Colorado Commission on Medicaid

Working session

Tuesday, November 10th, 2026

Facilitated by SHG Advisors

Plan for the day

9:00 – 9:45	Open, how we decide, what we have heard, how we got here, the Governor's request, Amendment 87, the federal outlook
9:45 – 10:15	**Long-term lines with consensus:** votes on three to carry and five to set aside
10:15 – 1:55	**Long-term buckets:** who is covered, how the program is run, managed care and the ACC, behavioral health, LTSS, financing
2:05 – 4:00	**Short-term lines:** the same six buckets, in the same order
4:00 – 4:15	Report back: the day's votes and what carries to November 18th
4:15 – 5:00	Public comment

Breaks 12:05 – 12:25 (food in the room) and 1:55 – 2:05. Times are estimates.

More than 1.2 million Coloradans rely on these programs.

Children, families, pregnant women, older adults, and people with disabilities. Every line on today's docket changes something for someone.

What we have heard

1,196

survey responses, July 28th – November 8th

76

written submissions to the experiences form, through October 29th

6

community meetings hosted by members, ending with Sen. Mullica (Oct 6th) and Rep. Taggart (Oct 29th)

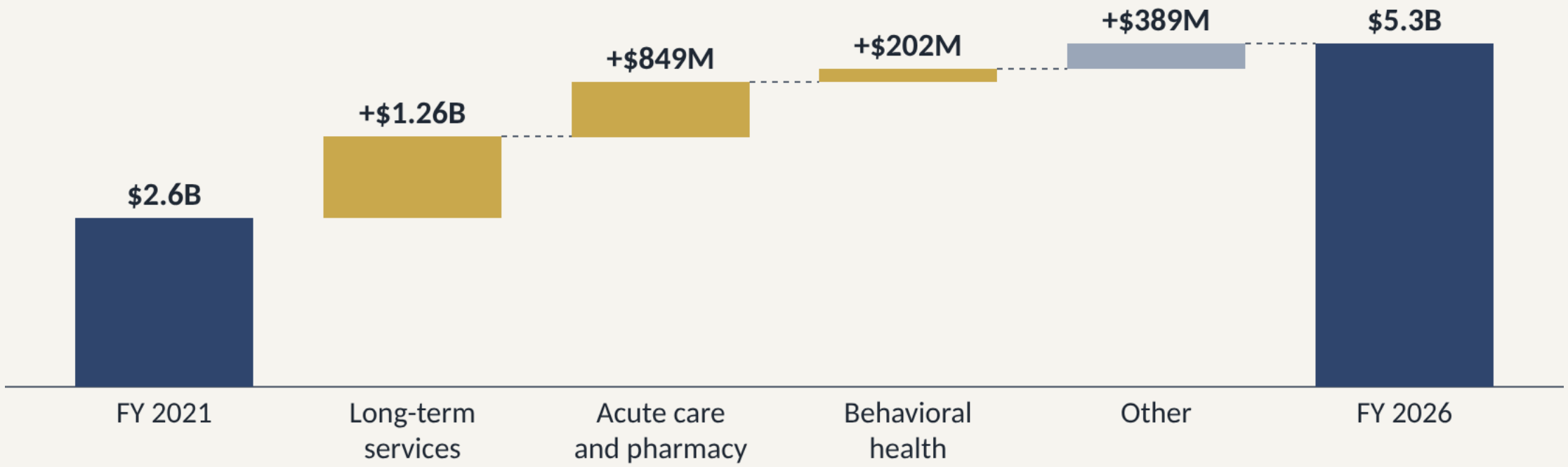
Themes across every source

- Protect home- and community-based services and family caregivers.
- Getting and keeping coverage is failing now; the first H.R. 1 losses came October 1st.
- The volume and pace of change is itself a cost to members and providers.
- Look at administration and contractors before members.
- People do not trust the numbers.

Source: SHG combined summary of stakeholder input, November 8th, 2026. Paraphrased; no one is identified.

How we got here

Medicaid general fund doubled in five years



Drivers HCPF named: Community First Choice and paid family caregiving; specialty drugs; removing prior authorization for psychotherapy, residential substance use treatment, and peer services.

Source: HCPF, Medicaid Cost Growth Trends, September 17th, 2026. General fund, FY 2020-21 to FY 2025-26. Other = remainder of the $2.7B increase.

How we got here

What drove the growth, by cause

When	Federal	State law	Cost and acuity
2014	ACA expansion at a 90% federal match	Hospital provider fee pays the state share	–
2019 – 22	–	Home care wages +$53M; Cover All Coloradans +$88M; psychotherapy prior authorization removed	–
2020 – 23	Continuous coverage; extra federal match	–	Enrollment peaks
2023 – 25	Unwind; extra match ends	Community First Choice +$22M (projected to save $52M)	Sicker members stay; long-term care +44%, to $4.1B
2025 – 27	H.R. 1: revenue −$1.2B; fee step-down Oct 2027; work requirements	–	FY 2026-27 forecast $443M over

Dollar figures for state laws are FY 2025-26 general fund estimates. Sources: HCPF benefit expansions table and cost-growth materials (Sept 17th, 2026); Colorado Sun/CPR and KUNC (Dec 2025); Governor's office (Aug 2025); Denver7 (Sept 2026).

The evidence record is closed

Clarification – answered in the room

- What a figure in the record means
- Which population it covers
- Whether two figures describe the same thing

New analysis – written into the recommendation

- Costing, modeling, or data not yet provided
- Becomes an implementation step: who acts, by when, how it is reported

Department staff are here to clarify, not to present. Contested figures are marked unverified so members decide knowing that.

The Governor's FY 2027-28 budget request

4.3%

Proposed Medicaid growth, aligned with the TABOR growth rate

15%

Expected Medicaid growth on current spending trends

$1.6B

Projected statewide shortfall for FY 2027-28

Reported Medicaid reductions total about $600 million. The Governor will submit an updated request in early January; the incoming administration and the JBC take it from there.

