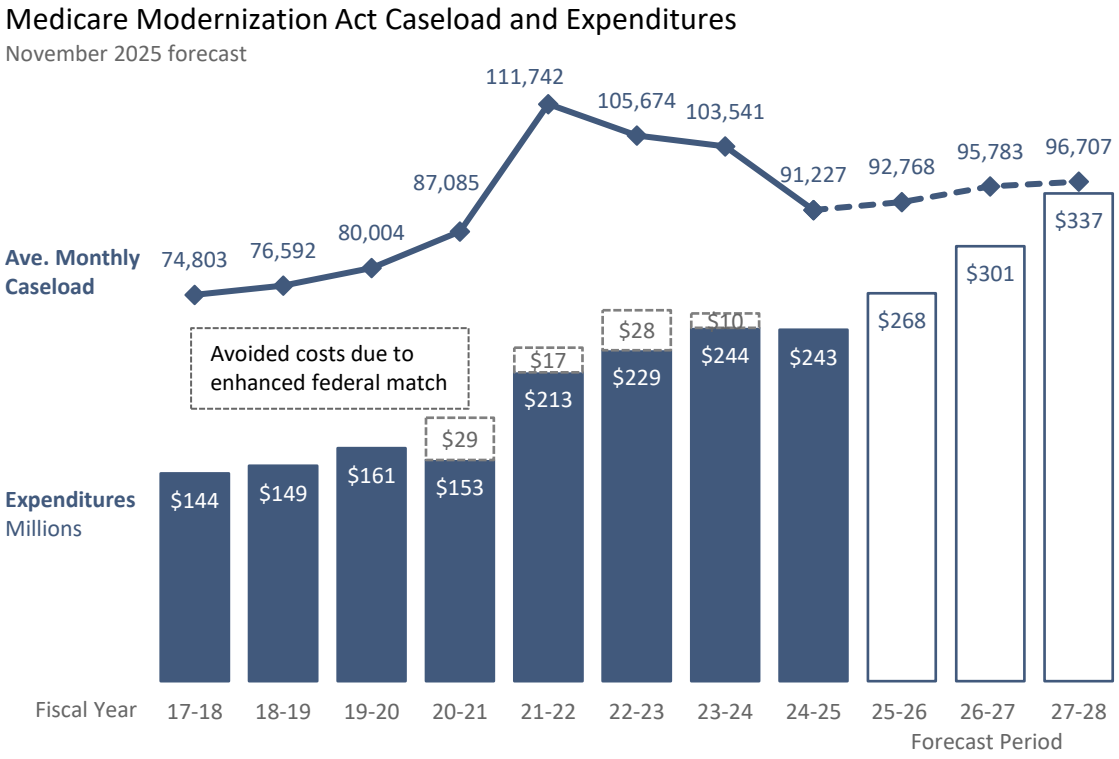
The Department is expanding the services it forecasts. The Department has long prepared a forecast for the Medicare Modernization Act. The health services for children lacking access due to their immigration status is a new program where the Department needs to project the costs. In addition, there are some smaller programs the Department has not historically projected that the Department plans to start forecasting. The Department didn't update the expected expenditures for these smaller programs in the November forecast, but it says it plans to submit a projection with the February forecast. All of these programs operate as entitlement programs. The Department has statutory authority to overexpend the appropriation for all of them except for the reproductive health for people not eligible for Medicaid.

Medicare Modernization Act

The federal Medicare Modernization Act (MMA) requires states to reimburse the federal government for a portion of prescription drug costs for people dually eligible for Medicare and Medicaid. In 2006 Medicare took over responsibility for these drug benefits, but to defray federal costs the federal legislation required states to make an annual payment based on a percentage of what states would have paid in Medicaid, as estimated by a federal formula.

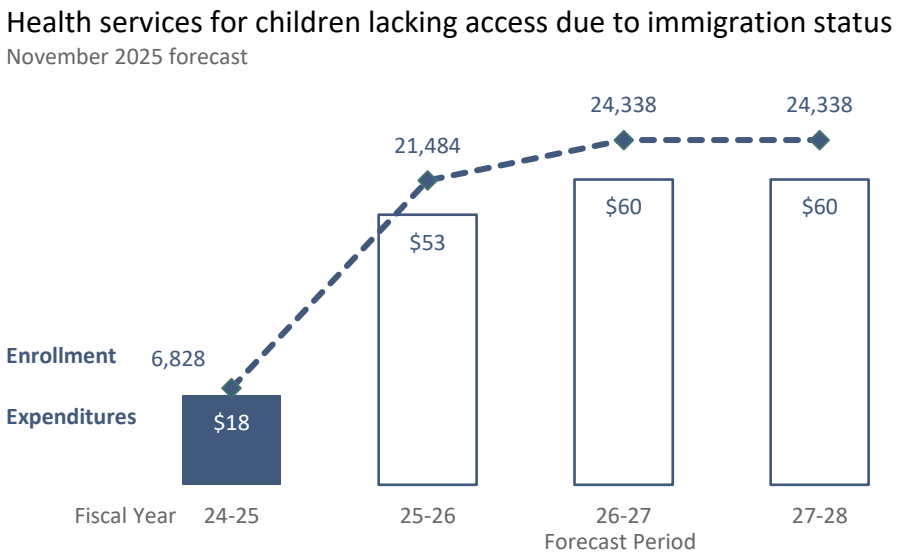
The state's obligation is influenced by the number of people dually eligible for Medicare and Medicaid and estimates in the federal formula of drug prices and utilization. Expenditures have been growing faster than caseload due to increasing prices for pharmaceuticals.

This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes.



Health Services for Children Lacking Access Due to Immigration Status

The Department provides health insurance coverage to children who would otherwise qualify for Medicaid or CHP+ except for their immigration status. The services are paid with the General Fund. There is no federal match. The benefits mirror Medicaid and CHP+. The Department has overexpenditure authority if the cost of services exceeds the appropriation. The program started in January 2025.



Recommendation

Staff recommends approval of the request. The new forecast uses more recent data than the forecast used for the original appropriation. The forecast used for the original FY 2025-26 appropriation incorporated data through December 2024. This supplemental request incorporates data through June 2025. The Department will submit a new forecast in February that uses data through December 2025. If that February forecast is significantly different than the forecast used for this supplemental, then the JBC staff may recommend a supplemental add-on to the Long Bill. All of the expenditures contained in the supplemental are for programs authorized in current law.

The projection for FY 2025-26 is up $16.7 million General Fund or 5.2 percent. The table below shows the major contributors to the change from the FY 2025-26 appropriation to the Department's November 2025 forecast for FY 2025-26. It does not show differences from FY 2024-25 expenditures.

FY 2025-26

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 25-26 Appropriation					
Medicare Modernization Act	$272,802,633	$272,802,633	$0	$0	$0
Children Lacking Access Due to Immigration	32,075,606	32,075,606	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - Appropriation	$329,839,664	$321,795,204	$0	$0	$8,044,460
FY 25-26 Projection (Nov)					
Medicare Modernization Act	$268,225,649	$268,225,649	$0	$0	$0
Children Lacking Access Due to Immigration	53,360,259	53,360,259	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - FY 25-26 Projection	$346,547,333	$338,502,873	$0	$0	$8,044,460
Projection Higher/-Lower than Appropriation					
Medicare Modernization Act	-$4,576,984	-$4,576,984	$0	$0	$0
Children Lacking Access Due to Immigration	21,284,653	21,284,653	0	0	0
Reproductive Health	0	0	0	0	0
Abortion Care	0	0	0	0	0
Health-Related Social Needs (HRSN)	0	0	0	0	0
Reentry Services	0	0	0	0	0
Total - Difference	$16,707,669	$16,707,669	$0	$0	$0
Percent Change					
Medicare Modernization Act	-1.7%	-1.7%	n/a	n/a	n/a
Children Lacking Access Due to Immigration	66.4%	66.4%	n/a	n/a	n/a
Reproductive Health	0.0%	0.0%	n/a	n/a	n/a
Abortion Care	0.0%	0.0%	n/a	n/a	n/a
Health-Related Social Needs (HRSN)	0.0%	0.0%	n/a	n/a	0.0%
Reentry Services	0.0%	0.0%	n/a	n/a	0.0%
Total - Percent change	5.1%	5.2%	n/a	n/a	0.0%

→ S6.05 Immigrant family planning

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$500,000	-$500,000	$0	$0	$0	0.0
Recommendation	0	0	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$500,000	$500,000	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **NO**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

Explanation: The Department argues that this request is the result of data that was not available when the original appropriation was made, but the JBC had this debate last year and intentionally included a buffer in the appropriation.

Request

The Department requests a reduction to the appropriation for immigrant family planning services based on historic expenditures.

The request reduces the Department's funding by:

Current year: $500,000 General Fund

Statutes require the Department to provide reproductive health care to people who would qualify for Medicaid except for their immigration status. The appropriation primarily pays for Long Acting Reversible Contraceptives (LARCs). The program serves a little over 4,000 people per year.

Recommendation

Staff does not recommend the request. The JBC debated this issue last year and the overfunding in the line item was intentional.

The statutes define both the eligibility criteria and the benefits. The Department does not control the utilization. This structure is similar to Medicaid. If utilization is higher than projected, the Department will receive more claims. The Department either needs a way to pay those claims or a way to contain costs.

Last year, the JBC staff presented four different options:

1. **Eliminate the program --** This would save $2.6 million General Fund. Eliminating the program would reduce access to care, but this is a relatively new program, it serves a small number of people, and there is no federal match. Eliminating the program may increase Medicaid expenditures for unwanted pregnancies.
2. **Give the Department authority to control the expenditures --** The program is designed as an entitlement. If the General Assembly wants the Department to live within the appropriation, then the Department needs some means to control costs, such as caps and waitlists or the ability to modify the eligibility and benefits.
3. **Give the program overexpenditure authority --** Every other entitlement program operated by the Department has authority to overexpend the appropriation if actual utilization and expenditures are higher than the projection.
4. **Build a buffer into the appropriation --** We don't know what the costs will be, so build a reserve into the appropriation in case the actuals are higher than expected.

The JBC choose option 4. The Department projected expenditures of $1,706,220 General Fund and the JBC introduced the Long Bill with an appropriation of $2,614,490 to provide a buffer in the appropriation.

It is worth noting that actual expenditures in FY 2024-25 ended up being higher than the Department's projection of expenditures for FY 2025-26. The Department's more recent November forecast shows the Department spending the full $2.6 million appropriation in FY 2025-26. The Department did not provide a revised forecast with this supplemental request. The Department did not explain what they plan to do if actual expenditures exceed the FY 2025-26 appropriation.

The program started in FY 2022-23. The table below summarizes actual and appropriated expenditures since then.

Expenditures by Fiscal Year

Fiscal Year	Category	Amount
FY 2022-23	Actual	$242,952
FY 2023-24	Actual	$1,356,927
FY 2024-25	Actual	$1,893,286
FY 2025-26	Appropriation	$2,614,490

→ S7d NEMT corrective action plan

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$17,647,557	-$5,275,534	-$3,548,245	$0	-$8,823,778	0.0
Recommendation	-17,647,557	-$5,275,534	-$3,548,245	$0	-$8,823,778	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made.

Request

The Department requests a reduction to account for a corrective action plan with a major provider for non-emergency medical transportation (NEMT).

The request decreases the Department's forecast by:

- Current year: $17.6 million total funds, including $5.3 million General Fund
- Year 1: $20.8 million total funds, including $6.3 million General Fund

The request captures the projected savings from a decrease in payments to MedRide. MedRide is the largest provider of NEMT services statewide. Based on performance issues, the Department attempted to terminate MedRide's participation in Medicaid in January 2025. MedRide challenged the Department's action and a court order temporarily prevented the Department from terminating MedRide's participation. Rather than continuing to pursue termination, the Department entered a settlement agreement. The settlement agreement imposed new limitations on the provider effective June 2025. Since the settlement agreement, payments to MedRide have decreased significantly from the assumptions in the November forecast. MedRide's share of total trip volume decreased from about 16 percent prior to the settlement agreement to roughly 13 percent.

Key provisions of the settlement agreement with MedRide include:

- Comprehensive re-credentialing of all drivers and vehicles to ensure full regulatory compliance prior to transport.
- Establishment of a formal member eligibility validity verification process.
- Appointment of a third-party auditor to review claims before submission, which MedRide pays for; and
- Implementation of a ride volume cap, 1,400 daily trips, pending sustained demonstration of compliance and operational integrity.

Recommendation

Staff recommends approval of the request. This is an adjustment to account for new information that was not included in the November forecast, rather than a request for a discretionary decision by the General Assembly. This could be handled through the Department's February forecast. Unlike with *S7c Recovery audits*, the JBC staff sees no harm in handling it as a policy action through the supplemental process.

The November forecast did not account for the settlement agreement. Since the settlement agreement, actual expenditures for MedRide are trending below the expected amount based on the Department's November forecast of NEMT and MedRide's share of total NEMT volume. The Department's projection of the savings due to the settlement agreement appear reasonable to the JBC staff based on the actual expenditures for MedRide.

The Department characterizes the settlement with MedRide as decreasing improper payments for NEMT, rather than decreasing legitimate services for Medicaid members. If there was need for these services, the JBC staff would expect a shift in utilization to other providers. However, monthly data does not suggest ride volume is shifting from MedRide to other providers. Trip volume for other providers follows a fairly stable trend while MedRide data shows a level shift down. This provides some reason to believe the Department's assertion, but it is not conclusive. There are many possible explanations for the decrease in MedRide trips. For example, maybe members are struggling to connect with alternative service providers when the settlement agreement prevents them from using MedRide.

The Department is working toward a statewide broker for NEMT, which would address any potential confusion about how to get connected with services. In August 2025, the Department announced it would award the statewide broker contract to MediDrive, which shares a similar name but no relation to MedRide. However, there was an appeal of the contract award and the Department had to convene a new evaluation committee. That new evaluation committee just announced that the statewide broker contract will go to MediDrive.

S7d NEMT corrective action plan

Item	Total Funds	General Fund	Hospital Provider Fee	BCCP Fund [1]	Federal Funds
FY 2025-26					
Settlement agreement projection	-$17,647,557	-$5,275,534	-$3,548,122	-$123	-$8,823,778
FY 2026-27					
Settlement agreement projection	-$20,751,726	-$6,295,946	-$4,079,776	-$141	-$10,375,863

[1] Breast and Cervical Cancer Prevention and Treatment Fund

The projected savings in FY 2025-26 are somewhat lower than in FY 2026-27 and ongoing due to the delay between when services are delivered and paid.

→ S7g Federal match supplemental payments

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$0	-$3,633,121	$0	-$28,263	$3,661,384	0.0
Recommendation	0	-3,633,121	0	-28,263	3,661,384	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree this request is the result of data that was not available when the original appropriation was made regarding the availability of an enhanced federal match.

Request

The Department requests a decrease in state funds and an increase in federal funds to reflect a change in the federal match rate for certain supplemental payments.

The request changes the Department's expected expenditures as follows:

- Current year: A decrease of $3.6 million General Fund and $28,263 reappropriated funds and a corresponding increase of $3.7 million federal funds
- Year1: A decrease of $8.5 million General Fund and $28,263 reappropriated funds and a corresponding increase of $8.6 million federal funds
- Year 2: A decrease of $3.6 million General Fund and $28,263 reappropriated funds and a corresponding increase of $3.6 million federal funds

In addition to base Medicaid payments, the Department makes supplemental payments for select providers and services. The most common supplemental payments go to hospitals, using the hospital provider fee as the state match. Historically, the supplemental payments were made with a 50 percent federal match. A few years ago, the Department convinced the federal government that hospital supplemental payments are related to the specific populations served and so the supplemental payments for populations that qualify for an enhanced federal match should get that higher match, retroactive to October 1, 2019. The change significantly benefited hospitals, because they could spend less from the hospital provider fee and match more federal funds.

In this request, the Department identified two other supplemental payments that should qualify for an enhanced federal match for the same reasons as the hospital supplemental payments. The Pediatric Specialty Hospital Payments go to Children's Hospital to help offset the costs of providing care to a large number of Medicaid and indigent care clients. The Commission on Family Medicine makes payments to sponsoring hospitals to offset the costs of providing residency programs for family medicine physicians.

The Department can go back two years and retroactively claim the enhanced federal match for these supplemental payments. The request assumes the additional federal funds from retroactive claims will arrive in FY 2026-27, resulting in an additional one-time General Fund savings in that fiscal year. The projected General

Fund savings varies slightly by fiscal year based on the projected caseload mix and the proportion of total clients served that qualify for the enhanced federal match. The small change in reappropriated funds is related to money transferred from the University of Colorado's School of Medicine for the Commission on Family Medicine.