Sources: Colorado Newsline, Colorado Sun, Denver7, November 2nd–4, 2026. Confirm against the Governor's letter to the JBC.

Where the Governor's proposals land on the docket

–$173.5M GF

18 changes in R-06, Medicaid Sustainability (–$664.6M total funds), FY 2027-28

–$344.3M GF more

HCPF says further reductions are needed to hold GF growth to the TABOR rate – to be identified in the January 2nd supplemental, drawing on the Commission's recommendations

Not in the request

CFC and community long-term care (23), the CHASE hierarchy (11), the hospital UPL (3), RAE loss ratios (5), residential SUD (25)

Largest items by general fund: adult dental (N, –$39.8M), BH supportive services billing (J, –$37.8M), teaching-hospital payments (L, –$25.4M), the BH Incentive Program (K, –$18.6M), and psychotherapy prior authorization (I, –$14.5M).

Source: SHG crosswalk for Commission members, November 3rd, 2026, from HCPF's FY 2027-28 R-06 request and appendices. Information, not endorsement.

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

When

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

Where it can go

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

Allowed health care uses

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

What it means here

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

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

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

What changed

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

What keeps moving

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

How the Commission plans

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

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

How the Commission decides

Members vote today

Each line gets a vote. A line with seven votes goes forward as a recommendation, with its conditions written into the language.

Seven of ten

Seven votes make a recommendation; six members make a quorum. With nine members present, a line still needs seven.

Short of seven is still published

A line without seven votes is recorded as a minority position, with its supporters' reasoning.

Adoption

The full report, drafted from today's votes and November 18th, is adopted at the December 9th meeting.

SB 26-187 sets the seven-vote rule and quorum. Report due December 11th, 2026.

What to expect

What the December 11th report will contain

Ready to act

Seven votes and a clear path: who acts – the Department, the JBC, or a bill – what they do, and by when.

Ready, with conditions

Seven votes with the conditions written in – a costing first, a pilot, a report back – each naming who does it and by when.

Direction set, more work needed

Seven votes on direction where the details need a study, a work group, federal approval, or the next administration.

Minority positions

Lines short of seven, published with their supporters' reasoning so anyone can carry them later.

Every recommendation names who is responsible, how success is measured, how results are reported, and milestones for course correction.

Report due December 11th, 2026.

Before we vote

Most lines on today’s docket do not have a cost estimate

80 of 128
lines are not yet costed

13
carry only a stakeholder’s estimate

15
have a Department figure

That is the reality of a compressed calendar and an evidence record that is now closed. It is frustrating to be asked for direction without a number, and that frustration is fair.

How we handle it today

A line can carry with its costing as the first condition: who estimates it, by when, and what comes back to the JBC before anything takes effect. A member who will not recommend a line without a number can say so; that vote is recorded and published.

Source: Docket v4.2, fiscal estimate column. The other 20 lines are cost neutral (14) or listed as costing money (6).

HCPF flagged eight of the 128 lines as legally limited

HCPF reviewed every docket line against federal and state law. The Commission decides what to do with each flagged line.

Docket line	HCPF's point	Suggested handling
72a Hard growth limit on the state Medicaid contribution	A growth cap cannot be enforced by denying or reducing services to people who are eligible (42 U.S.C. 1396a(a)(8), 1396b(i); 42 CFR 440.230).	Already in the set-aside vote; the review confirms it.
15a An outcome measure for every program, with a wind-down rule	Required benefits, including EPSDT screening and treatment for children, must be covered regardless of outcome scores, so an automatic or blanket wind-down cannot apply to them (42 U.S.C. 1396a(a)(10)(A); 1396d(r)(5)).	Keep the outcome measures; replace the automatic wind-down with JBC review, and state that required benefits, including EPSDT, are measured but never wound down.
78 One accountable LTSS structure in the Governor’s office	HCPF, as the single state Medicaid agency, may not delegate its authority to supervise the plan or to issue Medicaid policies and rules (42 U.S.C. 1396a(a)(5); 42 CFR 431.10(e)).	The suggested wording already puts the single LTSS lead inside HCPF, which answers the concern.

Sources: HCPF fact sheet, "Legal Limits on Docket Proposals," and HCPF follow-up responses (line **87**), both received November 9th, 2026.

HCPF flagged eight of the 128 lines as legally limited (continued)

Docket line	HCPF's point	Suggested handling
121 An Office of Recovery and a voice for people in recovery	No entity outside HCPF may hold decision-making authority over Medicaid programs (42 U.S.C. 1396a(a)(5); 42 CFR 431.10(e)).	Make it an advisory role: people in recovery and peer workers represented on HCPF's federally required Beneficiary Advisory Council.
64 Waitlist before new arrivals access HCBS waivers	Federal law bars denying eligibility because a person has not lived in the state for a set period. Waiver enrollment limits are allowed, but not based on length of residence (42 CFR 435.403(j)(1)).	The waitlist part falls. Ask HCPF whether tracking residency of people in state-only programs can stand on its own.
70 Pilot policy changes before statewide rollout	Pilots cannot override federal statewideness and comparability requirements without federal waiver authority (42 U.S.C. 1396a(a)(1), (a)(10)(B)).	Only the pilot part is affected: pilot where federal authority allows or is obtained, otherwise phase in. The rule-change calendar, spacing and notice parts stand.

Sources: HCPF fact sheet, "Legal Limits on Docket Proposals," and HCPF follow-up responses (line **87**), both received November 9th, 2026.