Recommendation

Staff recommends approval of the request. The Department identified an opportunity to decrease the General Fund obligation and increase federal matching funds with no change in services or total compensation to providers.

S7g Federal match supplemental payments

Item	Total Funds	General Fund	Reapprop. Funds	Federal Funds
FY 2025-26				
Pediatric Specialty Hospital	0	-2,147,082	0	2,147,082
Colorado Commission on Family Medicine	0	-1,486,039	-28,263	1,514,302
Total	$0	-$3,633,121	-$28,263	$3,661,384
FY 2026-27				
Pediatric Specialty Hospital	0	-2,107,054		2,107,054
Colorado Commission on Family Medicine	0	-1,457,776	-28,263	1,486,039
Total	$0	-$3,564,830	-$28,263	$3,593,093
Retroactive claims reconciled in FY 2026-27				
Pediatric Specialty Hospital	0	-2,830,259	0	2,830,259
Colorado Commission on Family Medicine	0	-2,138,844	0	2,138,844
Total	$0	-$4,969,103	$0	$4,969,103

→ S15 Public school health services

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$11,112,717	$0	-$5,556,359	$0	-$5,556,358	0.0
Recommendation	-11,112,717	0	-5,556,359	0	-5,556,358	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding certified public expenditures by schools.

Request

The Department requests a decrease in spending authority based on projected certified public expenditures by school districts and Boards of Cooperative Education Services (BOCES).

The request decreases the Department's forecast by:

- Current year: $11.1 million total funds
- Year 1: $3.2 million total funds

Through the School Health Services Program, school districts and BOCES identify their expenses in support of Medicaid eligible children. The Department submits them as certified public expenditures to claim federal matching funds. The Department disburses the federal matching funds, less administrative expenses, to the school districts and BOCES. The schools use the funds to offset their costs of providing services or to expand services for low-income, underinsured, or uninsured children and to improve coordination of care between school districts and health providers.

This is a small true up to reflect actual expenditure trends.

Recommendation

Staff recommends approval of the request. The expenses for Public School Health Services are driven by school expenditures that can be claimed for a federal match. The actual local certified public expenditures are not under the direct control of the Department. The availability of data to forecast the expenditures is limited and delayed, so this is a line item that frequently receives mid-year adjustments.

Eligibility & benefit changes

Eligibility & benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
S10 DOJ housing vouchers	-5,580,999	-2,790,499	0	-2,790,500	0.0	TD
S6.04 Continuous coverage	-13,604,503	-5,613,171	-358,438	-7,632,894	0.0	EK
S6.08 Tests for specific drugs	-12,930,713	-1,719,785	-949,114	-10,261,814	0.0	EK
S6.09 Outpatient psychotherapy prior authorization	0	0	0	0	0.0	EP
S6.10 Pediatric behavioral therapy reviews	0	0	0	0	0.0	EP
S6.17 IDD youth transitions	$0	$0	$0	$0	0.0	TD
S6.18 IDD waitlist	0	0	0	0	0.0	TD
S6.19 Senior dental	0	0	0	0	0.0	EK
S6.20 Community health workers	0	0	0	0	0.0	EK
S6.25 Biosimilars	-5,131,802	-982,330	-516,862	-3,632,610	0.0	EK
S6.26 3rd Party pay for drugs	-4,071,186	-1,226,741	-268,926	-2,575,519	0.0	EK
S6.29 LTSS presumptive eligibility	-1,303,093	-690,802	0	-612,291	0.0	TD
S6.30 HCBS hours soft cap	-2,416,695	-1,208,349	0	-1,208,346	0.8	TD
S6.31 Caregiving hours soft cap	-396,415	-198,208	0	-198,207	0.0	TD
S6.32 Homemaker hours soft cap	-74,350	-37,175	0	-37,175	0.0	TD
S6.34 Community connector units	-2,533,994	-1,266,997	0	-1,266,997	0.0	TD
S7n Ambulatory surgical centers eligible benefits	0	0	0	0	0.0	EK
Total	-$48,043,750	-$15,734,057	-$2,093,340	-$30,216,353	0.8	

→ S6.04 Continuous coverage

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$13,604,504	-$5,613,172	-$358,438	$0	-$7,632,894	0.0
Recommendation	-13,604,504	-5,613,172	-358,438	0	-7,632,894	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

Explanation: [JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding federal approval for the eligibility.

Request

The federal government rescinded the Department's authorization to provide continuous coverage for children to age three and for adults for one year after release from prison.

The federal action reduces the Department's forecast by:

- Current year: $13.6 million total funds, including $5.6 million General Fund
- Year 1: $27.2 million total funds, including $11.2 million General Fund

House Bill 23-1300 required the Department to seek federal authorization to provide this continuous coverage. The Centers for Medicare and Medicaid Services (CMS) initially approved the waiver but has since withdrawn the approval. In a July 17 letter to states CMS argued that continuous eligibility can lead to overpayment and unsustainable expenditures for people who would not normally be eligible.

Recommendation

Staff recommends approval of the request. The federal action means Colorado cannot receive matching federal funds to implement these continuous coverage provisions. The only alternative would be legislation to create a state-financed program. Such a program would be complicated to administer and the General Fund would need to cover the total cost, rather than just a share of the costs.

→ S6.08 Tests for specific drugs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$12,930,713	-$1,719,785	-$949,114	$0	-$10,261,814	0.0
Recommendation	-12,930,713	-$1,719,785	-$949,114	$0	-$10,261,814	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available regarding the need for budget reductions and potential improper payments for drug testing.

Request

The Department implemented prior authorization requirements before paying for more than 16 urine tests in a year that determine the specific drugs in a patient.

The Department implemented the limit October 1, 2025. The limit reduces the Department's forecast by:

- Current year: $12.9 million total funds, including $1.7 million General Fund.
- Year 1: $14.1 million total funds, including $1.9 million General Fund.

The limit applies to definitive drug tests that determine specific drugs, metabolites, or quantities. They do not apply to presumptive drug tests that are the standard for monitoring substance use as part of treatment.

In December, the Medical Services Board approved a further reduction in the limit to 12 tests in a year. This will incrementally increase the savings. However, due to a backlog of changes needed in the Medicaid Management

System, including changes to implement H.R. 1, the Department does not plan to implement system changes to enforce the second reduction to the limit until July 2027.

From 2021 to 2024 the members receiving these services nearly doubled from 22,813 to 43,194. Spending increased 4.5 times from $12 million to $54 million. Based on medical guidelines, the Department believes much of the testing is unnecessary and lacks clinical justification. Certain laboratories are outliers, averaging significantly higher tests per member. The Department says the outlier billing is driven by standing-order arrangements that bypass presumptive drug testing or reflex to definitive drug testing on every positive presumptive test regardless of clinical context.

Recommendation

Staff recommends approval of the request. The Department made a compelling case that some of the billing violates the Department's standards for medical necessity. The Department's medical necessity standards related to these definitive drug tests are consistent with guidance from both the Centers for Medicare and Medicaid Services and the American Society of Addiction Medicine. The proposal is not establishing new standards for definitive drug testing but trying to enforce the Department's existing standards. Since the Department implemented the prior authorization requirements in October, utilization has decreased in a range consistent with the Department's projection.

→ S6.19 Senior dental [legislation]

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$500,000	-$500,000	$0	$0	$0	0.0
Recommendation	-500,000	-500,000	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department proposes reducing senior dental grants.

Current year: The Department proposes a reduction of $500,000 General Fund in the current year.
Year1: The proposed reduction increases to $2,000,000 General Fund in FY 2026-27 and thereafter.

The senior dental grants currently provide approximately $4.0 million annually to community health centers, nonprofit dental clinics, and public health agencies. The grant recipients use the money for dental care to low-

income elderly people. To receive services, a client must be 60 or over, must have income under 250 percent of the federal poverty guidelines, and generally must not have other insurance. However, if the client has a Medicare Advantage Plan that includes dental coverage, then the Department will pay the difference in coverage. Some Medicare Advantage Plans provide minimal dental coverage. The Dental Health Care Program for Low Income Seniors Annual Report indicates 25 grantees served 4,657 seniors in FY 2024-25.

The Department estimates that with the proposed reduction in funding it could serve approximately 2,295 seniors per year.

Recommendation

Staff recommends legislation to eliminate the funding. The reduction impacts access to care, but this is a grant program above and beyond the Department's core services. There is no federal match. There is no difference between the staff recommendation and the request in FY 2025-26, but in FY 2026-27 and on-going the staff recommendation would save $4.0 million General Fund annually versus the request for $2.0 million.

The Department's proposal decimates the program to achieve $2.0 million in General Fund savings toward balancing. The staff perspective is that this type of reduction in the program scope needs to be worth the savings. If the General Assembly is comfortable with a 50 percent reduction, then just cut the whole thing to get $4.0 million in General Fund savings.

The opposite argument is that preserving 50 percent of the funding at least allows the Department to serve some seniors.

Cutting the program does not require legislation, but eliminating it would require legislation.

→ S6.20 Community health workers [legislation]

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$5,713,346	-$1,364,558	-$342,750	$0	-$4,006,038	0.0
Recommendation	-5,713,346	-$1,364,558	-$342,750	$0	-$4,006,038	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department proposes further delaying the start of coverage for community health workers from January 1, 2026 to January 1, 2028.

The request temporarily reduces the Department's forecast by:

- Current year: $5.7 million total funds, including $1.4 million General Fund
- Year 1: $13.4 million total funds, including $3.2 million General Fund
- Year 2: 7.7 million total funds, including $1.8 million General Fund

Community health workers provide education, care coordination, and navigation to connect Medicaid members and underserved populations to health and social services. Senate Bill 23-002 directed Medicaid to cover community health worker services and then S.B. 25-229 delayed the implementation from July 1, 2025 to January 1, 2026.

The Department didn't identify this as requiring a bill, but the delay last year was done through a bill. The language added by S.B. 25-229 says the Department will reimburse community health workers beginning January 1, 2026, "subject to available appropriations, upon receiving any necessary federal authorization". The Department argues that if there are no appropriations they don't need to implement the reimbursements by January 1, 2026, and therefore the proposed delay can be accomplished through the budget process.

Recommendation

Staff recommends ending the program rather than delaying it. This new reimbursement has not yet been implemented, so stopping it would not take away existing benefits. There is some overlap with work already done through the Accountable Care Collaborative (ACC). The ACC is tasked with providing health system navigation and resource coordination. Service costs for the community health workers are expected to increase in future years. The Fiscal Note assumed demand exceeds the supply of providers and more people will get credentialed to provide services as the program becomes established. The Fiscal Note projected General Fund costs would increase to $3.2 million in the second year and continue increasing in future years. The Department did not explain how the General Assembly will be more able to afford the program in FY 2027-28 than in FY 2026-27.

If the JBC approves either the staff recommendation or the request, staff recommends legislation. The delay last year was done through a bill. There is a specific start date identified in statute. That start date is "subject to available appropriations" and that might be an argument for making the change through the budget, but legislation would eliminate any ambiguity about the legislature's intent. The implementation delay last year was the subject of much debate. Using the budget process to further delay the implementation of the program might not provide the same forum for discussion as legislation.

The staff recommendation would generate some additional administrative savings. The Department received funding for 1.0 FTE to implement the program. The JBC staff will need to work with the Department to isolate the FTE costs and determine the appropriate timing to remove the appropriation.

→ S6.25 Biosimilars

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$5,131,802	-$982,330	-$516,862	$0	-$3,632,610	0.0
Recommendation	-5,131,802	-982,330	-516,862	0	-3,632,610	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions and the availability of specific biosimilars for drugs driving cost trends.

Request

The Department is implementing policies that require people to try certain lower cost biosimilar drugs rather than paying for higher cost branded biologic drugs.

The Department implemented the first limitations July 15, 2025, and further restrictions January 1, 2026. The limits reduce the Department's forecast by:

- Current year: $5.1 million total funds, including $982,330 General Fund
- Year 1: $12.3 million total funds, including $2.4 million General Fund

Like generic drugs, biosimilars have no clinically meaningful differences in safety, purity, or effectiveness. Unlike generics, biosimilars are not chemically identical to the original. The biosimilars are made from living cells and there are non-clinically meaningful variations.

Recommendation

Staff recommends approval of the request. Biosimilars are approved by the federal Food and Drug Administration to be just as safe and effective as the original. HCPF policies allow the provider to request coverage of the branded drug if clinically necessary. This is not the same as requiring the client to fail on a different type of lower cost treatment. The biosimilars are the same treatment to address the same ailment in the same way using the same type of microorganisms, just produced by a different manufacturer.

→ S6.26 3rd Party pay for drugs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$4,071,186	-$1,226,741	-$268,926	$0	-$2,575,519	0.0
Recommendation	-4,071,186	-1,226,741	-268,926	0	-2,575,519	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department will no longer pay as the primary insurer for drugs when a member has 3rd party insurance but uses a pharmacy that is out-of-network for that 3rd party insurer.

The Department implemented the limit January 1, 2026. The new limit reduces the Department's forecast by:

- Current year: $4.1 million total funds, including $1.2 million General Fund
- Year 1: $9.8 million total funds, including $2.9 million General Fund

If a Medicaid member has 3rd party insurance and that 3rd party insurer has a closed pharmacy network, such as Kaiser, then the member will no longer be able to get full coverage for prescriptions at any pharmacy that might be convenient to them, such as Walgreens or King Soopers. Instead, they will need to go to an in-network pharmacy that might be less convenient to them. The 3rd party insurer will pay as the primary insurer and then Medicaid, as the secondary insurer, will cover any additional costs that are part of the Medicaid benefit but not part of the 3rd party insurer's benefit.

Recommendation

Staff recommends approval of the request. Medicaid is supposed to be the insurer of last resort. This may inconvenience some Medicaid members compared to prior practice, because Medicaid had been paying for drugs in these settings in the past. However, Medicaid should not be paying as the primary insurer if there is another insurer that covers the drugs. If that other insurer requires clients to use in-network pharmacies, then communicating that restriction to members is the responsibility of that other insurer.

There will be no "gotcha" bills where services are delivered and then the client gets a larger bill than expected. The client will know the price after insurance before purchasing the drugs. However, if a client is not aware of their coverage restrictions, they could show up at an out-of-network pharmacy. The Department says that the pharmacy would redirect them to a provider that accepts their coverage.

→ S7n Ambulatory surgical center eligible services

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$248,471	-$54,664	-$14,908	$0	-$178,899	0.0
Recommendation	0	$0	$0	$0	$0	0.0
Staff Recommendation Higher/-Lower than Request	$248,471	$54,664	$14,908	$0	$178,899	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department expanded Medicaid coverage of services at ambulatory surgical centers (ASCs) to include spinal surgeries and urology procedures effective January 1, 2026.

The change lowers the Department's forecasted expenditures by:

- Current year: $248,471 total funds, including $54,664 General Fund
- Year 1: $496,941 total funds, including $109,327 General Fund

The Department already covers spinal surgeries and urology procedures when delivered at a hospital. The change expands the settings where providers can get Medicaid reimbursement. To the extent ASCs offer the newly eligible services, clients will have more options for where they receive services.

An ASC delivers surgeries and procedures that do not require hospitalization. The Medicaid rates for services delivered in an ASC are lower than for the same services delivered in a hospital, due to the lower overhead. The request assumes 30 percent of these services will shift from hospitals to ASCs and the difference in rates for that 30 percent is the source of the savings.

Recommendation

Staff recommends assuming no savings. Staff supports allowing more covered services to receive reimbursement when delivered at an ASC to encourage the delivery of services in the most cost-effective setting. The JBC staff's concerns are not with the policy but with the projection of savings. The Department assumes 30 percent of the utilization will shift from hospitals to ASCs with no evidence to support that assumption. The assumption relies on expected changes in provider and client behaviors that are difficult to predict and may not happen at all, let alone on the scale assumed by the Department.

Furthermore, the projection of savings in FY 2025-26 depends on implausible assumptions. The FY 2025-26 savings projection assumes the shift in utilization will happen beginning day one, like turning on a lightbulb,

rather than ramping up as ASCs, providers, and clients adapt to the change in policy. Also, the FY 2025-26 savings projection does not account for the delay between when services are provided and paid.