HCPF flagged eight of the 128 lines as legally limited (continued)

Docket line	HCPF's point	Suggested handling
53 ABLE-account reimbursement of HCBS costs	Not allowed under current federal law: Congress would need to amend the ABLE and Medicaid statutes, and any reimbursement would be split between the federal and state shares (26 U.S.C. 529A; 42 U.S.C. 1396p).	Set aside, or move to a short list of requests to Colorado's congressional delegation.
87 Sliding-scale parental fee for children on waivers or CFC	A parental-income fee conflicts with Social Security income rules for waiver children: Colorado is a Section 1634 state, and a child at institutional level of care is a household of one, so parental income cannot be counted. For children on Community First Choice only, federal rules bar premiums below 150% of the poverty level (42 CFR 447.55). HCPF tried this under FY18 R-8 and dropped it.	Set aside, or replace with a request that HCPF report any cost-sharing options federal rules allow for these families.

Sources: HCPF fact sheet, "Legal Limits on Docket Proposals," and HCPF follow-up responses (line **87**), both received November 9th, 2026.

How each bucket runs

Consent-ready

Seven or more marked Proceed outright. Voted as a group; any member may pull a line for its own vote.

Reject

Seven or more marked Reject. Voted as a group; recorded as considered and not carried.

Conditional

Seven or more support it, mostly with caution. Members confirm the conditions, then vote.

Discuss

Everything else. Discussed one at a time, then voted.

Unmarked lines count as no response. Each group needs seven of the nine members who responded.

Before we start

The theme we heard from everyone: stability

What we heard

Families, providers and members in every source said the pace of change is itself a cost: new rules, caps and memos arriving faster than anyone can absorb them.

Why it matters

Providers said no one can invest in a system that keeps changing; families said they cannot plan care. 116 Department memos in 2025 came up in several rooms.

What it asks of us

Decide the direction first, then make short-term changes that fit it – so the same people are not hit by a change this year that is reversed next year.

Source: SHG combined summary of stakeholder input, November 8th, 2026.

Before we start

Why we start with long-term direction

Several short-term lines only make sense under one long-term answer. Deciding direction first keeps us from voting for short-term fixes that a long-term decision would undo.

Example 1: behavioral health managed care

If the Commission keeps managed care, short-term line **5** – validate, then enforce, RAE loss ratios – is how to make it work. If it ends capitated behavioral health managed care (long-term line **92**), line **5** matters much less.

Example 2: Community First Choice

If CFC continues, short-term line **23** – the CFC program-integrity package – is the fix. If CFC is sunset (long-term line **88**), line **23** would be work spent on a program that is ending.

Long-term direction · this morning

Long-term questions, in six buckets

Conditional: 7+ support it, mostly with caution. Discuss: no majority yet.

Bucket	Consent-ready	Conditional	Discuss	Reject
Who is covered	0	3	2	1
How the program is run	2	3	0	1
Managed care and the ACC	0	3	2	0
Behavioral health	1	4	1	1
Long-term services and supports	0	0	6	0
Financing	0	1	5	2

Counts of long-term docket lines, from the sheets of the nine members who responded.

Long-term lines with consensus · carry forward · 1 of 2

Seven or more members marked Proceed

Effect on short-term lines. **Line 96** (Re-evaluate the Behavioral Health Ombudsman Office): No short-term line is removed. Short-term line **6** (One set of processes across the RAEs and BHASOs) is where the consumer protections would sit. **Line 115** (Evaluate a single state-directed Pharmacy Benefit Administrator): No short-term line is removed. Short-term line **24** (Pharmacy cost measures) stays and sets the baseline.

Docket line and proposition	What kind of change	Members	What members wrote
96 Re-evaluate the Behavioral Health Ombudsman Office: redirect its resources to proactive accountability by the agencies, BHASOs and RAEs, with consumer protections strengthened so that people can still raise concerns and get help. ***Suggested wording reflecting members' notes:*** *Re-evaluate the Behavioral Health Ombudsman Office: redirect its resources to proactive accountability by the agencies, BHASOs and RAEs, with a simultaneous emphasis on strengthening consumer protections so that people can still raise concerns and get help in a timely manner.*	Restructure – redirects existing resources Acts by: bill Not yet costed	7 Proceed 2 Caution 0 Reject	One member was hesitant to recommend a change that is not costed but open to it; another wants consumer protections kept, perhaps through a more efficient structure.

Seven or more members marked Proceed (continued)

Docket line and proposition	What kind of change	Members	What members wrote
115 Commission an independent evaluation of moving Medicaid pharmacy administration to a single state-directed Pharmacy Benefit Administrator, as Ohio has, covering implementation cost, net General Fund savings, effects on pharmacies and members, and changes to managed care financing. Relates to line **24**.	Study that could lead to savings Acts by: Department; bill if needed Not yet costed	8 Proceed 0 Caution 0 Reject	No comments noted.

Seven or more members marked Proceed

Effect on short-term lines. **Line 14** (Reconcile fiscal-note savings with actual results): No short-term line is removed. Carrying **14** could absorb parts of short-term line **16c** (Dynamic budgeting: track how cuts shift costs elsewhere) and line **80** (Notice and justification before benefit or eligibility changes).

Docket line and proposition	What kind of change	Members	What members wrote
14 Require a reconciliation of every major Medicaid policy change's fiscal-note savings claim against actual results, transmitted to the JBC annually, beginning with Community First Choice, HB21-1021 peer services, Cover All Coloradans and the nurse assessor program that sunset December 2025; count downstream appeal, administrative and workforce costs in every savings estimate, and present each reduction in state-share and total-funds terms.	Accountability and reporting Acts by: bill or budget note Cost neutral	7 Proceed 1 Caution 1 Reject	One member asked for more detail on how the reconciliation would work.

Seven or more members marked Proceed – line 14 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
14 *(continued)* Require every major administrative-efficiency proposal to show current spending, implementation cost, projected savings and actual results, separating General Fund, total funds, additional federal revenue and costs shifted to counties or providers, so the same saving is not counted twice across lines. ***Suggested wording reflecting members' notes:*** *Require an annual reconciliation, reported to the JBC, of each major Medicaid policy change's projected savings against actual results – starting with Community First Choice, peer services, Cover All Coloradans and the nurse assessor program – counting downstream appeal, administrative and workforce costs and showing state-share and total-funds effects. HCPF and JBC staff publish the method before the first report.*			

Long-term lines with consensus · set aside · 1 of 2

Seven or more members marked Reject

Docket line and proposition	What kind of change	Members	What members wrote
73a Consider merging CDHS and HCPF.	Restructure Acts by: bill Not yet costed	0 Proceed 2 Caution 7 Reject	Merging two large departments is not a good idea and does not necessarily make government work better or cost less; it would create a department consuming more than half the general fund. One member who marked caution supports consolidation in principle but said it depends on leadership and is a huge task.

Seven or more members marked Reject (continued)

Docket line and proposition	What kind of change	Members	What members wrote
51 A permanent, planned use of long-unclaimed Unclaimed Property Trust Fund balances as an offset to the provider-fee ratchet, instead of ad hoc annual draws.	Financing – an offset, not a saving Acts by: bill Not yet costed	2 Proceed 0 Caution 7 Reject	No comments noted.

Seven or more members marked Reject

Docket line and proposition	What kind of change	Members	What members wrote
72a A hard growth limit: the state Medicaid contribution grows at inflation only, within TABOR's band. **HCPF legal note:** A growth cap cannot be enforced by denying or reducing services to people who are eligible (42 U.S.C. 1396a(a)(8), 1396b(i); 42 CFR 440.230).	Spending limit Acts by: bill Not yet costed	1 Proceed 1 Caution 7 Reject	One member noted that rates cannot simply be capped at inflation.
72b Grandfather current rates and apply any reductions to new enrollees only. Split from line **72**.	Cost containment Acts by: bill Not yet costed	0 Proceed 1 Caution 7 Reject	Members questioned whether it would be legal and how it would work.

Seven or more members marked Reject (continued)

Docket line and proposition	What kind of change	Members	What members wrote
72c Require legislative approval when a service category grows more than a set percentage in a year (Idaho HB 345). Split from line **72**.	Spending control Acts by: bill Not yet costed	1 Proceed 1 Caution 7 Reject	One member called it not practical; another agreed in concept but wanted detail on how it would work.

Starting assumption · who is covered, and what benefits include

Do the Commission's recommendations protect coverage, and look first to how benefits are organized, paid for, and managed?

A temperature check, not a vote. The long-term lines on who is covered – **107**, **112**, **85**, **33** and **34** – follow on the next slide.

Who is covered, and for which benefits

Already voted this morning in the consensus votes: set aside **72b** (Apply reductions to new enrollees only). Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
107 As a guiding principle for the Department and the Commission's recommendations, cover as many people as possible: narrower coverage for more people is generally preferable to more robust coverage for fewer people. ***Suggested wording reflecting members' notes:*** *As a guiding principle, cover as many people as possible, with each recommendation showing its fiscal effect and its effect on people who need long-term services and supports.* **Conditional**	Eligibility Acts by: Department, bill Not yet costed	6 Proceed 1 Caution 2 Reject	The fiscal picture, and the effect on people who need long-term care.

Who is covered, and for which benefits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
112 Where federal law and rules allow, repeal legislation and rules adopted since 2019 that added benefits or coverage, or that removed utilization-management tools from HCPF or the RAEs. Read with lines **24**, **33** and **34**. ***Suggested wording reflecting members' notes:*** *Review each benefit, coverage or utilization-management change adopted since 2019 for its cost and effect, and recommend repeal or change one by one where federal law allows.* **Conditional**	Benefits Acts by: Medical Services Board, bill, CMS approval Not yet costed	1 Proceed 6 Caution 1 Reject	Too broad as a blanket repeal; review benefit additions one by one.

Who is covered, and for which benefits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
85 Replace the eligibility cliff for people leaving Medicaid: 12-month transitional medical assistance, premium assistance, or a Basic Health Program for 133–200% FPL, with graduated cost sharing above the limit so a dollar more in earnings does not end coverage. Relates to **12** and **29** but for the expansion population. ***Suggested wording reflecting members' notes:*** *Have HCPF cost options for smoothing the eligibility cliff – 12-month transitional medical assistance, premium assistance or a Basic Health Program – including effects on reinsurance and Connect for Health Colorado, and identify a funding source before any is adopted.* **Conditional**	Eligibility Acts by: Department, bill, CMS approval Not yet costed	2 Proceed 5 Caution 1 Reject	Show the cost and how it is funded; a Basic Health Program could affect reinsurance and Connect for Health.

Who is covered, and for which benefits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
33 Put CHIP, Cover All Coloradans, optional benefit levels and eligibility thresholds on the docket by name, so the Commission decides whether to decide rather than leaving them to the JBC; include the income level at which HCBS waivers and targeted case management are available. ***Suggested wording reflecting members' notes:*** *Recommend that the JBC review CHIP, Cover All Coloradans, optional benefits and eligibility thresholds with Department cost data as part of the budget, applying the Commission's guiding principle on coverage.* **Discuss**	Eligibility Acts by: bill, budget Not yet costed	1 Proceed 2 Caution 4 Reject	Purpose unclear; decisions sit with the JBC and the legislature; concern about Cover All Coloradans.