While the Department didn't provide any evidence, the Department made several arguments for why physicians may want to shift utilization to ASCs. The Department says the supplemental is in response to requests from physicians to allow these specific services at ASCs. According to the Department, physicians often prefer ASCs. The ASCs can have more flexible scheduling and shorter wait times compared to hospitals. ASCs are less likely to need to delay or reschedule procedures due to unforeseen demands and emergencies that can happen in the hospital setting. Most ASCs are majority owned by physicians. Compared to hospitals, ASCs perform a narrower scope of procedures with smaller teams, which can provide members with more specialized and personalized care. There is evidence to suggest services delivered in ASCs result in fewer complications and unplanned hospitalizations.[1]

These same reasons might cause clients to prefer ASCs, the Department argues. However, that assumes that clients are aware of these differences between ASCs and hospitals and the evidence regarding outcomes.

The Department provided no arguments for why the shift in utilization will be 30 percent, rather than 1 percent or 50 percent or 70 percent. As far as the JBC staff can tell, the 30 percent assumption is just a haunch about how much utilization might shift.

The projected savings of $54,664 General Fund in FY 2025-26 and $109,327 General Fund in FY 2026-27 are relatively small, so the risk if the projection proves wrong is small. At the same time, the value of the savings toward balancing is similarly small. The JBC's historic standards for when to assume savings from a policy change are much higher than what the Department provided for this request.

It is particularly problematic that the savings depend on changes in provider and client behavior. There might be evidence to support that eating broccoli instead of ice cream results in better health outcomes. However, telling someone to eat broccoli instead of ice cream will not necessarily result in savings. That depends on a change in behavior. Offering clients services in an ASC or a hospital does not mean they will choose the ASC. The hospital most likely has better name recognition. Clients may perceive the hospital as offering advantages, such as better resources to address complications that might arise during the service.

[1] The Safety of Performing Surgery at Ambulatory Surgery Centers Versus Hospital Outpatient Departments in Older Patients With or Without Multimorbidity; Comparing Quality at an Ambulatory Surgery Center and a Hospital-Based Facility: Preliminary Findings; Returns to specialization: Evidence from the outpatient surgery market; Nationwide Study Finds Ambulatory Surgery Centers Treat 15% More Patients in Socially Vulnerable Areas for Cardiac Interventions.

Provider rates

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
S6.01 Accountable care incentives	$0	$0	$0	$0	0.0	EK
S6.02 Behavioral health incentives	-5,996,844	-1,500,000	-1,498,422	-2,998,422	0.0	EP
S6.03 Primary care stabilization	-9,170,070	-3,000,000	-338,064	-5,832,006	0.0	EK
S6.11 Provider rates -1.6%	-108,167,253	-38,277,173	-5,938,052	-63,952,028	0.0	EK
S6.12 Community connector -15%	-6,026,470	-3,013,235	0	-3,013,235	0.0	TD
S6.13 Nursing minimum wage	0	0	0	0	0.0	EK
S6.14 Individual residential srvcs & supports	-2,900,558	-1,450,279	0	-1,450,279	0.0	TD
S6.15 Pediatric behavioral therapy rates	-5,440,445	-2,720,222	0	-2,720,223	0.0	EP
S6.16 Dental rates	-13,779,299	-2,516,100	-2,080,674	-9,182,525	0.0	EK
S6.23 & S7j Rates above 85% Medicare	-16,320,469	-4,612,165	-1,158,753	-10,549,551	0.0	EK
S6.24 Drug rates	-2,634,322	-628,713	-196,419	-1,809,190	0.0	EK
S6.27 Specialty drug rates	-279,321	-104,522	-13,405	-161,394	0.0	EK
S6.28 Drug dispensing fees	-281,817	-84,918	-18,616	-178,283	0.0	EK
S6.33 Community connector -23%	-3,055,311	-1,527,656	0	-1,527,655	0.0	TD
S7e XL wheelchair transport	-32,916,295	-9,899,892	-6,558,355	-16,458,048	0.0	EK
Provider stabilization gifts	20,000,000	0	20,000,000	0	0.0	EK
Total	-$186,968,474	-$69,334,875	$2,199,240	-$119,832,839	0.0	

→ S6.01 Accountable care incentives

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$2,317,086	-$750,000	-$408,543	$0	-$1,158,543	0.0
Recommendation	0	0	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$2,317,086	$750,000	$408,543	$0	$1,158,543	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department is reducing incentive payments through the Accountable Care Collaborative.

The Department implemented the reduction retroactively for FY 2025-26. Reducing the incentive payments decreases the forecast by:

- Current year: $2.3 million total funds, including $750,000 General Fund
- Year 1: $2.3 million total funds, including $750,000 General Fund

The Primary Care Medical Providers (PCMPs) and Regional Accountable Entities (RAEs) can earn the incentive payments by improving health outcomes to meet performance goals.

The Department's forecast has savings built into it from the historic performance of the Accountable Care Collaborative in improving health outcomes and reducing expenditures. Ostensibly, the incentive payments motivate and finance the PCMPs and RAEs to innovate, perform interventions, and provide the preventive care that leads to better outcomes. The Department does not expect a decrease in the savings from better health outcomes as a result of the proposed decrease in incentive payments.

Recommendation

Staff recommends denying the request.

Reduction may decrease the savings from the Accountable Care Collaborative

The JBC staff is concerned that reducing the incentive payments will reduce the savings generated by the Accountable Care Collaborative (ACC). The Accountable Care Collaborative (ACC) is intended to save money by achieving better health outcomes. Each iteration and expansion of the ACC has included projected savings. For example, Phase III of the ACC projected savings in FY 2025-26 of $34.5 million total funds, including $11.2 million General Fund, for increased care management during client transitions from an inpatient or residential facility to the community. The projection assumed a 10 percent decrease in adult hospital readmissions based on similar interventions in North Carolina and a 25 percent reduction in child hospital readmissions in 3 rural regions based on a study of children's hospitals in Minnesota.

As an example of the accomplishments of the ACC, the Department noted an increase between 2022 and 2024 in care meeting the Department's timeliness targets. Clients receiving timely prenatal care rose from 60.8 percent to 74.2 percent and clients receiving timely postpartum care rose from 47.4 percent to 69.1 percent.

When the Department first created the ACC, it did detailed analysis comparing expenditures for similar populations enrolled in the ACC and not enrolled in the ACC in the same year. In addition, the Department looked at expenditures for populations before the ACC and trended them forward to compare the expected costs with the actual costs after the ACC. It did the same thing with indicators of health outcomes. These different analyses suggested that the ACC was achieving better health outcomes and thereby savings. The Department was able to estimate the value of these savings.

Over time, it has become more difficult to reliably project costs absent the ACC for comparison to costs with the ACC. There are savings from the ACC reflected in the Department's actual expenditures. The savings are built into the cost trends. The Department cannot reliably separate out and quantify the cost savings because too much time has passed and we no longer have a good baseline to project what expenditures would be without the ACC.

The Department argues that the performance-based payments of the ACC motivate providers to implement innovative programs that achieve better health outcomes. The performance-based payments enable providers to operate these programs by providing a revenue stream for activities that fee-for-service payments would not reimburse.

The JBC staff is concerned that reducing the incentive payments will reduce the savings based on the Department's own analysis. The Department says that in the first year of ACC Phase III the incentive payments will reward providers completing projects. The Department does not expect a decrease in the incentive payments to impede the completion of these projects. However, in subsequent years the incentive payments transition to rewarding health outcomes. The Department says:

> If reductions to the quality program extend beyond FY 2025-26, we would expect a proportional decline in our projected ACC Phase III savings. Specifically, the ACC Phase III quality program includes incentives for the RAEs to reduce the inpatient readmissions rate, which was the basis for our savings projections. RAEs' overall performance may be lower due to the reduced resources allocated to support this work if the possible quality incentive payments are reduced … In general, providers and RAEs want to provide high quality care, but they often face time and resource constraints. Without incentives, we wouldn't expect large improvements to quality metrics because providers and RAEs would no longer have the opportunity to access additional resources and funding that can justify the time required to implement quality improvement work.

This request is for an ongoing reduction that impacts future years. The request does not include any adjustment for the decrease in ACC savings that the Department expects in those future years.

Intended policy and impact are unclear

The JBC staff is unsure about both the intended percentage reductions and the impacts on the RAEs versus the primary care providers. The request describes this as a 25 percent reduction in the incentive payments and says 75 percent of the incentive funds are distributed to the primary care providers and 25 percent to the RAEs. Subsequently, the Department provided a table describing the reduction that does not match those percentages.

Incentive Payments

Item	Original	Proposed	Difference	Percent
Regional Accountable Entities	$13,285,499	$12,126,956	$1,158,543	8.7%
Primary Care Medical Providers	6,642,749	5,484,206	1,158,543	17.4%
Total	$19,928,248	$17,611,162	$2,317,086	11.6%

The Department was unable to provide an adequate explanation of the differences between the narrative and the table prior to this supplemental publication.

Communications with the Department suggest the incentive payments in the table above are intended to represent the incentive payments related to Phase III. They do not include incentive payments already in the budget from previous ACC funding. However, last year's budget request showed the increase in incentive payments for Phase III as $6.1 million.

The JBC staff wanted to understand how much the request decreases the total incentive pool, to better understand the decrease in financial motivations for the providers. The Department provided three different estimates of the incentive pool, ranging from $43.8 million in the hearing responses to $56.9 million in the November forecast and $53.5 million in an unpublished estimate for the JBC staff. These estimates are in a similar range but the difference between the top estimate and bottom estimate is $13.1 million, or 30 percent.

This variation in the estimates is not as concerning as the discrepancies noted above, but contributes to the JBC staff's unease that the intended policy and impacts on stakeholders are not clear.

The Department says all three estimates used different methods and data through different points in time. The Department says the last estimate is based on the most recent data. However, the JBC staff used the estimate from the hearing responses in the table below, because it was the only one that included data for the behavioral health base payments and incentive payments, which is relevant for the next subsection.

Current ACC Payments

Item	Care management	Behavioral health	Total
Base payments	$191,402,226	$136,717,106	$328,119,332
Incentive payments	43,806,868	26,580,173	70,387,041
Total FY 25-26	$235,209,094	$163,297,279	$398,506,373

Proposed Reductions

Item	R6.01 ACC incentives	R6.02 BH incentives	Total
Proposed reduction	-$2,325,290	-$12,644,332	-$14,969,622
% of incentives	-5.3%	-47.6%	-21.3%
% of total	-1.0%	-7.7%	-3.8%

Reduction is not sized appropriately relative to other reductions

If the tables above correctly describe the Department's request, which is a big "if" for the reasons described above, then the Department is proposing a reduction in incentive payments of 5.3 percent for care management and 47.6 percent for behavioral health. The Department provided no policy explanation for the difference in the reductions for care management versus behavioral health. The reductions are presumably similar in purpose. They both impact the RAEs. An unknown portion of the decreases are passed through to providers. In one case the recipients of the pass throughs are primary care providers and in the other behavioral health providers. The two reductions are wildly disproportionate to each other with no explanation.

→ S6.03 Primary care stabilization

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$4,585,035	-$1,500,000	-$169,032	$0	-$2,916,003	0.0
Recommendation	-9,170,070	-$3,000,000	-$338,064	$0	-$5,832,006	0.0
Staff Recommendation Higher/-Lower than Request	-$4,585,035	-$1,500,000	-$169,032	$0	-$2,916,003	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions and delays in federal approval.

Request

The Department is delaying the start of annual primary care stabilization payments to pediatric, small, or rural providers that do not receive cost-based reimbursements.

The Department is delaying the start of the payments from the budgeted July 1, 2025 to January 1, 2026.

Current year: One-time savings of $4.6 million total funds, including $1.5 million General Fund.

The stabilization payments are a new component of Phase III of the Accountable Care Collaborative. They are not the same as the payments from the Provider Stabilization Fund authorized by S.B. 25-290 that use a loan from the Unclaimed Property Trust Fund. These payments will go to primary care providers that are not Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs). The FQHCs and RHCs receive cost-based reimbursements.

The Department estimates 271 primary care providers will qualify for the primary care stabilization payments. Of the qualifying providers, 59 are in a rural category, 125 are not rural but pediatric, and 87 are neither rural nor pediatric but small. Some of the providers fit in multiple categories. The Department provided this breakdown by category:

- Small: 87
- Rural: 37
- Pediatric: 80
- Small & Rural: 14
- Small & Pediatric: 45
- Rural & Pediatric: 6
- Small, Rural, Pediatric: 2

The intended payments are $3.10 per member per month, so the payments increase or decrease based on the number of Medicaid clients where the provider is the primary care medical provider.

Recommendation

Rather than the requested delay in the start of the provider stabilization payments, staff recommends not starting them at all. The staff recommendation saves $3.0 million General Fund in FY 2025-26 and on-going, compared to the request for one-time savings of $1.5 million General Fund in FY 2025-26 and no savings in future years.

The primary care stabilization payments are a new initiative. They were budgeted to begin in FY 2025-26, but they did not exist prior to FY 2025-26. The staff recommendation does not cut historic funding levels. While the

General Assembly had good reasons to fund the stabilization payments, the JBC staff assumes that stopping new payments is less likely to impact access to care than cutting existing payments. These providers served Medicaid clients before the primary care stabilization payments and the JBC staff assumes they will continue to serve Medicaid clients in the future, whether the providers receive the primary care stabilization payments or not.

The Department has not yet received federal approval for the primary care stabilization payments. The Department can't draw the federal match to make the payments for the first half of the fiscal year. If the Department receives federal approval within this quarter, then it could make the payments retroactively back to January 1, 2026, as requested, but that is not the staff recommendation.

General Fund Savings by Fiscal Year

Item	FY 2025-26	FY 2026-27	On-going
Staff Recommendation	-$3,000,000	-$3,000,000	-$3,000,000
Request	-$1,500,000	$0	$0
Difference	-$1,500,000	-$3,000,000	-$3,000,000

Potential counter arguments

Part of the argument for the payments is that these providers struggle to participate in the Department's value-based payment programs. Participating in the value-based payments requires additional administrative work and investments in electronic medical record systems. Even if the providers use electronic medical records, they need to connect them and configure them to report data for the value-based payments. Many of the Department's value-based payments are not targeted at these particular providers.

Although the payments have not yet started, the Department argues that the providers are operating under the assumption these payments will begin in the current fiscal year. Staff notes that all of the Department's communications indicate that the payments are pending federal approval, which has not yet been granted. If the providers are counting on this funding, then those providers are premature. Even though the General Assembly initially appropriated money, there is not yet federal approval. The money is still uncertain, even if the JBC decides that it wants to keep the stabilization payments.

The Department raised concerns that provisions of H.R. 1, including the work requirements and six-month eligibility renewals, may cause patients to access care less consistently. That impacts the financial stability of these providers.

The Department paraphrased a provider who argued that small independent practices, especially in pediatrics, are reducing their Medicaid panel sizes, reducing staff, or closing. The Department did not provide any data to support this anecdotal assertion. The Medicaid Provider Rate Review Advisory Committee (MPRRAC) did not highlight access to care concerns for these services. That doesn't mean the argument is invalid, but the MPRRAC is supposed to be a forum for identifying and investigating these types of provider rate and access to care concerns.

The providers say these payments will allow team-based care, such as integrated behavioral health, care coordination, and nurse care management for diseases and chronic conditions. Also, they will support more time with clients than the fee-for-service payments allow. That time, they argue, allows them to discuss questions with patients and families, such as vaccine hesitancy.

→ S6.11 Provider rates -1.6%

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$108,167,253	-$38,277,173	-$5,938,052	$0	-$63,952,028	0.0
Recommendation	-108,167,253	-38,277,173	-5,938,052	0	-63,952,028	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department is undoing the 1.6 percent provider rate increase for Medicaid providers that was appropriated in FY 2025-26.

The Department reverted to the FY 2024-25 rates effective October 1, 2025. The rate decrease reduces the Department's forecast by:

- Current year: $108.2 million total funds, including $38.3 million General Fund
- Year 1: $161.0 million total funds, including $57.0 million General Fund

The adjustment does not apply to behavioral health and managed care providers or providers with rates set by state or federal law.

Recommendation

Staff recommends approval of the request. The provider rate reduction may impact access to care, but the impacts are indirect and likely in the future.

The effect of a provider rate reduction on access to care is difficult to project. A reduction in rates may cause some providers to decrease the number of Medicaid clients they accept. A rate reduction could destabilize some providers who rely heavily on Medicaid reimbursement. Some providers may increase charges to other payers to compensate for decreased Medicaid reimbursement. Some providers may absorb the reduction, perhaps cutting costs and becoming more efficient. The experiences of individual providers will vary.

A one-year change in provider rates is not likely to break the camel's back. Access to care issues typically arise from chronic underfunding of provider rates. That said, the table below illustrates that the across-the-board provider rate increases for the Department have not kept pace with inflation for many years. That might be a reason to deny the request.