Who is covered, and for which benefits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
34 Cap benefits for the expansion population: set the alternative benefit plan at the federal minimum essential health benefits with annual limits on optional services (adult dental, vision, non-emergency transportation where permitted), rather than reducing eligibility, if the CHASE trigger hits. Opposed (October 20th): a behavioral health provider association, because the cap would fall disproportionately on people with mental health and substance use conditions; a dental association opposes further limiting the adult dental benefit, citing recent rate cuts, the reinstated annual cap and emergency department cost shifts in other states.	Benefits Acts by: Department, bill, CMS approval Not yet costed	1 Proceed 2 Caution 5 Reject	Expansion benefits are not growing disproportionately; discuss before any cap; some favor eligibility changes instead.

Who is covered, and for which benefits – line 34 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
34 *(continued)* ***Suggested wording reflecting members' notes:*** *If the CHASE trigger hits, consider limits on optional benefits for expansion adults only after reviewing which benefits are growing fastest and their effect on emergency and hospital costs, rather than moving the benefit plan to the federal minimum.* **Discuss**			

How the program is run, and how the state knows it is working

Already voted this morning in the consensus votes: carried **14** (Reconcile fiscal-note savings with actual results); **115** (Evaluate a single state-directed Pharmacy Benefit Administrator); set aside **72c** (Utilization trigger requiring legislative approval). Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
16a Publish the actuarial assumptions and confidence intervals behind every Medicaid forecast and fiscal note on a standing dashboard, and build service-category forecasting with the all-payer claims database as an independent check.	How the program is run Acts by: Department Cost neutral	3 Proceed 6 Caution 0 Reject	Proceed on forecast assumptions; cost and method of dynamic budgeting needed.

How the program is run, and how the state knows it is working – line 16a (continued)

Docket line and proposition	What kind of change	Members	What members wrote
16a *(continued)* ***Suggested wording reflecting members' notes:*** *Publish the actuarial assumptions and confidence intervals behind every Medicaid forecast and fiscal note on a standing dashboard, and report the cost and method of service-category forecasting before building it.* **Conditional**			

How the program is run, and how the state knows it is working (continued)

Docket line and proposition	What kind of change	Members	What members wrote
40 A standing legislative Medicaid oversight body to carry unresolved items past December 11th (similar to Connecticut, Kentucky, North Carolina). ***Suggested wording reflecting members' notes:*** *Create an interim, time-limited Medicaid oversight committee, including members from outside the legislature, to carry unresolved items past December 11th without duplicating the JBC.* **Conditional**	How the program is run Acts by: bill Cost neutral	4 Proceed 4 Caution 1 Reject	Time-limited or interim; avoid duplication; include members from outside the legislature.

How the program is run, and how the state knows it is working (continued)

Docket line and proposition	What kind of change	Members	What members wrote
15a A defined outcome measure for every Medicaid program and contract, published annually, with a rule that a program the data show is not delivering is wound down. Also proposed (October 20th): rural-appropriate measures using multi-year trends and regional benchmarks where annual facility rates are unreliable (a rural health advocacy group). A peer-support organization proposes measuring peer support by progress toward the person's self-identified recovery and wellness goals.	How the program is run Acts by: Department, bill Not yet costed	2 Proceed 6 Caution 0 Reject	Outcome measures yes; the automatic wind-down rule is the sticking point.

How the program is run, and how the state knows it is working – line 15a (continued)

Docket line and proposition	What kind of change	Members	What members wrote
15a *(continued)* ***Suggested wording reflecting members' notes:*** *Require a defined outcome measure for every Medicaid program and contract, published annually; programs that miss their measures come back to the JBC for review rather than winding down automatically, and required benefits, including EPSDT for children, are measured but never wound down.* **HCPF legal note:** Required benefits, including EPSDT screening and treatment for children, must be covered regardless of outcome scores, so an automatic or blanket wind-down cannot apply to them (42 U.S.C. 1396a(a)(10)(A); 1396d(r)(5)). **Conditional**			

Managed care and the ACC

Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
19 Reduce the number of RAEs and BHASOs – to two, or one with regions – or, in the alternative, standardize them (line **6**); a further alternative heard: bar for-profit entities from behavioral health managed care contracts, as Minnesota does. Alternatives proposed (October 20th): prioritize Colorado-based companies for behavioral health managed care contracts while keeping federal consumer-choice compliance, and pilot two or more MCOs for physical health managed care in one county to test payer choice (a behavioral health provider association); consider approaches other states use to preserve community-rooted nonprofit plans and local accountability (a RAE).	How the program is run Acts by: Department, bill Not yet costed	2 Proceed 5 Caution 2 Reject	Worth exploring given uneven RAE performance; not yet settled on the number.

Managed care and the ACC – line 19 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
19 *(continued)* A behavioral health provider asks whether a for-profit managed care organization that cannot administer Medicaid responsibly should continue to do so; BHA lists targeted regional contracting among its focus areas. ***Suggested wording reflecting members' notes:*** *Use existing RAE and BHASO performance measures to set targets, publish results by entity in one comparable report, and require remediation and, if not met, contract consequences.* **Conditional**			

Managed care and the ACC (continued)

Docket line and proposition	What kind of change	Members	What members wrote
108 Tie a larger share of Medicaid payments to value and outcomes rather than units of service, across programs, wherever possible. Relates to lines **15**, **27**, **44**, **71**, **95** and **15b**. ***Suggested wording reflecting members' notes:*** *Increase the share of Medicaid payment tied to value and outcomes, starting with a Department plan that names the programs, measures and timeline, with results reported annually.* **Conditional**	Payment Acts by: Department, CMS approval Not yet costed	3 Proceed 5 Caution 0 Reject	More detail on how paying for outcomes would work.

Managed care and the ACC (continued)

Docket line and proposition	What kind of change	Members	What members wrote
90 End the Accountable Care Collaborative's primary care case management and care coordination payments, or limit them to adults and fund a pediatric primary care payment model from the children's share – care coordination, team-based care and preventive care, paid when delivered rather than on outcome metrics, with the AAP PACK report and Commission testimony on pediatric payment as the reference – keeping a per-member payment for pediatric primary care practices. Relates to **7**, **15**, **19** and **71**. Opposed (October 20th): a RAE. HCPF reports it will reduce provider incentive payments, not yet specified (HCPF, October 20th).	Payment Acts by: Department, bill, CMS approval Department figure	1 Proceed 6 Caution 2 Reject	Standardize case management best practice across RAEs; may follow from other payment changes rather than stand alone.

Managed care and the ACC – line 90 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
90 *(continued)* ***Suggested wording reflecting members' notes:*** *Standardize care management practice and payment across the RAEs, and evaluate in the next ACC procurement whether primary care case management payments should be limited to adults, with a pediatric primary care payment model funded from the children's share.* **Conditional**			

Managed care and the ACC (continued)

Docket line and proposition	What kind of change	Members	What members wrote
43 Move behavioral health claims payment onto shared or state-administered infrastructure, keeping RAEs for network and coordination; standardize prior authorization statewide and integrate with provider records. Opposed (October 20th): a RAE. HCPF reports strengthened monitoring and retroactive review of outpatient psychotherapy, with RAEs directed to explore utilization management for outlier billing and to apply targeted prior authorization in FY 2026-27; prior authorization for outpatient psychotherapy is constrained by SB22-156 (HCPF, October 20th).	How the program is run Acts by: Department Not yet costed	0 Proceed 6 Caution 2 Reject	Does it save money or add consistency? Interoperability as an alternative; in place of fewer RAEs?

Managed care and the ACC – line 43 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
43 *(continued)* ***Suggested wording reflecting members' notes:*** *Require interoperable claims and prior-authorization systems across the RAEs and BHASOs, with one statewide prior-authorization standard, before considering moving behavioral health claims payment to state-administered infrastructure.* **Discuss**			

Managed care and the ACC (continued)

Docket line and proposition	What kind of change	Members	What members wrote
92 End capitated managed care for behavioral health: pay behavioral health services fee-for-service or through an administrative-services contract, keeping network and care-coordination functions where they add value; first, have HCPF cost the administrative saving at constant utilization. Opposed (October 20th): a behavioral health provider association, which asks that any move proceed through analysis, stakeholder engagement and targeted pilots, and a RAE. Another behavioral health provider association is neutral on managed-care structure provided cost-based safety-net payment first has a defined home and high-acuity and no-refusal responsibility is assigned.	How the program is run Acts by: Department, bill, CMS approval Not yet costed	0 Proceed 2 Caution 6 Reject	Federal funds tied to managed care; fee-for-service cost; pilots first; hold RAEs accountable instead.

Managed care and the ACC – line 92 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
92 *(continued)* ***Suggested wording reflecting members' notes:*** *Before any change to capitated behavioral health managed care, have HCPF design a replacement payment model that addresses what fee-for-service would lose – state-directed payments, residential mental health coverage, quality-tiered and value-based contracts, and the ability to end a provider contract – and cost the administrative saving; if warranted, test an administrative-services model as a pilot in one region.* **Discuss**			

Behavioral health: who administers it, and where its funding sits

Already voted this morning in the consensus votes: carried **96** (Re-evaluate the Behavioral Health Ombudsman Office); set aside **73a** (Consider merging CDHS and HCPF). Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
7a Consolidate care coordination – including the care coordination now run through BHA and the BHASOs – into HCPF's structure on a shared risk-stratification platform, so one entity coordinates for the same member; • stop paying for coordination HCBS providers already carry in their rate; • give providers a channel into RAE care coordination; • publish cost per engaged member against other states. Alternative proposed (written submission, October 5th): complete the 2020 Blueprint's transfer of individualized care coordination from the BHA to the BHASOs, scaled to need, and return funding not needed for an essential function to the general fund.	How the program is run Acts by: Department, bill Not yet costed	6 Proceed 3 Caution 0 Reject	Clarify which parts can move now; members want the full proposal understood before a major change.

Behavioral health: who administers it, and where its funding sits – line 7a (continued)

Docket line and proposition	What kind of change	Members	What members wrote
7a *(continued)* Also proposed (October 20th): • comprehensive safety net providers and CCBHCs coordinate care for the highest-need people they serve, under managed-care oversight and without financial risk, with duplicative RAE and BHASO coordination reduced and records matched against provider rosters to find duplication (a behavioral health provider association); • supporters of the BHASO transfer add that the State define who does what (another behavioral health provider association)..			

Behavioral health: who administers it, and where its funding sits – line 7a (continued)

Docket line and proposition	What kind of change	Members	What members wrote
7a *(continued)* ***Suggested wording reflecting members' notes:*** *Move toward one care coordinator per member: as a first step, HCPF maps every care coordination function now paid through the RAEs, BHASOs, BHA, and HCBS providers, identifies duplicate payments, and reports which can be consolidated now under existing authority and which need statute, before any larger transfer.* **Conditional**			

Behavioral health: who administers it, and where its funding sits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
18 Move the Behavioral Health Administration's payment, contracting and care-coordination functions into HCPF, leaving licensing and crisis outside the payer; consolidate the behavioral health programs scattered across nine to twelve departments that contract with the same providers. Opposed (October 20th): a behavioral health provider association would keep the BHA as a cabinet-led agency with a streamlined role, review each BHA position's function, workload and statutory or federal basis, and complete the 2020 Blueprint's delegation of roles to BHASOs and providers. Members discussed consolidating administrative costs across behavioral health agencies and asked for an analysis of consolidating the behavioral health programs spread across nine to twelve departments (October 7th meeting).	How the program is run Acts by: bill Not yet costed	3 Proceed 5 Caution 1 Reject	Decide whether BHASOs and block grants belong with HCPF; support for parts, not yet the whole.