Provider rates vs inflation

Fiscal Year	Across-the-board rate adjustment	CPI-U Medical Care	National Health Expenditures
FY 2010-11	-1.0%		3.4%
FY 2011-12	-0.8%		4.0%
FY 2012-13	0.0%		2.6%
FY 2013-14	2.0%		5.1%
FY 2014-15	2.0%		5.4%
FY 2015-16	0.5%	3.5%	4.5%
FY 2016-17	0.0%	2.7%	4.2%
FY 2017-18	1.4%	2.5%	4.6%
FY 2018-19	1.0%	2.0%	4.4%
FY 2019-20	1.0%	5.1%	10.4%
FY 2020-21	-1.0%	0.4%	4.2%
FY 2021-22	2.5%	4.5%	4.6%
FY 2022-23	2.0%	0.1%	7.5%
FY 2023-24	0.5%	3.3%	8.2%
FY 2024-25	2.0%	2.8%	7.1%
FY 2025-26	0.0%		5.4%

The proposed across-the-board reduction attempts to spread the impact over a broad group of providers and minimize the budget reductions impacting any single provider. In addition to the across-the-board reduction, the Department is requesting several targeted provider rate reductions based on analysis of those specific rates and circumstances.

→ S6.13 Nursing minimum wage [legislation]

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$8,719,922	-$4,359,961	$0	$0	-$4,359,961	0.0
Recommendation	-8,719,922	-4,359,961	0	0	-4,359,961	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department is ending a supplemental payment to nursing facilities that commit to pay all employees at least $15 per hour.

The Department implemented the reduction retroactively for FY 2025-26. Ending the supplemental payment reduces the forecast by:

- Current year: $8.7 million total funds, including $4.4 million General Fund
- Year 1: $8.7 million total funds, including $4.4 million General Fund

The statewide minimum wage will exceed $15 per hour in 2026. Statute says the supplemental payment is in effect, "as long as the statewide minimum wage is less than fifteen dollars per hour". The statute also says the supplemental payment is, "subject to available appropriations".

Originally, the supplemental payment went to nursing facilities impacted by local minimum wage requirements. House Bill 19-1210 required supplemental payments when a nursing facility had to comply with a local minimum wage or was located nearby and chose to match the minimum wage. House Bill 22-1333 changed the supplemental payment so that any nursing facility statewide that paid employees at least $15 per hour could qualify. Only 3 nursing facilities did not claim the supplemental payment in calendar year 2024.

The proposed reduction is approximately 0.85% of total Medicaid reimbursement to nursing homes. The impacted nursing homes will see reductions ranging from 0.3 percent to 1.7 percent.

To put the reduction in context, it is helpful to know that the process for setting nursing facility rates is changing from a statutory formula to the annual budget process. Prior to H.B. 23-1228, the statutory formula effectively resulted in 3.0 percent increases in per diem rates every year. House Bill 23-1228 removed the statutory formula and set the increases at 10 percent in FY 2023-24, 3 percent in FY 2024-25, 1.5 percent in FY 2025-26, and by amounts determined through the annual budget process in FY 2026-27 and thereafter. The Department did not include nursing rates in the 1.6 percent reduction or the 85 percent of Medicare reduction. The Department did not request an increase in the per diem rates for FY 2026-27. Thus, for FY 2025-26 the nursing homes received a 1.5 percent increase that this proposal would partially offset with a decrease that varies by provider but is 0.85 percent in aggregate.

Recommendation

Staff recommends legislation to implement the request. The request spreads some of the burden and pain to nursing homes from budget balancing reductions in provider rates. However, it still gives preferential treatment to nursing home rates consistent with the General Assembly's historic practices.

There are good reasons to be concerned about nursing home rates. Nursing homes work with extremely vulnerable populations, operate on thin margins, and have limited opportunities to spread costs to other payers, since Medicaid is the primary payer. Most of the nursing home costs are for compensation and many of the employees in nursing homes work at or near minimum wage, putting intense pressure on nursing home budgets when minimum wage requirements increase. These factors make nursing homes particularly sensitive to provider rate reductions. These are probably contributing reasons behind why the General Assembly created the minimum wage supplemental payment for nursing homes.

However, nursing homes are not the only providers in this position. For example, these characteristics also describe most of the home- and community-based services providers. The home- and community-based services providers have not shared the same statutory rate protections as nursing homes and they are part of the Department's proposed across-the-board rate reductions..

The Department's request attempts to strike a balance between spreading the impacts of provider rate reductions broadly and equitably to minimize the impacts on individual providers, while acknowledging specific challenges facing nursing home providers.

The legislature already decided that the supplemental payments are not permanent. The statute requiring the supplemental payments is scheduled to repeal July 1, 2026. The supplemental payments are in effect as long as the statewide minimum wage is less than $15. As of January 2026, the statewide minimum wage is $15.16 per hour.

The Department's action ended the supplemental payments before the time contemplated in the statute. The Department ended the supplemental payments retroactively to the beginning of the fiscal year, six months before the statewide minimum wage exceeded $15 per hour. The appropriation assumed that the Department would continue making the supplemental payments through the end of the fiscal year.

The Department argues that the statute makes the supplemental payments subject to available appropriations. The Governor's executive orders restricted the appropriation. Because the executive orders took away the funding, the Department argues that it does not need to make the supplemental payments.

Based on discussions with Legislative Legal Services, staff recommends legislation to end the supplemental payments. The Department can make an argument for why terminating the supplemental payments was legal, but a stakeholder could challenge that interpretation. A statutory change would eliminate any ambiguity about the legislature's intent. These supplemental payments were authorized by statute and so ending them through a statutory change, rather than the budget process, makes sense.

→ S6.16 Dental rates

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$13,779,299	-$2,516,100	-$2,080,674	$0	-$9,182,525	0.0
Recommendation	-13,779,299	-$2,516,100	-$2,080,674	$0	-$9,182,525	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department is reducing select dental rates to 95 percent of the benchmark.

The Department implemented the reductions October 1, 2025. The rate reductions decrease the Department's forecast by:

- Current year: $13.8 million total funds, including $2.5 million General Fund
- Year 1: $20.7 million total funds, including $3.8 million General Fund

The reductions apply to codes that received a large targeted rate increase in FY 2024-25. The decreases vary by code, but the aggregate impact is a 15 percent reduction for the affected codes. The Department did not provide data showing the reduction relative to total projected dental expenditures, but in FY 2024-25 the Department described the affected codes as the most common and representing a little over half the utilization.

Recommendation

Staff recommends approval of the request. This is a smaller scale version of something the Department proposed last year that the JBC staff recommended but the JBC did not adopt. The arguments are the same as last year.

In FY 2024-25, the General Assembly approved an unusually large increase for these dental codes that was out of proportion with the General Assembly's historic priorities. The increase was $78.5 million total funds, including $14.3 million General Fund and $8.6 million from the Adult Dental Fund. This compares to an increase in the same year for home- and community-based services of $79 million total funds to try to keep pace with increases in the minimum wage. For the last several years, the General Assembly has prioritized spending the limited resources for provider rate increases on home- and community-based services, so a similarly sized increase for dental services was highly unusual.

The Department's FY 2024-25 analysis indicated a large variance between dental rates and the benchmark, but the selected benchmark was generous compared to other rates and not a good proxy for provider costs. The Department's selected benchmark for dental rates included average fees from all payers, including both public and private. The Department's analysis indicated that dental rates paid at 49.8 percent of the benchmark. The selected benchmark was an American Dental Association (ADA) 2020 survey. The Department compares most rates to Medicare. The Medicare rates attempt to pay at cost and are typically lower than private insurance. When Medicare rates are not available, the Department usually uses other state Medicaid program rates as the benchmark. There are no comparable Medicare rates and the Department decided to use the ADA survey instead of comparing to other states, primarily due to time. A more recent ADA 2022 survey was available, but the Department's request used the ADA 2020 survey due to a technical error. The legislature approved the Department's request, rather than updating for the 2022 survey, for budget balancing reasons. Using an out-of-date survey dampened some of the impact of selecting a benchmark that included private pay.

Dental is an optional benefit. If the General Assembly wants to balance the budget by reducing benefits, dental would be near the top of the list of viable options. Rather than reducing dental benefits, the staff recommendation is to scale back the provider rate increase provided in FY 2024-25.

With the proposed reduction, provider rates for dental services will still be significantly higher than they were prior to FY 2024-25. For this reason, the JBC staff does not expect the proposed reduction to significantly impact access to care.

The table below summarizes the proposed reduction by code.

Dental rate reduction

Item	Code	Estimated Expenditure	July 2024 Rates	95% of Benchmark	Total Impact
Periodic oral evaluation	D0120	$13,282,199	$38.35	$32.41	-$2,057,269
Limited Oral Evaluation Problem Focused	D0140	4,921,585	$53.14	$44.90	-763,151
Comprehensive Oral Evaluation	D0150	7,696,701	$61.03	$51.57	-1,193,033

Item	Code	Estimated Expenditure	July 2024 Rates	95% of Benchmark	Total Impact
Prophylaxis Adult	D1110	14,157,549	$97.50	$82.39	-2,194,057
Prophylaxis Child	D1120	10,709,631	$73.04	$61.72	-1,659,817
Topical fluoride varnish	D1206	8,483,748	$41.96	$35.46	-1,314,213
Sealant Per Tooth	D1351	5,974,526	$57.10	$48.25	-925,999
Prev resin rest, perm tooth	D1352	51,404	$99.32	$83.93	-7,965
Interim Caries Arresting Medicament Application, Per Tooth	D1354	166,311	$54.53	$46.08	-25,772
Crown, Porcelain/Ceramic substrate	D2740	22,766,526	$849.16	$717.54	-3,528,817
Crown Porcelain High Noble Metal	D2750	1,662,728	$841.06	$710.70	-257,714
Crown Porcelain Base Metal	D2751	1,023,417	$767.03	$648.14	-158,630
Crown Porcelain Noble Metal	D2752	468,522	$798.29	$674.56	-72,618
Crown Full Cast High Noble Metal	D2790	24,100	$868.62	$733.98	-3,736
Crown Titanium	D2794	0	$836.88	$707.16	0
Prefab Stainless Steel Crown Primary	D2930	13,217,544	$198.49	$167.72	-2,048,989
End thxpy, anterior tooth	D3310	2,897,685	$799.76	$675.80	-449,131
End thxpy, bicuspid tooth	D3320	4,987,749	$917.71	$775.46	-773,128
End thxpy, molar	D3330	5,784,941	$1,109.31	$937.37	-896,650
Retreatment Root Canal Anterior	D3346	104,220	$911.61	$770.31	-16,154
Retreatment Root Canal Bicuspid	D3347	142,963	$1,044.12	$882.28	-22,159
Retreatment Root Canal Molar	D3348	303,339	$1,246.06	$1,052.92	-47,018
Periodontal Scaling & Root Planning	D4341	2,859,762	$266.51	$225.20	-443,273
Periodontal Scaling 1 to 3 Teeth	D4342	9,045,977	$189.68	$160.28	-1,402,107
Periodontal Maintenance	D4910	2,628,950	$149.01	$125.91	-407,548
Full Year Impact		$133,362,077			-$20,668,949
FY 2025-26 Impact (Assuming October 1, 2025 Implementation)					-13,779,299

In addition to the direct General Fund savings, the staff recommendation reduces the General Fund obligation for a TABOR refund in any year when a TABOR refund is due. The source of revenue to the Adult Dental Fund is transfers from the Unclaimed Property Trust Fund. Revenue to the Unclaimed Property Trust Fund is exempt from TABOR, because the money is held for another party, but when the General Assembly uses it for another purpose it becomes revenue subject to TABOR.

Dental rate reduction by fund source

Item	Total Funds	General Fund	Hospital Provider Fee	Adult Dental Fund	Federal Funds
FY 2025-26	-13,779,299	-2,516,100	-571,841	-1,508,833	-9,182,525
FY 2026-27	-20,668,949	-3,774,150	-857,761	-2,263,250	-13,773,788

→ S6.23 and S7j Rates above 85% Medicare

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$16,320,469	-$4,612,165	-$1,158,753	$0	-$10,549,551	0.0
Recommendation	-16,320,469	-$4,612,165	-$1,158,753	$0	-$10,549,551	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions and the Governor's executive orders to reduce expenditures.

Request

The Department proposes reducing rates to 85 percent of the Medicare benchmark.

The reductions would take effect April 1, 2026. The Department initially estimated the savings in S6.23 and then made technical corrections and submitted a revised projection in S7j. The revised estimate reduces the forecast by:

- Current year: $12.3 million total funds, including $3.5 million General Fund
- Year 1: $53.2 million total funds, including $15.0 million General Fund

This only applies to rates with a Medicare benchmark and it excludes primary care and evaluation and management services. The reduction is applied only if the rate is above 85 percent after the 1.6 percent across-the-board reduction. It does not reduce the rates to 85 percent of the benchmark and then apply another 1.6 percent reduction.

In S7j the Department made corrections to the originally estimated savings in S6.23. First, the Department added reductions for services that had been erroneously omitted from the initial calculation related to family planning, lab and pathology, and durable medical equipment, prosthetics, orthotics, and supplies. Second, the Department removed some savings for services incorrectly identified as radiology services that are actually part of the primary care evaluation and management services that the Department intended to exempt from the reduction. Third, the Department removed some savings related to neurological and psychological testing services and abortion services where there is no adequate Medicare benchmark.

The projected savings for FY 2025-26 assume that the Department implements the new rates April 1, 2026 and they take into account the delay between when services are provided and paid. The Department is in the process of creating rules and seeking federal approval. The reduction for FY 2026-27 shows the full projected annual savings.

Recommendation

Staff recommends approval of the request. The Department's overall request includes a combination of across-the-board reductions and targeted reductions for provider rates. This request targets the largest reductions to the rates that are the highest relative to Medicare. The theory is that providers doing the best relative to Medicare are the most able to absorb rate reductions.

The provider rate reduction may impact access to care, but the impacts are indirect and difficult to project. A reduction in rates may cause some providers to decrease the number of Medicaid clients they accept. A rate reduction could destabilize some providers who rely heavily on Medicaid reimbursement. Some providers may increase charges to other payers to compensate for decreased Medicaid reimbursement. Some providers may

absorb the reduction, perhaps cutting costs and becoming more efficient. The experiences of individual providers may vary, but the Department expects no net negative impact on access to care from this magnitude of a rate reduction.

Medicare rates are a useful benchmark for many Medicaid rates. Medicare reviews and adjusts their rates annually. The Medicare methodology is designed to try to pay providers at cost. Typically, Medicare surveys a representative sample of actual provider costs and draws conclusions about a reasonable rate for an efficient provider. Medicare uses a relative value scale to set rates for similar services based on how much more or less time that service is expected to take than the surveyed provider costs. When data is limited for a cost component, Medicare may use other sources, such as economic data, to extrapolate reasonable or expected costs. Medicare then applies inflation factors to adjust for the time between today and when the actual data was collected. Also, Medicare applies regional cost of living adjustments to account for how provider costs in Colorado differ from other parts of the country. Medicare's methods are not perfect, but the Department does not have the resources to estimate provider costs independent of Medicare, nor does the Department have access to data to improve on Medicare's estimates. Rather than duplicating the work of Medicare, the Department uses Medicare rates as a proxy for provider costs when an equivalent Medicare rate is available.

An adequate Medicare benchmark is not always available because Medicaid covers some services not covered by Medicare. Most notably this occurs for long-term services and supports, but there are some more narrow services where Colorado's Medicaid coverage is broader than Medicare. Medicare primarily covers the elderly, but it also serves younger people with disabilities under certain conditions. So, Medicare often has an equivalent rate even for Medicaid services to children and pregnant women.

Over the last several years, the General Assembly has approved several requests from the Department to rebalance Medicaid rates to within a range of the equivalent Medicare rates. Most often, the proposed range has been 80-100 percent of the Medicare benchmark. In a few cases the range was wider due to budget constraints, such as 75-100 percent. Also, there are cases where the Department proposed rates at 100 percent of Medicare, or allowing rates to stay above Medicare, for "high value" services that the Department wanted to encourage as preventive of higher cost services.

Colorado's Medicaid rates quickly get out of sync with Medicare rates. Medicare is constantly updating rates while Colorado Medicaid only updates rates when the legislature provides funding or federal or state rules require changes.

S6.23 and S7j Rates above 85% Medicare

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds
FY 2025-26				
S6.23 Estimate	-$12,307,017	-$3,477,963	-$873,798	-$7,955,256
S7j Revision	-4,013,452	-1,134,202	-284,955	-2,594,295
Total	-$16,320,469	-$4,612,165	-$1,158,753	-$10,549,551
FY 2026-27				
S6.23 Estimate	-$53,241,533	-$15,046,057	-$3,780,149	-$34,415,327
S7j Revision	-17,091,440	-4,830,041	-1,213,492	-11,047,907
Total	-$70,332,973	-$19,876,098	-$4,993,641	-$45,463,234

The table below shows the reductions by category. Note that the first column is the estimated expenditure for the rates that are above 85 percent of Medicare and not the total estimated expenditures for the category.

Reductions by Category

Item	Rates >85% estimate	85% estimate	Difference
Dialysis	$257,871	$220,033	-$37,838
Family Planning	5,765,783	4,253,554	-1,512,229
DMEPOS	89,481,936	83,259,191	-6,222,745
EEG Ambulatory Monitoring	1,430,511	1,044,684	-385,827
Eyeglasses & Vision	27,037,367	25,111,858	-1,925,508
FFS Behavioral Health	11,534,029	11,149,169	-384,860
Laboratory and Pathology	158,907,406	143,757,594	-15,149,811
Maternity	27,019,476	22,166,219	-4,853,257
Neuro, Psych Testing Services	2,578,555	2,560,686	-17,869
Outpatient OT	147,121	146,077	-1,044
Outpatient PT	2,968,421	2,600,972	-367,449
Outpatient ST	6,260	5,771	-489
Physician Services - Cardiology	11,637,113	9,852,058	-1,785,055
Physician Services - Ear, Nose, and Throat	2,157,779	1,970,649	-187,130
Physician Services - EEG Ambulatory Monitoring	338	244	-94
Physician Services - Gastroenterology	295,911	273,023	-22,889
Physician Services - Health Education	257,049	194,244	-62,806
Physician Services - Ophthalmology	2,679,550	2,123,130	-556,419
Physician Services - Other Physician Services	56,340,591	47,872,854	-8,467,736
Physician Services - Radiology	107,355,760	91,538,527	-15,817,233
Physician Services - Respiratory	1,124,262	824,072	-300,191
Physician Services - Sleep Studies	7,427,851	5,406,079	-2,021,771
Physician Services - Vascular	1,557,669	1,424,346	-133,323
Physician Services - Women's Health & Family Planning	14,149,860	13,013,315	-1,136,545
Primary Care and Evaluation & Management Services	135,651,621	135,651,621	0
Surgery - Cardiovascular System	1,944,904	1,717,554	-227,350
Surgery - Digestive System	892,047	864,594	-27,453
Surgery - Eye & Auditory System	1,459,202	1,254,733	-204,469
Surgery - Integumentary System	396,812	359,023	-37,789
Surgery - Musculoskeletal System	175,242	165,037	-10,205
Surgery - Other Surgeries	2,793,799	2,492,172	-301,627
Surgery - Respiratory System	552,669	491,124	-61,545
Anesthesia	13,293,246	10,231,928	-3,061,319
Total	$689,278,010	$623,996,136	-$65,281,875

To get the current year estimate, the Department adjusted these savings to account for an April 1, 2026 implementation and the delay between when services are rendered and billed. For the FY 2026-27 estimate the Department inflated the total for the November forecast.

→ S6.24 Drug rates

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$2,634,322	-$628,713	-$196,419	$0	-$1,809,190	0.0
Recommendation	-2,634,322	-628,713	-196,419	0	-1,809,190	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department proposes changing the methodology used to determine drug rates in order to reduce expenditures.

Pending federal approval, the changes would take effect April 1, 2026, and reduce the forecast by:

- Current year: $2.6 million total funds, including $628,713 General Fund
- Year 1: $15.8 million total funds, including $3.8 million General Fund

Based on federal guidance, the Department must pay for most drugs at cost, but there are different ways to determine the "cost". For most drugs, the Department uses the actual acquisition cost in Colorado, or an alternative based on the National Average Drug Acquisition Cost. Pharmacies voluntarily contribute data for the actual acquisition cost. When there is insufficient data to determine the actual acquisition cost or the alternative, maybe because the drug is new or low volume, the Department uses the wholesale acquisition cost but applies a discount. The wholesale acquisition cost is known to overstate the actual acquisition cost. The proposed new methodology would first increase the discount applied to the wholesale acquisition cost from 3.5 percent to 4.0 percent for branded drugs and from 20.0 percent to 22.0 percent for generic drugs. Then, the methodology would reimburse for all drugs using the lesser of the actual acquisition cost, the National Average Drug Acquisition Cost, or the wholesale acquisition cost less the discount.

The federal Centers for Medicare and Medicaid Services must approve this proposed change to the drug payment methodology. If approved, the Department projects that the number of drugs paying at the wholesale acquisition cost less the discount will increase from 1.0 percent to about 10.0 percent.

The Department describes the change as impacting pharmacies, rather than the drug manufacturers.

Recommendation

Staff recommends approval of the request. The Department's options to reduce rates for drugs are limited due to federal requirements to pay at "cost". This request would spread some of the burden of provider rate

reductions to pharmaceuticals. It impacts a small portion of drugs. The rate reductions are variable by drug. Because of the variable reductions, it is difficult for the JBC staff to assess the impact on providers. However, this is less than a one percent reduction from the $1.6 billion the Department spent on drugs in FY 2024-25. The reduction seems unlikely to impact access to care.

The impact of the reduction does compound with the proposed reduction in *S6.28 Drug dispensing fees*. That reduction is targeted to the largest chain pharmacy providers.

→ S6.27 Specialty drug rates

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$86,155	-$32,238	-$4,135	$0	-$49,782	0.0
Recommendation	-365,476	-136,760	-17,540	0	-211,176	0.0
Staff Recommendation Higher/-Lower than Request	-$279,321	-$104,522	-$13,405	$0	-$161,394	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department proposes reducing rates paid to hospitals for a handful of specialty drugs delivered during outpatient care.

The reductions would take effect April 1, 2026, and they reduce the forecast by:

- Current year: $86,155 total funds, including $32,238 General Fund
- Year 1: $516,928 total funds, including $193,431 General Fund

Most hospital drug costs get captured in the bundled payment model for hospital services, but the Department pays directly for these newer drugs. Otherwise, the hospital payment model would not accurately capture the extremely high costs for these drugs, because the model relies on historic information.

These drugs have special requirements around handling, monitoring, patient education, and compliance such that they are delivered in a hospital, rather than a pharmacy or clinic. The drugs impacted by this change cost more than $75,000 for one dose therapy, or $32,000 per dose for multi-dose therapies, or $22,000 per dose for therapies costing more than $125,000 per year.

The Department would decrease rates from 100 percent to 92 percent of cost. This partially unwinds an increase from 90 percent to 97-100 percent of costs that occurred in January 2024. This change only affects reimbursements to hospitals and has no impact on pharmacies.

The proposed decrease primarily impacts Children's Hospital. There are small impacts on University Hospital and HCA Presbyterian St. Luke's. No other hospitals are impacted.

Recommendation

Staff recommends a slightly larger reduction than the Department requested. In the hearing responses, the Department noted that the average Medicaid reimbursement to hospitals, including the net benefit from the supplemental payments financed with the hospital provider fee, is 80 percent of cost. For this line of service that almost exclusively benefits one hospital, the current reimbursement is 97-100 percent of cost. The Department proposes reducing it to 92 percent of cost with no explanation of why 92 percent is the right share. The staff recommendation is to reduce the reimbursement to 80 percent of costs in line with the average reimbursement for hospital services.

The Department's hearing response indicates that from August 2018 to February 2022 the reimbursement was 72 percent of costs with no difference in access to care.

The change in total dollars is small compared to the budget for Children's Hospital and the incremental difference between the staff recommendation and the Department's request is even smaller.

The staff recommendation is intended to be more equitable in the treatment of all hospitals and to achieve slightly more savings toward balancing.

The table below summarizes the staff recommendation.

S6.27 Specialty drug rates

Item	FY 25-26	FY 26-27	FY 27-28
FY 2024-25 expenditure @ 97-100% of costs	$13,365,695	$13,365,695	$13,365,695
Estimated expenditure at 80% of costs	11,172,841	11,172,841	11,172,841
Difference	-2,192,854	-2,192,854	-2,192,854
Implementation adjustment	16.7%	100.0%	100.0%
Savings	-$365,476	-$2,192,854	-$2,192,854
General Fund	-136,760	-820,552	-820,552
Hospital Provider Fee	-17,540	-105,242	-105,242
Federal Funds	-211,176	-1,267,060	-1,267,060

→ S6.28 Drug dispensing fees

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$281,817	-$84,918	-$18,616	$0	-$178,283	0.0
Recommendation	-281,817	-84,918	-18,616	0	-178,283	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department seeks to reduce drug dispensing fees for the highest volume pharmacies.

The Department proposes reducing the dispensing fees April 1, 2026. Reducing the dispensing fees decreases the forecast by:

- Current year: $281,817 total funds, including $84,918 General Fund
- Year 1: $1.7 million total funds, including $509,509 General Fund

The Department pays pharmacies for the ingredients (the drugs) plus a dispensing fee for each prescription filled. The dispensing fees are tiered based on volume. The highest volume providers with the most economies of scale get paid the lowest dispensing fees.

For the highest volume tier, the Department proposes reducing the dispensing fee from $9.31 to $8.72, or a 6.3 percent reduction. For the second highest volume tier, the Department proposes reducing the dispensing fee from $10.25 to $9.93, or a 3.1 percent reduction. These reductions primarily impact large chain pharmacies, but some independent pharmacies with large volumes will see reductions. There is no impact on Federally Qualified Health Centers or independent rural pharmacies.

The proposed reductions are based on the Department's most recent cost of dispensing survey.

Recommendation

Staff recommends approval of the request. The percentage reductions are larger than the generalized provider rate reductions the Department is proposing, but they are supported by the Department's survey of dispensing costs. The impacts are primarily on large chain pharmacies with multiple lines of service and multiple payers. Relative to the scope of total business for these providers, these changes are small and unlikely to impact either the viability of the provider or access to care for Medicaid clients.

→ S7e XL wheelchair transport

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$32,916,295	-$9,899,892	-$6,558,355	$0	-$16,458,048	0.0
Recommendation	-32,916,295	-$9,899,892	-$6,558,355	$0	-$16,458,048	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding incorrect guidance to providers on billing codes.

Request

The Department asks to decrease rates in nine metro counties for providing transportation to people in extra-large wheelchairs.

The request decreases the Department's forecasted expenditures by:

- Current year: $32.9 million total funds, including $9.9 million General Fund
- Year 1: $60.5 million total funds, including $18.2 million General Fund

Transporting people in extra-large wheelchairs sometimes requires additional attendants and equipment to ensure safety. Therefore, the pickup rates are higher than for other non-emergency medical transportation (NEMT). In 2020, the Department was concerned that providers were confused about the correct billing codes to use for this type of transportation. To clarify the codes, the Department provided guidance to the service broker for the nine metro counties. However, that guidance made matters worse by incorrectly directing providers to use a code intended for specialty ambulance services. The specialty ambulance service code pays a pickup rate of $668.93. The correct code for transporting people in extra-large wheelchairs pays a pickup rate of $65. In November 2025 the Department corrected the billing guidance to NEMT providers.

Recommendation

Staff recommends approval of the request. Outside of the nine metro counties, providers mostly used the correct billing code and received a pickup rate of $65. Providers in the nine metro counties received a pickup rate of $668.93 for the same service. The difference in reimbursement clearly does not relate to any difference in service level, client acuity, or regional variation in provider costs. The providers in the nine metro counties did nothing wrong, because they correctly followed the Department's guidance (unless you want to argue that they had an ethical obligation to inform the Department that the rate was excessive). The variation in payment occurred due to a mistake in the Department's guidance that the Department corrected in November. The Department observed no issues with recruiting and retaining providers at the $65 pickup rate outside the nine

metro counties. Therefore, the Department expects a $65 pickup fee will not reduce access to care for clients in the nine metro counties.

The JBC staff asked how the Department didn't catch the error for 5 years, including a review by the Medicaid Provider Rate Review Advisory Committee in 2024. The Department responded:

> In the midst of the chaos caused by the fraud event in the fall of 2023, and HCPF's implementation of the numerous changes to the program in response, reviews of program details such as this did not happen until 2025. This aspect of the program had not been specified in published policy and so the issue was not immediately apparent.

The JBC staff asked if we need a change in procedures or an audit of NEMT rates. The Department responded:

> HCPF has already embarked on such an analysis with our contractor DeLoitte. DeLoitte has provided further recommendations to the Department on areas of cost savings for the NEMT program and rates, which include the base rate reduction that can be referenced in Appendix F - NEMT Rate Decreases.

S7e XL Wheelchair transport

Item	FY 2025-26	FY 2026-27
Old rate (billing code A0434)	$668.93	$668.93
New rate (billing code A0130+U9)	$65.00	$65.00
Difference	-$603.93	-$603.93
Projected annual metro county trips	93,434	100,143
November 2025 implementation [1]	58.33%	100.00%
Estimated savings	-$32,916,295	-$60,479,462
General Fund	-9,899,892	-18,189,779
Hospital Provider Fee	-6,558,156	-12,049,769
Breast and Cervical Cancer Prevention and Treatment Fund	-199	-366
Federal Funds	-16,458,048	-30,239,548

[1] Includes an adjustment for the delay between when services are delivered and paid.

→ Provider Stabilization gifts

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$0	$0	$0	$0	$0	0.0
Recommendation	20,000,000	0	20,000,000	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$20,000,000	$0	$20,000,000	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: This JBC staff recommendation is the result of data that was not available when the original appropriation was made regarding gifts to the provider stabilization fund.

Request

This is a staff-initiated supplemental. There is no request from the Department.

Recommendation

Staff recommends providing the Department with an additional $20.0 million spending authority from the Provider Stabilization Fund in FY 2025-26 and then again in FY 2026-27.

The Department has received gifts, grants, and donations for the Provider Stabilization Fund that it cannot spend without additional appropriations. The money in the fund is subject to annual appropriation. The defined revenue sources to the fund include money credited as a loan from the Unclaimed Property Trust Fund, money appropriated by the General Assembly, and gifts, grants, or donations. The current appropriation only provides spending authority for the loan from the Unclaimed Property Trust Fund. To date, the Department has received $14 million through the Rose Community Foundation. The Colorado Hospital Association says it has another $8 million more in outstanding commitments that it is working to collect and it is committed to raising $40 million in total.

The staff recommendation would allow the Department to spend $20 million in FY 2025-26 and $20 million in FY 2026-27 from the actual and expected gifts, grants, and donations.

The money in the Provider Stabilization Fund gets distributed to safety net providers that are a Comprehensive Community Behavioral Health Providers, Rural Health Clinic, Federally Qualified Health Center, or primary care providers serving at least 50 percent clients who are low income, enrolled in Medicare, or uninsured.

The Colorado Hospital Association says the contributors so far include:

- Aspen Valley Health
- Banner Health Foundation
- Children’s Hospital Colorado
- Colorado Hospital Association
- CommonSpirit Health
- Craig Hospital
- HCA HealthONE
- Intermountain Health
- Kaiser Permanente
- Lutheran Hospital Association of the San Luis Valley
- Melissa Memorial Hospital
- National Jewish Health
- UCHealth

Administration

Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
S6.06 SBIRT training grants	-500,000	-500,000	0	0	0	0.0	EP
S6.07 Immigrant services outreach	0	0	0	0	0	0.0	EK
S6.22 Provider credentialing ACC	0	0	0	0	0	0.0	EK
S7a Prepayment claims review	-4,467,500	-2,233,750	0	0	-2,233,750	0.0	EK
S7b Claims rules enforcement	-3,062,499	-957,601	-159,798	0	-1,945,100	0.0	EK
S7c Recovery audits	0	0	0	0	0	0.0	EK
S7o Member surveys	-264,567	-138,534	0	0	-126,033	0.0	EK
S8 Federal HR 1 compliance	5,366,498	0	513,069	0	4,853,429	4.0	EK
S9 Federal rule compliance	0	0	0	0	0	0.0	EK
S12 Eligibility administration	0	0	0	0	0	0.0	TD
S13 Disability determinations	1,275,000	802,544	-165,044	0	637,500	0.0	TD
S14 Home health admin	19,975	9,988	0	0	9,987	0.3	EK
S16 Technical adjustments	$16,571,751	$0	$34,002	$16,583,747	-$45,998	0.0	EK
Total	$14,938,658	-$3,017,353	$222,229	$16,583,747	$1,150,035	4.3	

→ S6.07 Immigrant services outreach [legislation]

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$375,000	$131,250	$0	$0	$243,750	0.0
Recommendation	375,000	131,250	0	0	243,750	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**

An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.

Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions and the uptake of the new benefits.

Request

The Department wants to stop three grants to nonprofits that pay for outreach related to health services for undocumented children and pregnant people.

The Department proposes ending the outreach contracts effective January 1, 2026, saving:

- Current year: $375,000 total funds, including 131,250 General Fund
- Year 1: $750,000 total funds, including $262,500 General Fund

The Department argues the outreach is not necessary. The providers and community are aware of the program and there is significant demand for the services, as evidenced by enrollment continuing to exceed expectations.

Recommendation

Staff recommends legislation to accomplish the requested change in funding. The Department's assertion that outreach is unnecessary appears reasonable based on the utilization of the program. The table below compares the expenditures for children to the original fiscal note. Actual expenditures in FY 2025-26 are running higher than the November forecast and the Department expects an upward revision in the February forecast.

Cover All Coloradans Children

Item	FY 2024-25	FY 2025-26
HB 22-1289 Fiscal Note	$2,102,665	$4,360,863
Updated appropriation	$16,037,803	$32,075,606
Actual/November forecast	$17,780,840	$53,360,259

It is possible this robust utilization is because of successful outreach efforts and it would be lower without the funding for outreach. However, the staff recommendation assumes the program has reached a critical mass of providers and clients and that utilization will continue to grow with or without the dedicated funding for outreach.

If the JBC wants to keep the outreach, the JBC staff is concerned that the fund sources assumed in the appropriation are not correct. The fund sources assume a 65 percent federal match for the pregnant adults. The majority of the utilization and outreach is targeted at the child population that does not receive a federal match. It seems likely that the federal matching funds may ultimately get denied and this will be a majority General Fund cost.

Staff believes that the best method to reduce outreach funding would remove a statutory provision requiring the Department to develop and implement an outreach strategy. House Bill 22-1289 created a new duty for the Department[2] to develop and implement an outreach strategy for Cover All Coloradans that includes:

- funding for community-based organizations to partner with the Department on outreach
- information on eligibility and enrollment to nonprofit partners, school districts, and charter schools
- information in multiple languages

The Department argues that it fulfilled this duty. The outreach strategy has evolved based on actual experience and no longer requires funding. Based on this argument, the Department does not believe legislation is necessary. However, the statute still says the Department is supposed to implement an outreach strategy that includes funding for community-based organizations.

The recommended bill does not necessarily need to run with the supplemental package. The Department has already suspended the outreach grants using the authority of the executive orders. Nor does the bill need to stand alone. At figure setting, the JBC will consider other requested changes to the Cover All Coloradans program.

Even if the JBC decides not to adopt the proposed changes to the benefits under Cover All Coloradans, recent federal guidance may require some statutory changes. The Department reports that the federal government

[2] See Section 25.5-8-107 (1)(i), C.R.S.

instructed the Department to remove the populations eligible through Cover All Coloradans from the Medicaid contracts with the Regional Accountable Entities (RAEs). The Department could, potentially, make separate state-only contracts with the RAEs, and those separate contracts could cover the same benefits. However, even if the Department keeps the same benefits, it may require a change in legislation to conform with the new federal guidance.

Finally, the Department is required to report on the outreach strategy, but the statute does not specify who receives the report. The Department pointed to a slide show presented at a stakeholder meeting that the Department says satisfies the reporting requirement. The JBC staff does not see how this "report" informs legislative policy. Either the statutory reporting requirement should get eliminated or the General Assembly should do a better job of describing expectations for the report.

→ S6.22 Provider credentialling ACC

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$650,000	-$40,950	-$33,800	$0	-$575,250	0.0
Recommendation	0	0	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$650,000	$40,950	$33,800	$0	$575,250	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department no longer plans to implement a centralized, statewide program for credentialing behavioral health providers for participation with all Regional Accountable Entities (RAEs).

Current year: The one-time savings from avoided system costs is $650,000 total funds, including $40,950 General Fund.

The change was intended to reduce the administrative burden on providers by allowing them to complete credentialing once for participation with all RAEs, rather than separate credentialing with different forms and potentially different rules for each RAE. The Department says this is a lower priority with the same businesses winning the bids for multiple RAEs.

Recommendation

Staff recommends denying the request. Centralized credentialing would remove an administrative burden for providers now and forevermore. The General Fund savings is only $40,950, due to the favorable federal match for information technology projects. The General Assembly heard from providers that different credentialling

procedures at different RAEs was problematic and a barrier to working with Medicaid clients. The small General Fund investment required to fix this administrative headache seems worth it.

Because the Department stopped the work based on the executive orders, there is a chance the Department might not be able to encumber the money in FY 2025-26 and would need to do the work in FY 2026-27. The JBC staff was not able to solicit feedback from the Department on this point prior to the supplemental recommendation.

In the request the Department did not mention competing demands from system changes needed to comply with H.R. 1. The JBC staff assumes the Department would have mentioned competing demands if they were a factor in the request.

→ S7a Claims reviews

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$4,467,500	-$2,233,750	$0	$0	-$2,233,750	0.0
Recommendation	-4,467,500	-2,233,750	0	0	-2,233,750	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions and the potential improper payments.

Request

The Department wants to expand claims reviews to avoid paying improper bills.

The Department projects net reductions in expenditures of:

- Current year: $4.5 million total funds, including $2.2 million General Fund
- Year 1: $29.2 million total funds, including $14.6 million General Fund
- Year 2: $14.0 million total funds, including $14.6 million General Fund

Scope of work

These reviews involve people evaluating claims. The Department does automated edits of claims to ensure they meet predefined criteria (see S7b Claims rules enforcement), but there are things the automated edits cannot currently evaluate. As an example, the Department has an automated edit that checks claims for non-emergency medical transportation to ensure a ride log was submitted, but at this time the automated edits cannot check that the submitted ride log contains the nine elements the Department requires. The Department

is constantly exploring new ways to automate procedures, but the Department can only implement so many system changes at a time.

The focus is on prepayment reviews, but the Departments says some of the money may get used for post-payment reviews.

The Department proposes an ongoing pool of money for the claims reviews. The savings estimates are based on targeting prepayment claims reviews for pediatric behavioral therapy, home- and community-based services, and durable medical equipment. The Department says these services involve complex billing requirements, rapidly growing utilization, and a demonstrated vulnerability to improper payments. The Department anticipates at least three years of work on these services. As provider behaviors change and the Department automates more claims edits, the money would get moved around to address different hot spots in the future.

Costs

Based on vendor estimates, the Department projects the claims reviews will cost $7.0 million total funds per year. The cost in FY 2025-26 is $1.6 million total funds based on the assumption that the contractor would review claims for two months. The federal match for administration is 50 percent. The cost estimate includes a fee per review and policy consulting services. There are no contingency fees.

Savings

The Department projects savings from avoided payments of $6.0 million total funds in FY 2025-26, $36.2 million total funds in FY 2026-27, and $14.0 million total funds in FY 2027-28 and thereafter. The services the Department wants to target receive a 50 percent federal match, so 50 percent of the savings is to the General Fund.

Most of the projected savings are related to pediatric behavioral therapy services. The Department identified five providers with outlier claims volume. These providers billed $110 million last year. The savings estimate assumes 25 percent of the billing was improper. In addition, a federal audit of payments for pediatric behavioral therapy informs the request. The federal audit is described in more detail below.

The Department used a similar methodology to estimate the much smaller projected savings from home- and community-based services and durable medical equipment. For these services the Department identified three outlier vendors and one outlier vendor respectively and assumed 20 percent of the claims were improper. The Department plans to look at all payments for these services, but the savings estimates are based only on the outlier providers.

Based on experience with other claims reviews, the Department assumes that the savings will spike in the first year. As providers learn, correct their billing errors, and resubmit proper claims, the Department expects that the ongoing savings will stabilize at a lower rate. From the outlier claims, the Department projects ongoing savings of 15 percent for pediatric behavioral therapy and 10 percent for home- and community-based services and durable medical equipment.

Federal audit of pediatric behavioral therapy

The Department is waiting for the final report from a federal audit of payments for pediatric behavioral therapy by the Office of the Inspector General. The audit found potentially improper payments related to missing

documentation, inadequate credentialing and oversight, and billing practices that do not meet requirements. The draft finding is that Colorado owes in the range of $60 million to the federal government for improper payments. Similar audits in other states are getting similar results for these services. Indiana is conducting post-payment claims reviews for pediatric behavioral therapy services and finding error rates of 90-95 percent.

The Department is challenging the federal audit findings. If the requested funding for claims reviews is approved, it will give the Department very strong data to push back on the federal findings and may reduce the repayment due.

Prior funding and savings

Beginning in FY 2023-24, the General Assembly gave the Department term-limited funding for claims reviews of non-emergency medical transportation (NEMT). Most of the work was done in prior years, but the FY 2025-26 budget includes the last $644,650 total funds for this purpose. There were no projected savings specifically tied to the funding, but the Department's forecast assumed lower NEMT expenditures as a result of multiple measures to contain fraud, including federal investigations and prosecutions.

As a budget saving measure in FY 2025-26, the General Assembly provided 2.0 FTE and $3.5 million contract funds to expand prepayment claims reviews to other high-risk services and projected savings of $19.6 million total funds, including $7.2 million General Fund.

An associated request for information asked the Department to report on how the funding for prepayment claims reviews was used, including the services prioritized for prepayment claims reviews and why, and the savings achieved. The Department's report on prepayment claims reviews said the new money is getting spent to review pediatric behavioral therapy and vision services and mentioned durable medical equipment, labs, and home health services. The report identified actual savings of $8.5 million from NEMT and vision services and estimated additional savings of "at least" $14 million from pediatric and behavioral therapy services and $1.2 million from vision. This begs a couple questions.

First, is the Department on track to achieve the projected savings of $19.6 million total funds, including $7.2 million General Fund. It is important to note that the projected $19.6 million in savings was above and beyond any savings from NEMT, because the Department's forecast already assumed a lower growth trend for NEMT due to the prepayment reviews and other anti-fraud measures. The RFI mentions only $15.2 million in savings beyond NEMT. The Department says that the potential savings from pediatric behavioral therapy services are far larger than originally expected, based on the draft federal audit findings. The Department believes it is on track to meet or exceed the targeted $19.6 million in savings. Work on the prepayment reviews of pediatric behavioral therapy has been delayed due to a legal agreement with providers who challenged the Department's actions, but that work is scheduled to begin in February.

Second, is the Department double counting the savings? The RFI indicates that most of the $19.6 million in projected savings from last year's appropriation will come from pediatric behavioral therapy. In this supplemental, the Department is projecting more savings from pediatric behavioral therapy. Specifically, the Department projects savings related to pediatric behavioral therapy of another $4.6 million in FY 2025-26, $27.5 million in FY 2026-27, and $16.5 million in FY 2027-28 and on-going. Again, the Department points to the federal audit and says the volume of work and the potential improper payments far exceeds the Department's initial assumptions.

Recommendation

With reservation, staff recommends approval of the request.

The General Assembly needs savings to balance the budget and reduce the cost trend for Medicaid. This request promises savings without reducing eligibility or benefits. The request may decrease access to care due to the pressure that reduced compensation puts on providers, but that potential impact is indirect and likely in the future. The request decreases compensation to providers, but that decrease is for improper payments that do not comply with the Department's existing billing rules. The Department just doesn't have the resources to enforce those billing rules without the request.

The reservation is because the JBC staff cannot verify the Department's expected savings. The Department says the expected error rate is based on, "analytics conducted across all provider types identifying high risk activity based on a multitude of features/indicators." This vague description doesn't provide enough information for the JBC staff to assess the validity of the Department's assumed savings. The draft federal audit findings on pediatric behavioral therapy services suggest to the JBC staff that the Department might be able to achieve the projected savings, but the recommendation to approve the request is putting a lot of faith in the Department's "analytics" without insight into the methodology or data.

The claims reviews will stop improper payments, but not all improper payments are illegitimate. Some of the payments stopped will be legitimate claims where the provider made a technical error or omission. Correcting these errors and omissions increases the administrative burden on the provider and the time from when services are rendered to when they get paid. When implementing claims controls, the juice needs to be worth the squeeze. The JBC staff is persuaded by the Department's arguments that these controls are worthwhile, but this is not a pain-free reduction. Providers will need to do more work to get paid for legitimate claims.

S7a Prepayment claims reviews

Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
Claims reviews	$1,500,000	$750,000	$0	$750,000
Policy consulting	62,500	31,250	0	31,250
Avoided payments	-6,030,000	-3,015,000	0	-3,015,000
Total	-$4,467,500	-$2,233,750	$0	-$2,233,750
FY 2026-27				
Claims reviews	$6,750,000	$3,375,000	$0	$3,375,000
Policy consulting	250,000	125,000	0	125,000
Avoided payments	-36,180,000	-18,090,000	0	-18,090,000
Total	-$29,180,000	-$14,590,000	$0	-$14,590,000
FY 2027-28				
Claims reviews	$6,750,000	$3,375,000	$0	$3,375,000
Policy consulting	250,000	125,000	0	125,000
Avoided payments	-20,990,000	-10,495,000	0	-10,495,000
Total	-$13,990,000	-$6,995,000	$0	-$6,995,000

→ S7b Claims rules enforcement

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$3,062,499	-$957,601	-$159,798	$0	-$1,945,100	0.0
Recommendation	-3,062,499	-$957,601	-$159,798	$0	-$1,945,100	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: The JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the need for budget reductions in the current fiscal year and the opportunity to reduce improper payments.

Request

The Department proposes new claims processing rules to deny improper claims.

The request assumes the new claims processing rules will edit claims by April 1, 2026, and reduce the Department's forecast by:

- Current year: $3.1 million total fund funds, including $957,601 General Fund
- Year 1: $12.3 million total funds, including $3.9 million General Fund
- Year 2: $6.5 million total funds, including $1.9 million General Fund

The Department says the new rules are based on industry billing standards used by the federal Centers for Medicare and Medicaid Services (CMS) and by commercial payers. The Department characterizes the rules as enforcing the Department's established coverage, coding, and documentation standards, rather than imposing new standards. The new rules will impact:

- Ambulance valid services – ensure accurate billing for valid services as defined by CMS
- Ambulance frequency limits – apply frequency controls to identify patterns of potentially inappropriate repetitive transports and prevent payments for services that exceed allowed limits
- Ambulance bundled services – prevent unbundling of services that are considered inclusive under standard billing rules, aligning with CMS and commercial payer practices
- Incomplete diagnoses – identify claims with incomplete diagnosis codes
- Labs – identify claims where the laboratory procedure code is not payable for the associated diagnoses
- Drug screening – apply nationally accepted frequency and medical-necessity standards to drug screening services to prevent excessive or duplicative testing
- Durable medical equipment – prevent early or duplicate replacement of durable medical equipment without medical necessity, while preserving legitimate replacements due to loss, damage, or medical change

The specific proposed claims rules and the projected savings are based on annual optimization studies by the Department's vendors and analysis of current claims that don't meet the criteria. Similar to the request for *S7a*

Claims reviews, the Department assumes that the savings will spike in the first year. As providers learn, correct their billing errors, and resubmit proper claims, the Department expects that the ongoing savings will stabilize at a lower rate.

Recommendation

Staff recommends approval of the request. The rules will not determine whether a service is a covered benefit. They will evaluate whether the claims for that service comply with existing coverage rules, documentation requirements, and nationally recognized payment standards. According to the Department, these are the same billing standards used by CMS and private insurers. These are not new or unusual billing requirements for providers that are unique to billing for Colorado Medicaid.

Unlike with *S7a Claims reviews*, the estimated savings through FY 2026-27 are highly defensible. The contractors conducted analysis on actual claims for two months and identified how many claims do not meet the rule criteria and then made an estimate for the year. What is more speculative is the ongoing savings in FY 2027-28 and beyond. The Department doesn't know how many of the improper claims were for legitimate services but contained a curable error. The Department is projecting the ongoing savings, but the projection is informed by the vendors' experiences when these rules have been applied by other state Medicaid programs and private insurance.

Part of the new claims processing rules address drug screening and the Department also submitted *S6.08 Tests for specific drugs* related to prior authorization requirements for definitive drug tests. The Department did not break out the portion of the savings for this request related to drug screening or describe the rules in detail, but the Department did say that the savings estimate is not a duplicate of the savings from the prior authorization requirements.