Behavioral health: who administers it, and where its funding sits – line 18 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
18 *(continued)* ***Suggested wording reflecting members' notes:*** *Move the BHA's payment and contracting functions into HCPF, leaving licensing, crisis and federal block-grant administration with the BHA; return to the General Assembly with a plan for BHASO contracting and care coordination before those move.* **Conditional**			

Behavioral health: who administers it, and where its funding sits (continued)

Docket line and proposition	What kind of change	Members	What members wrote
73b Move the Behavioral Health Administration's federal block-grant dollars into HCPF. Split from line **73**; read with line **18**. ***Suggested wording reflecting members' notes:*** *Study whether moving administration of the BHA's federal block grants into HCPF would reduce duplication, allowable under SAMHSA, and present on the findings and recommendations before any transfer.* **Conditional**	Financing Acts by: bill, CMS approval Not yet costed	2 Proceed 5 Caution 1 Reject	Open to parts of it, not yet the whole proposition.
94 Target behavioral health safety-net and indigent care funding at the highest need: • keep the statutory "no refusal" requirement for comprehensive safety net providers but focus it on the highest-acuity people; • redefine "priority populations" in statute;	Financing Acts by: Department, bill Not yet costed	3 Proceed 5 Caution 0 Reject	Show whether it saves money; members want the proposal explained further.

Behavioral health: who administers it, and where its funding sits – line 94 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
94 *(continued)* • let indigent care funding follow the person to any eligible provider – including specialty, essential and substance use treatment providers – through flexible BHASO funding rather than siloed streams. A behavioral health provider association would preserve early intervention while focusing on the highest-need people, have funding follow the obligation by contract to the designated provider, CSNP or ESNP, and, as BHA develops no-refusal enforcement, clarify who follows up after assessment and referral so that a CSNP that is not the primary treating provider does not automatically take on placement responsibility (October 20th). Another behavioral health provider association offers statutory language.			

Behavioral health: who administers it, and where its funding sits – line 94 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
94 *(continued)* ***Suggested wording reflecting members' notes:*** *Direct the BHA to show, with cost and caseload figures, how focusing the safety-net "no refusal" requirement on the highest-acuity people and letting indigent care funding follow the person would change spending and access, before statute is changed.*			
Conditional			
121 Create an Office of Recovery in the next administration to support the peer and recovery workforce, and give people with lived experience and recovery professionals a standing way to be heard on decisions about recovery services. Relates to lines **22** and **81**.	How the program is run Acts by: Department Not yet costed	0 Proceed 1 Caution 6 Reject	No new offices during a shortfall; concern that input would be ignored.

Behavioral health: who administers it, and where its funding sits – line 121 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
121 *(continued)* ***Suggested wording reflecting members' notes:*** *Ensure people in recovery and the peer workforce are represented on HCPF's federally required Beneficiary Advisory Council and Medicaid Advisory Committee (42 CFR 431.12), and require HCPF to report how their input was used – an advisory role, not a new office.* **HCPF legal note:** No entity outside HCPF may hold decision-making authority over Medicaid programs (42 U.S.C. 1396a(a)(5); 42 CFR 431.10(e)). **Discuss**			

Long-term services and supports: design and governance

Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
31 Move LTSS toward an individual budget model: each member receives a stated budget derived from assessed need and chooses services from a menu with a support broker – self-direction extended beyond CDASS and beyond the three services now allowed – with a defined "stacking" framework and, over time, the nine waivers consolidated into one. A narrower version (office hours, October 5th): one adult waiver and one children's waiver, each with a menu of services subject to authorization.	Benefits Acts by: Department, bill, CMS approval Not yet costed	3 Proceed 3 Caution 3 Reject	Needs CMS waiver changes and stakeholder work; weigh against **78** and **127**.

Long-term services and supports: design and governance – line 31 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
31 *(continued)* ***Suggested wording reflecting members' notes:*** *Develop, with stakeholders and CMS, a plan to move LTSS toward individual budgets based on assessed need and to consolidate the waivers, and compare it with managed LTSS (line **127**) before choosing a model.* **Discuss**			

Long-term services and supports: design and governance (continued)

Docket line and proposition	What kind of change	Members	What members wrote
48 Contract Area Agencies on Aging to deliver community-based services for older adults, as other states do. ***Suggested wording reflecting members' notes:*** *Evaluate whether contracting Area Agencies on Aging for selected community-based services for older adults would cost less or improve access, before any change.* **Discuss**	How the program is run Acts by: Department Not yet costed	2 Proceed 2 Caution 4 Reject	Savings not shown; may raise costs; possibly beyond the Commission's scope.

Long-term services and supports: design and governance (continued)

Docket line and proposition	What kind of change	Members	What members wrote
78 One accountable LTSS structure: a Governor's Office of LTSS or senior advisor with authority across HCPF, CDPHE, CDHS, CDEC and DOLA to set priorities, align or eliminate overlapping offices, hold a single interpretation of the rules across all case management agencies, move surveys from process to outcomes and restore an on-time survey cycle. Extends **73**.	How the program is run Acts by: Department, bill Not yet costed	1 Proceed 2 Caution 6 Reject	Consolidation and coordination yes, a structure in the Governor's office no; accountability inside HCPF instead.

Long-term services and supports: design and governance – line 78 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
78 *(continued)* ***Suggested wording reflecting members' notes:*** *Assign one accountable LTSS lead within HCPF, as the single state Medicaid agency, with authority to coordinate across CDPHE, CDHS, CDEC and DOLA, align overlapping offices, hold one interpretation of the rules across case management agencies, and restore an on-time, outcome-based survey cycle.* **HCPF legal note:** HCPF, as the single state Medicaid agency, may not delegate its authority to supervise the plan or to issue Medicaid policies and rules (42 U.S.C. 1396a(a)(5); 42 CFR 431.10(e)). **Discuss**			

Long-term services and supports: design and governance (continued)

Docket line and proposition	What kind of change	Members	What members wrote
88 Sunset Community First Choice and return personal care, homemaker and health maintenance services to the HCBS waivers, phased over more than one year. The larger alternative to the CFC package in line **23**; read with **57**.	Benefits Acts by: Department, bill, CMS approval Not yet costed	3 Proceed 3 Caution 3 Reject	Change CFC rather than end it; understand what drives its growth; some prefer a pause; weigh the 6% match.