S7b Claims rules enforcement

Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
System costs	$187,501	$14,213	$7,819	$165,469
Avoided payments	-3,250,000	-971,814	-167,617	-2,110,569
Total	-$3,062,499	-$957,601	-$159,798	-$1,945,100
FY 2026-27				
System costs	$750,000	$56,850	$31,275	$661,875
Avoided payments	-13,000,000	-3,887,260	-670,475	-8,442,265
Total	-$12,250,000	-$3,830,410	-$639,200	-$7,780,390
FY 2027-28				
System costs	$750,000	$56,850	$31,275	$661,875
Avoided payments	-6,500,000	-1,943,629	-335,237	-4,221,134
Total	-$5,750,000	-$1,886,779	-$303,962	-$3,559,259

→ S7c Recovery audits

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$0	-$7,322,432	$15,734,919	$0	-$8,412,487	0.0
Recommendation	0	0	0	0	0	0.0
Staff Recommendation Higher/-Lower than Request	$0	$7,322,432	-$15,734,919	$0	$8,412,487	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the expected recoveries. However, the JBC staff has concerns that the request departs from historic standard procedures for how to account for this type of new information through the budget process.

Request

The Department requests a decrease in General Fund and federal funds for an expected increase in cash funds from the Recovery Audit Contractor (RAC) Recoveries Cash Fund. The additional projected recoveries are from non-emergency medical transportation, pediatric behavioral therapy, and emergency medical transportation.

The request changes the Department's forecast by:

- Current year: decreases of $7.3 million General Fund and $8.4 million federal funds and an increase of $15.7 million cash funds
- Year 1: decreases of $6.7 million General Fund and $7.6 million federal funds and an increase of $14.2 million cash funds
- Year 3: decreases of $5.9 million General Fund and $6.8 million federal funds and an increase of $12.7 million cash funds

The projection of additional recoveries is based on the Department's analysis of potentially improper payments, adjusted for the statutory limit on the percentage of claims from a provider that can be audited in a year. The projected savings decrease over time because each time the Department makes a recovery it reduces the pool of potentially improper payments identified by the Department.

Recommendation

Staff recommends denying the request and instead including the projected savings in the forecast adjustment in the Long Bill. There is no discretionary decision for the General Assembly to make. When the Department sees areas that need auditing, it just conducts the audits. The Department has both state and federal obligations to ensure proper payments. There is no General Fund cost that the General Assembly needs to approve when the Department uses RAC services, because the contractor is paid a contingency fee from a share of the recoveries. Historically, the Department has not asked for a budget action to authorize audits. If the JBC includes the

recoveries as a distinct incremental adjustment in the supplemental bill, it may set a precedent or imply to legislators, providers, or advocates that the General Assembly approves individual audits. That politicizes the audits unnecessarily and opens the door to a new way for providers to skirt payment rules.

The Department's forecast typically includes a projection of the expected recoveries from RAC services and from other strategies to ensure proper payments. For example, the FY 2025-26 appropriation is based on the Department's February 2025 forecast of $76.1 million in recoveries and recoupments, including $20.9 million specifically attributable to RAC services and $55.2 million attributable to other methods.

The JBC staff is not sure why the Department departed from historic practice and submitted a supplemental request for these recoveries and the associated savings, rather than just including them in the forecast. If the information wasn't ready before the November forecast, the Department could have included the information in the upcoming February forecast. The Governor set a savings goal for the Department. Maybe the Department wanted to include the savings from these audits toward that goal. However, the Department already has the authority and obligation to do these audits. Satisfying a presentation objective to show the Department or Governor achieving their savings goals is not a compelling reason to change the historic practice for how these types of recoveries have been handled in the budget process.

Statutes limit the Department's RAC program, including provisions in S.B. 25-134 that was sponsored by the JBC. For example, there are limits on the number of audits, the frequency of audits, and the percentage of claims for a provider that the Department can audit in a year. If the General Assembly wants more control over the audits, it should be done through legislation rather than through the budget process.

Both the state and federal government conduct audits of Medicaid payments. If the Department does not do the audits, then there is a chance federal auditing will find improper payments, and then the Department is responsible for repaying the federal government with no means to collect from the providers.

To the JBC staff, the projected savings appear reasonable and defensible. The recommendation is to account for the savings as part of the forecast adjustment in the Long Bill, rather than as a policy adjustment in the supplemental.

→ S7o Member surveys

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	-$264,567	-$138,534	$0	$0	-$126,033	0.0
Recommendation	-264,567	-138,534	0	0	-126,033	0.0
Staff Recommendation Higher/-Lower than Request	$0	$0	$0	$0	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the actual contract costs in FY 2025-26 and the availability of federal grant funds to offset General Fund in FY 2026-27.

Request

The Department requests a reduction in funding for required surveys of members receiving home- and community-based services. For FY 2025-26, the Department's contract obligations are less than the appropriation. For FY 2026-27, the Department plans to use federal funds from the Money Follows the Person grant to cover part of the costs. Beginning in FY 2026-27, the Department proposes using state FTE to replace some of the contract funds to reduce the cost of the surveys. The request doesn't show the FTE in the budget until FY 2027-28, because the FTE would be federally funded in FY 2026-27.

The request reduces the Department's expected expenditures by:

- Current year: $264,567 total funds, including $138,534 General Fund
- Year 1: $689,861 total funds, including $351,181 General Fund
- Year 2: $285,055 total funds, including $148,779 General Fund, but an increase of 2.0 FTE
- Year 3: $188,805 total funds, including $100,654 General Fund, but an increase of 2.0 FTE

The surveys ask members about satisfaction with the services, experiences within the program, and additional services they may need. Multiple federal rules require the surveys to ensure quality services.

The Money Follows the Person demonstration grant provides time-limited federal funds to help move people from nursing homes to community settings. There are no matching state funds and the federal funds do not appear in the Long Bill. The Department expects federal approval to use a portion of the grant funds for the survey costs in FY 2026-27.

The original appropriations assumed all of the work would be done by contractors. The Department wants to bring the management, compliance, and reporting work in house. Costs for required memberships and field interviewers would remain with the contractor. The number of field interviewers needed varies annually based on what surveys are due in that year, so using contract services is beneficial. The Department projects that state FTE for the management, compliance, and reporting work will cost less than contract services. Also, the Department argues that using state FTE will help develop long-term internal expertise in quality measurement, more consistent methodological oversight, and more sustainable data infrastructure.

Recommendation

Staff recommends the request through FY 2027-28, but not the requested annualization in FY 2028-29. The reduction in FY 2025-26 is because the appropriation overestimated the actual cost. The reduction in FY 2026-27 is due to a combination of the federal Money Follows the Person grant paying for a portion of the survey costs and the Department using state FTE instead of contract services. Most of the savings in FY 2026-27 are one-time

and the Department will need General Fund in FY 2027-28, but the Department expects modest on-going savings in FY 2027-28 from the conversion of contract services to state FTE.

For FY 2028-29, the Department argues that it needs an increase in funds because of a projected increase in field interviewers based on the specific surveys due that year. That part of the request is not directly related to the supplemental. It is far in the future and the JBC staff did not attempt to analyze the merits of that part of the request. Instead, the JBC staff recommends that the Department submit a standard request through the budget process for FY 2027-28, if the Department believes it cannot absorb the small incremental and intermittent cost of a few more field interviewers in some years versus others.

Current Contract Services

Item	Total Funds	General Fund	Federal Funds
Current Appropriation			
FY 14-15 R16 New operational and membership funds for developmental disabilities	$69,102	$34,551	$34,551
FY 17-18 R13 Quality of care and performance improvement projects	345,759	179,130	166,629
FY 22-23 Office of Community Living enhancements	540,000	270,000	270,000
Total	$954,861	$483,681	$471,180

Projected Costs

Item	FY 25-26	FY 26-27	FY 27-28
Current contract services	$954,861	$954,861	$954,861
Projected costs			
Contract services	$690,294	$633,675	$432,550
2.0 FTE	0	237,256	237,256
Costs covered by Money Follows the Person grant	0	-605,931	0
Subtotal - Projected costs	$690,294	$265,000	$669,806
Difference	-$264,567	-$689,861	-$285,055
General Fund	-138,534	-351,181	-148,778
Federal Funds	-126,033	-338,680	-136,277

→ S8 Federal HR 1 compliance

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$400	$100	$100	$100	$100	1.0
Recommendation	800	200	200	200	200	2.0
Staff Recommendation Higher/-Lower than Request	$400	$100	$100	$100	$100	1.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding the changes needed to implement H.R. 1.

Request

The Department requests funding for system changes, member support, and fraud prevention related to complying with H.R. 1.

The request increases the Department's expected expenditures by:

- Current year: $5.4 million total funds, including $333,708 General Fund
- Year1: $45.8 million total funds, including $5.6 million General Fund
- Year 2: $48.1 million total funds, including $7.5 million General Fund
- Year 3: $28.5 million total funds, including $5.6 million General Fund

The majority of costs are driven by community engagement requirements and six-month eligibility redeterminations. Beginning in 2027, H.R. 1 requires expansion adults eligible through the Affordable Care Act (ACA) to:

- engage in work, education and training, or community service for 80 hours each month
- renew their eligibility every six-months

The Department needs resources for system changes and to help members navigate the new requirements. The request includes funding for outreach, call center resources, and grievances and appeals.

County administration costs will increase to determine member compliance with the work requirements and redetermine eligibility more frequently.

In addition, H.R. 1 includes new requirements aimed at preventing fraud.

Recommendation

Staff recommends approval of the request with modification to the fund sources. H.R. 1 requires major changes to the Department's eligibility procedures. There is significant risk that members who could qualify for Medicaid will not due to administrative hurdles. County workloads will increase to adapt to the new procedures. The Department's request looks like a reasonable initial estimate of the resources needed. However, there is significant uncertainty about how some of the provisions of H.R. 1 will work, including the procedures for verifying community engagement, and the federal guidance is evolving. The JBC staff expects multiple iterations on the funding plan over the next few years.

The Department's request allocated the expenditures by fund source in proportion to the Department's total enrollment. However, almost all of the workload identified by the Department is driven by the community engagement requirement and six-month eligibility renewals. These provisions relate specifically to the expansion populations financed from the hospital provider fee. For simplicity, the JBC staff recommendation

switches all of the costs attributed to the General Fund to the hospital provider fee. The JBC staff is open to revising this cost allocation over time as the Department identifies small components of the changes that impact the whole population versus just the expansion populations.

The JBC's common policy for new FTE does not normally provide for benefits in the first year. However, the Department's request for 15.0 FTE is significant enough that the JBC staff decided to recommend the benefits.

The tables below summarize the staff recommendation for the first two years.

S8 Federal HR compliance FY 2025-26

Item	Total Funds	Hospital Provider Fee	Federal Funds	FTE
Compliance Administration				
Compliance Program Manager	$0	$0	$0	0.0
Stakeholder Engagement Contractor	130,800	64,223	66,577	0.0
Work Requirements & Eligibility Redeterminations				
System Changes Contractors - MMIS	3,810,600	438,219	3,372,381	0.0
MMIS Rollforward Funding	-438,219	-438,219	0	0.0
System Changes Contractors - CBMS	837,600	93,058	744,542	0.0
CBMS Rollforward Funding	-93,058	-93,058	0	0.0
System Changes Staff	203,369	23,388	179,981	1.5
Community Engagement				
Operations, Compliance, & Escalations Staff	68,101	33,438	34,663	1.0
Operations, Compliance, & Escalations Contractors	96,169	47,219	48,950	0.0
Customer Call Center Increased Staffing	0	0	0	0.0
Customer Call Center Operations Staff	0	0	0	0.0
Customer Call Center Technology Contracts	0	0	0	0.0
Eligibility Auditing & Review Staff	102,153	26,151	76,002	1.5
County Administration	0	0	0	0.0
CBMS Interface Maintenance	500,000	245,500	254,500	0.0
Communications Staff	0	0	0	0.0
Social Media & Texting Campaign Contractor	96,831	47,544	49,287	0.0
Customer Outreach Process	0	0	0	0.0
Outreach Campaign	0	0	0	0.0
Informational Inserts	0	0	0	0.0
Additional Mailing	0	0	0	0.0
Texting Campaign	0	0	0	0.0
Appeals Staff	0	0	0	0.0
Appeals Contractor	0	0	0	0.0
Appeals Printing Supplies	0	0	0	0.0
Appeals Increased Licenses	0	0	0	0.0
OCL Grievances & Appeals	52,152	25,606	26,546	0.0
Disability Assessment Increases	0	0	0	0.0
Equifax Costs	0	0	0	0.0
Fraud, Waste, and Abuse Provisions				
Post-Payment Review and Complex Audits Staff	0	0	0	0.0
Fraud Referrals Contractor	0	0	0	0.0
Accounting Specialist Contractor	0	0	0	0.0
Targeted Case Management Review Contractor	0	0	0	0.0
Marketplace TPL Contractor	0	0	0	0.0
Total Request	$5,366,498	$513,069	$4,853,429	4.0

S8 Federal HR compliance FY 2026-27

Item	Total Funds	Hospital Provider Fee	Federal Funds	FTE
Compliance Administration				
Compliance Program Manager	138,410	67,959	70,451	1.0
Stakeholder Engagement Contractor	261,600	128,446	133,154	0.0
Work Requirements & Eligibility Redeterminations				
System Changes Contractors - MMIS	13,090,560	1,505,414	11,585,146	0.0
MMIS Rollforward Funding	-1,505,414	-1,505,414	0	0.0
System Changes Contractors - CBMS	3,784,980	420,511	3,364,469	0.0
CBMS Rollforward Funding	-420,511	-420,511	0	0.0
System Changes Staff	378,289	43,503	334,786	3.0
Community Engagement				
Operations, Compliance, & Escalations Staff	223,485	109,731	113,754	2.0
Operations, Compliance, & Escalations Contractors	396,216	194,542	201,674	0.0
Customer Call Center Increased Staffing	3,102,048	1,523,105	1,578,943	0.0
Customer Call Center Operations Staff	1,199,990	307,198	892,792	0.0
Customer Call Center Technology Contracts	288,609	73,884	214,725	0.0
Eligibility Auditing & Review Staff	335,228	85,818	249,410	3.0
County Administration	17,413,807	4,353,451	13,060,356	0.0
CBMS Interface Maintenance	1,000,000	491,000	509,000	0.0
Communications Staff	110,175	54,096	56,079	1.0
Social Media & Texting Campaign Contractor	199,472	97,941	101,531	0.0
Customer Outreach Process	100,000	49,100	50,900	0.0
Outreach Campaign	700,000	343,700	356,300	0.0
Informational Inserts	200,000	98,200	101,800	0.0
Additional Mailing	655,500	321,851	333,649	0.0
Texting Campaign	100,000	49,100	50,900	0.0
Appeals Staff	276,820	135,918	140,902	2.0
Appeals Contractor	110,500	54,256	56,244	0.0
Appeals Printing Supplies	33,000	16,203	16,797	0.0
Appeals Increased Licenses	45,576	22,378	23,198	0.0
OCL Grievances & Appeals	107,433	52,749	54,684	0.0
Disability Assessment Increases	555,750	272,873	282,877	0.0
Equifax Costs	1,194,175	586,340	607,835	0.0
Fraud, Waste, and Abuse Provisions				
Post-Payment Review and Complex Audits Staff	301,079	147,829	153,250	3.0
Fraud Referrals Contractor	193,662	95,088	98,574	0.0
Accounting Specialist Contractor	198,432	97,430	101,002	0.0
Targeted Case Management Review Contractor	832,500	408,757	423,743	0.0
Marketplace TPL Contractor	185,000	90,835	94,165	0.0
Total Request	$45,786,371	$10,373,281	$35,413,090	15.0

→ S9 Federal rules compliance

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$400	$100	$100	$100	$100	1.0
Recommendation	800	200	200	200	200	2.0

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Staff Recommendation Higher/-Lower than Request	$400	$100	$100	$100	$100	1.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **NO**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: The Department implies that this request is the result of data that was not available when the original appropriation was made regarding new federal rules. These new rules increase the Department's workload, but the Department did not make a case for why the compliance work urgently needs to start in FY 2025-26 and cannot be absorbed within existing resources.

Request

The Department requests funding for 7 new positions, including 5 that would start in FY 2025-26, plus contract resources, to comply with several new federal rules.

The request increases the Department's funding by:

- Current year: $173,016 total funds, including $73,531 General Fund, and 1.3 FTE
- Year 1: $3.4 million total funds, including $1.0 million General Fund, and 6.1 FTE
- Year 2: $5.7 million total funds, including $1.5 million General Fund, and 7.0 FTE

The request is driven by new final rules issued by the federal Centers for Medicare and Medicaid Services. In particular, the Department cites:

- CMS-2442-F - Ensuring Access to Medicaid Services
- CMS-2439-F – Medicaid and Children’s Health Insurance Program Managed Care Access, Finance and Quality
- CMS-0057-F – CMS Interoperability and Prior Authorization Rule

Each of these new rules contain provisions that drive increased workload for the Department.

Recommendation

Staff recommends denying the request for FY 2025-26 and revisiting the request for FY 2026-27 at figure setting. The costs identified by the Department for FY 2025-26 are only $173,016 total funds, including $73,531 General Fund. The JBC staff believes the Department can absorb these costs in the first year.

The Department's request does not explicitly address how the request meets the JBC's supplemental criteria. Many of the new rule requirements start in FY 2026-27, but the Department did not walk through why the staff need to be on board in March of 2026. The request seems better suited for the normal budget process.

Adding administrative FTE in the current budget environment requires careful consideration. The JBC has an overwhelming number of supplemental budget reductions to consider for the Department. If the JBC can get through all the supplemental requests, then a lot of the decisions that the JBC would normally make during figure setting will already be made. The JBC will likely have more time at figure setting to consider this request than as part of the supplemental package. The request for FTE to comply with H.R. 1 is urgent. The scale of

increase for this request to comply with new federal rules is such that the Department could absorb the FY 2025-26 costs.

→ S14 Home health admin

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$38,022	$12,405	$6,604	$0	$19,013	0.3
Recommendation	27,359	13,680	0	0	13,679	0.3
Staff Recommendation Higher/-Lower than Request	-$10,663	$1,275	-$6,604	$0	-$5,334	0.3

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: The Department agree that this request is the result of new data that was not available when the original appropriation was made regarding the volume of appeals. There is an increase in appeals and the Department does not have funding to address them, but an argument could be made that the Department could and should have anticipated the increase. The JBC staff recommends the appeals staff, but could make an argument that the request does not meet the JBC's supplemental criteria.

Request

For long-term home health, the Department requests one term-limited position for a projected surge in appeals and one new position that would start in FY 2027-28 for policy oversight of the benefit.

- Current year: $38,022 total funds, including 12,405 General Fund and 0.3 FTE
- Year 1: $95,738 total funds, including $31,237 general Fund, and 1.0 FTE
- Year 2: $128,278 total funds, including $41,856 General Fund, and 1.2 FTE
- Year 3: $113,357 total funds, including $36,986 General Fund, and 1. FTE

In August 2025, the Department started new reviews of medical necessity for long-term home health. A big part of the medical necessity reviews is a new assessment where trained nurses use a standardized tool to evaluate the needs of members wanting in-home nursing. The Department believes the new nursing assessment is more consistent, reliable, supported by evidence, and equitable in identifying the needs of clients than the various program-specific assessments it replaces. The Department expects an increase in full and partial denials of service.

As people get reassessed and gain or lose benefits compared to what they previously received, the Department expects a temporary surge in appeals. To help manage the expected surge in appeals, the Department requests one term-limited position from March 2026 through February 2028.

The Department's November forecast assumes savings from the nursing assessments. In FY 2025-26 the Department projects savings of $14.3 million total funds, including $7.1 million General Fund. In FY 2026-27, the

Department projects savings of $48.1 million total funds, including $24.1 million General Fund. If the Department is unable to resolve appeals in a timely manner, some of the projected savings could be in jeopardy. For example, private duty nursing for one member for 16 hours per day for six months while an appeal is pending would cost $154,000. Through long-term home health a certified nurse assistant for 8 hours per day for six months while an appeal is pending would cost $59,000.

In addition, the Department requests one on-going position to help manage and continually improve the in-home nursing benefits. The Department wants to make sure it has the resources to listen to stakeholders, work through problems, and actively manage the high-cost benefits. The on-going position would start in January 2028.

Recommendation

Staff recommends approval of the term-limited position to manage appeals but not the on-going position to manage the benefit.

Appeals

Whenever the Department implements new assessments for services it is disruptive. Some people who have received services for a long time will gain or lose services compared to prior practice. This naturally leads to a lot of appeals, with clients arguing the new assessment does not accurately capture their needs and the Department evaluating each appeal on a case-by-case basis. These appeals must get resolved in a timely manner. The client needs to know what services they will get, but also there are budget ramifications. The Department cannot reduce appealed services until the appeal is resolved.

An argument could be made that a surge in appeals was a predictable outcome and the Department should have requested funding through the regular budget process, rather than a supplemental. Last year was a difficult budget year with a lot of scrambling to reduce the Department's budget. That is not an excuse but may partly explain what happened. The Department argues that the timelines for the medical necessity reviews were not finalized until late in 2024, but the JBC staff notes that we knew the reviews were coming and the budget included expected savings. Whatever the reasons that the Department did not anticipate the need and request the funding last year, the Department needs to deal with the actual increase in appeals that it is seeing.

On-going benefit management

The Department did not make a compelling case for why an on-going position to manage the benefit is needed. The Department argues that implementing medical necessity reviews for long-term home health creates a significantly higher standard for service authorization and the Department expects this will require careful ongoing review and evolution of the program and policy. The JBC staff argues that the Department has always had controls on long-term home health. These controls were temporarily suspended to evaluate problems with them and to develop the new reviews, but the program management did not go away. This is not a new need for the Department.

Maybe the Department could justify a position based on the complexity and utilization of the long-term home health benefit increasing over time and the administrative funding not keeping pace. However, the Department did not make that argument or present any data to support it. Staff assumes that the Department's relations

with stakeholders are currently strained, due to the new medical necessity reviews. Additional staff to work with the stakeholders would be nice for the Department. However, this is a difficult budget year and this looks to the JBC staff like a nice to have position, rather than an essential position.

Finally, the Department's proposal is for the ongoing position to start in FY 2027-28. The Department can submit a budget request for the position in FY 2027-28. There is no reason that today's General Assembly needs to make a decision on whether to fund this position that won't start until two years from now.

Technical differences

The staff calculation differs from the Department due to applying the JBC's common policies for new FTE. In addition, the JBC staff assumes all of the state share will come from the General Fund. The Department assumed some of the state share would come from the hospital provider fee. With few exceptions, mostly for the disability buy-in, the users of these services are not expansion populations financed with the hospital provider fee. Finally, the JBC staff did not include assume any centrally appropriated costs in the out years. The centrally appropriated amounts for one position are de minimis and this is a temporary position. The JBC staff believes the Department can absorb the centrally appropriated costs.

S14 Home health admin

Item	Total Funds	General Fund	Federal Funds	FTE
FY 2025-26				
Personal services	$19,975	$9,988	$9,987	0.3
Operating	7,384	3,692	3,692	0.0
Total	$27,359	$13,680	$13,679	0.3
FY 2026-27				
Personal services	$66,584	$33,292	$33,292	1.0
Operating	1,280	640	640	0.0
Total	$67,864	$33,932	$33,932	1.0
FY 2027-28				
Personal services	$46,609	$23,305	$23,304	0.5
Operating	896	448	448	0.0
Total	$47,505	$23,753	$23,752	0.5

→ S16 Technical adjustments

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$21,733,422	$0	-$45,998	$21,825,418	-$45,998	0.0
Recommendation	16,571,751	0	34,002	16,583,747	-45,998	0.0
Staff Recommendation Higher/-Lower than Request	-$5,161,671	$0	$80,000	-$5,241,671	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: JBC staff and the Department agree that this request is the result of a technical error in calculating the original appropriation for CBMS and data that was not available when the original appropriation was made regarding the need for budget reductions.

Request

The Department proposes an increase in the reappropriated funds spending authority for the Colorado Benefits Management System (CBMS) to allow the Department to bill other agencies correctly. In addition, the Department requests rollforward authority for a project delayed by changes in the federal landscape, a reduction in audit funding to reflect the actual contract, and budget neutral shifts of funding between line items to better reflect how the money is actually spent.

Current year: An increase of $21.7 million total funds, mostly for reappropriated funds for CBMS

Recommendation

Staff recommends approval of the request with modifications. Each component of the request is described in more detail below.

Reappropriated funds for CBMS

In order to bill participating agencies correctly for CBMS costs, the Department needs additional reappropriated funds spending authority. Each state agency is appropriated funding for their share of CBMS operations. When the Department took over the primary management of CBMS from the Office of Information Technology, the Department was given reappropriated funds spending authority to bill the other participating agencies for CBMS costs. The Department made several technical errors in figuring out the amounts appropriated to those other agencies and the reappropriated funds spending authority needed for the Department. The money for the sending agencies is already built into the budget. The Department just needs an increase in reappropriated funds spending authority to receive the full transfers from the other agencies.

Subsequent to the original request, the Department discovered some additional small errors that are corrected in the table below.

Staff recommends the changes to CBMS spending authority summarized in the table below.

Spending Authority for CBMS

Agency	Current RF	Needed CF	Needed RF	CF Change	RF Change
Human Services	$14,847,374	$0	$31,377,858	$0	$16,530,484
Early Childhood	560,254	0	560,254	0	0
Public Health and Environment	117,688	0	126,334	0	8,646
Old Age Pension Program	1,652	0	1,652	0	0
Labor and Employment	0	0	44,617	0	44,617
RTD	0	80,000	0	80,000	0
Total	$15,526,968	$80,000	$32,110,715	$80,000	$16,583,747

Rollforward authority for CBMS

The Department requests rollforward authority for one-time funding provided in in FY 2025-26 for R7 County administration and CBMS changes. The funding was intended to expand integrated character recognition (ICR), Interactive Voice Recognition (IVR) for members, and a policy bot into CBMS. The Department has had to delay the work due to urgent changes needed to comply with H.R. 1.

Staff recommends allowing the Department to rollforward the full project appropriation for FY 2025-26 to FY 2026-27. In addition, staff recommends reducing the FY 2026-27 appropriation because maintenance funding will no longer be need for this project in that fiscal year.

Rollforward authority for CBMS

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2025-26 Appropriation					
Integrated Character Recognition (ICR)	$8,381,508	$439,025	$265,106	$1,699,769	$5,977,608
Interactive Voice Recognition (IVR) self-service tool	649,834	34,038	20,554	131,788	463,454
Policy Bot	645,396	33,806	20,414	130,886	460,290
Total	$9,676,738	$506,869	$306,074	$1,962,443	$6,901,352
FY 2026-27					
Maintenance funding no longer needed	-$2,217,554	-$290,059	-$155,794	-$449,719	-$1,321,982

Accessibility

The Department received funding in the Payments to OIT line item to ensure website content is accessible to people with disabilities. The Department must comply with state and federal laws and is under a settlement agreement with the federal Department of Justice that requires publishing accessible information.

The compliance work is getting done by a private contractor, rather than through the Office of Information Technology. Therefore, the Department requests shifting the $150,000 total funds to the General Professional Services and Special Projects line item.

Staff recommends approval.

Accessibility

Item	Total Funds	General Fund	Federal Funds
Payments to OIT	-$150,000	-$75,000	-$75,000
General Professional Services	$150,000	$75,000	$75,000
Total	$0	$0	$0

Primary Care Fund audit

The Department requests a reduction to the Provider Audits and Services for an audit of the Primary Care Fund. The funding is no longer needed because the audit work is conducted internally. A previous reduction to the Provider Audits and Services did not capture the full savings.

Staff recommends approval.

Primary Care Fund Audit

Item	Total Fund	Primary Care Fund	Federal Funds
Provider Audits and Services	-$91,996	-$45,998	-$45,998

→ S17 Overexpenditures

The table below shows requested and recommend changes to the **FY 2024-25** appropriation.

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Request	$92,049,252	$66,845,455	$25,203,797	$0	$0	0.0
Recommendation	109,143,378	68,588,825	25,203,797	15,350,756	0	0.0
Staff Recommendation Higher/-Lower than Request	$17,094,126	$1,743,370	$0	$15,350,756	$0	0.0

Does JBC staff believe the request meets the Joint Budget Committee's supplemental criteria? **YES**
An emergency or act of God; a technical error in calculating the original appropriation; data that was not available when the original appropriation was made; or an unforeseen contingency.
Explanation: [JBC staff and the Department agree that this request is the result of data that was not available when the original appropriation was made regarding actual expenditures for Medicaid.

Request

The Department requests an adjustment to the FY 2024-25 appropriations to release restrictions on the FY 2025-26 appropriations imposed by the State Controller due to over-expenditures in prior years.

FY 2024-25: The Department requests a one-time increase in the FY 2024-25 appropriation of $109.1 million total funds, including $68.6 million General Fund.

Because of the entitlement nature of the Medicaid program, statute[3] allows the Department to overexpend Medicaid line items, except administrative line items, as long as the overexpenditures are consistent with the statutory purposes of the Medicaid program. However, the State Controller restricts the current fiscal year's appropriation until the General Assembly approves a supplemental for the prior year overexpenditures. This restriction allows the legislature an opportunity to review the reasons for overexpenditures and to decide if the overexpenditures could have been avoided with better management of the appropriation or if the overexpenditures occurred as a result of an unforeseen event or forecast error.

Mechanically, the release of the restrictions on the FY 2025-26 appropriations is accomplished by amending the FY 2024-25 appropriations.

Recommendation

Staff recommends releasing the restrictions as requested. The amount in the staff recommendation differs from the request. The staff recommendation uses the official letter from the State Controller describing the actual restrictions imposed. The Department's request was developed before all accounting adjustments were complete and included some technical errors.

It is important to note that the State Controller restricts funds when the Department overspends but not when the Department underspends. Also, the State Controller does not restrict the Department's federal funds. Taking into account underexpenditures as well as overexpenditures and all fund sources, the net difference between the appropriation and expenditures for the forecasted line items was $141.2 million total funds, including $54.0 million General Fund, rather than amount listed in the table below.

FY 2024-25 Overexpenditures

Division	Line Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds
Executive Director's Office	Colorado Benefits Management Systems, Operating and Contract Expenses	$15,350,756	$0	$0	$15,350,756
Medical Services Premiums	Medical and long-term Care Services for Medicaid Eligible Individuals	46,153,277	46,153,277	0	0
Behavioral Health Community Programs	Behavioral Capitation Payments	5,371,383	5,371,383	0	0
Office of Community Living	Adult Comprehensive Services	3,704,152	478,777	3,225,375	0
Office of Community Living	Adult Supported Living Services	1,959,736	1,959,736	0	0
Office of Community Living	Children's Extensive Support Services	5,830,197	5,830,197	0	0
Office of Community Living	Case Management for People with Disabilities	642,696	642,696	0	0
Indigent Care Program	Safety Net Provider Payments	20,246,694	0	20,246,694	0
Indigent Care Program	Primary Care Fund Program	409,393	0	409,393	0
Other Medical Services	Medicare Modernization act State Contribution Payment	536,414	536,414	0	0
Other Medical Services	Public School Health Services	1,322,335	0	1,322,335	0
Other Medical Services	Health Benefits for Children Lacking Access Due to Immigration Status	1,743,037	1,743,037	0	0

[3] Section 24-75-109, C.R.S.

Division	Line Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds
Transfers to Other State Department Medicaid-Funded Programs	Child Welfare Services	3,400,285	3,400,285	0	0
Transfers to Other State Department Medicaid-Funded Programs	Mental Health Institutes	2,473,023	2,473,023	0	0
Total		$109,143,378	$68,588,825	$25,203,797	$15,350,756

One of the overexpenditures was not due to forecast error and was not authorized by statute. The Department overspent the appropriation for the Colorado Benefits Management System (CBMS) by $15.4 million reappropriated funds. The CBMS is an administration line item in the Executive Director's Office and the statute does not grant overexpenditure authority for the line item.

Each state agency is appropriated funding for their share of CBMS operations. When the Department took over the primary management of CBMS from the Office of Information Technology, the Department was given reappropriated funds spending authority to bill the other participating agencies for CBMS costs. The Department made several technical errors in figuring out the amounts appropriated to those other agencies and the reappropriated funds spending authority needed for the Department. The money for the sending agencies was already built into the budget. The Department did not have the reappropriated funds spending authority to receive the full transfers from the other agencies.

The overexpnediture should not have happened and was prohibited by law. However, the remedy is the same. The State Controller restricted the Department's FY 2025-26 appropriation for the amount of the FY2024-25 overexpenditure.

The CBMS overexpenditure was clearly due to a technical error in the appropriation. There was funding at the sending agencies to support the expenditures by the Department. The staff recommendation is to release the overexpenditure restriction so that CBMS can operate properly in FY 2025-26.

Appendix A: Numbers Pages

Appendix A details the supplemental changes recommended by staff, including the actual expenditures for the previous state fiscal year, the appropriation for the current fiscal year, and the requested and recommended appropriation changes for the current fiscal year. Appendix A organizes this information by line item and fund source.