Long-term services and supports: design and governance – line 88 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
88 *(continued)* ***Suggested wording reflecting members' notes:*** *Keep Community First Choice but change it: identify what is driving its growth by population and service, then set guardrails – including the integrity package in short-term line **23** – that keep the enhanced federal match; revisit a sunset only if growth is not controlled.* **Discuss**			

Long-term services and supports: design and governance (continued)

Docket line and proposition	What kind of change	Members	What members wrote
125 Create a Medicaid Prescribed Pediatric Extended Care benefit or pilot – day centers providing skilled nursing and therapies for medically complex and technology-dependent children, paid on a shared-care basis – as an added option, not a replacement for one-on-one home nursing. ***Suggested wording reflecting members' notes:*** *Ask HCPF to report the cost, federal authority and likely demand for a Prescribed Pediatric Extended Care benefit as an option alongside home nursing, before any pilot.* **Discuss**	Benefits Acts by: Department, CMS approval Not yet costed	0 Proceed 1 Caution 6 Reject	Much more information needed.

Long-term services and supports: design and governance (continued)

Docket line and proposition	What kind of change	Members	What members wrote
127 Move long-term services and supports – home and community-based services and, as some states do, nursing facility care – into capitated managed care (managed long-term services and supports, or MLTSS), or pursue another LTSS delivery-system reform, such as a different case management system. 23 states used MLTSS as of 2023 (NCSL), and the Department's Manatt/MISO report listed it among "other potential opportunities." In Colorado today, HCBS is paid fee-for-service (HCPF). Relates to lines **19**, **31** and **92**.	How the program is run Acts by: Department, bill, CMS approval Not yet costed	1 Proceed 5 Caution 2 Reject	Used in 23 states; weigh against **31** and **78**.

Long-term services and supports: design and governance – line 127 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
127 *(continued)* ***Suggested wording reflecting members' notes:*** *Evaluate managed LTSS, as used in 23 states, against an individual budget model (line **31**) and a single accountable LTSS lead (line **78**), with costs and member effects, before choosing a delivery-system reform.* **Discuss**			

Hospital financing: the CHASE fee and the payment limit

What is at stake

H.R. 1 steps the hospital provider fee down from October 2027. Under current law, coverage for expansion adults absorbs the loss first: the first step alone is about $121M in fees and $1.1B in federal funds. Replacing all of the fee's share of expansion coverage with general fund would cost about $740M (HCPF, September 2nd).

What hospitals are asking

Line **11** – amend the CHASE provider-fee hierarchy so coverage is not the only absorber, protecting rural and frontier hospitals. Line **3** – preserve the hospital upper payment limit federal draw. HCPF will pursue a new methodology prospectively; estimates of $270M and $569M differ, and the amount depends on what CMS approves.

Sources: HCPF (Sept 2nd and Oct 2nd, 2026); Denver Health memo (Sept 8th, 2026).

Hospital financing: the Department and the Commission

What the Department has said

It declined the payment-limit change because about $270M of unfunded room would have to be filled before fee revenue supports coverage for about 438,000 people. It will pursue a method prospectively with the hospital association.

Where members stand

Line **3** (preserve the hospital payment-limit federal draw): all nine marked Proceed. Line **11** (amend the CHASE provider-fee hierarchy): no majority yet – 3 Proceed, 3 Caution, 2 Reject. Neither is in the Governor's request.

Sources: HCPF (Oct 2nd, 2026); October 7th meeting; member sheets; SHG crosswalk (Nov 3rd, 2026).

Financing beyond the general fund

Already voted this morning in the consensus votes: set aside **51** (Planned use of unclaimed property funds); **72a** (Hard growth limit on the state Medicaid contribution). Conditional lines first, then lines for discussion.

Docket line and proposition	What kind of change	Members	What members wrote
56 Hospital global budgets or an AHEAD-style multi-payer model instead of supplemental payments; • a rural global budget pilot beginning with obstetrics; • a statewide rural clinically integrated network; • rural public health districts as special districts operating within a global budget. Also proposed (October 20th): voluntary, locally designed regional rural collaboratives under the RHTP that share staff, infrastructure, data and service capacity, piloted and scaled if successful, and alignment of RHTP, the Hospital Improvement Program and CHASE under one rural performance framework within an all-payer strategy (a rural health advocacy group).	Payment Acts by: Department, bill, CMS approval Not yet costed	1 Proceed 7 Caution 0 Reject	Start as a pilot; define whether rural or all hospitals; much to evaluate first.

Financing beyond the general fund – line 56 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
56 *(continued)* A perinatal quality collaborative supports the obstetrics pilot, asking how baselines avoid locking in underservice and what happens to HQIP quality funding. ***Suggested wording reflecting members' notes:*** *Pilot a rural hospital global budget, beginning with obstetrics, and evaluate cost, access and quality before any statewide multi-payer model.*			
Conditional			
11 Amend the CHASE funding hierarchy so the expansion population is not the sole absorber of provider-fee reductions, with rural and frontier hospitals, and Denver Health, held harmless as the fee ratchets down; read with line **3**.	Financing Acts by: bill Department figure	3 Proceed 3 Caution 2 Reject	Work with hospitals and take CHA's requests into account; how expansion and supplemental payments share fee reductions.

Financing beyond the general fund – line 11 (continued)

Docket line and proposition	What kind of change	Members	What members wrote
11 *(continued)* Alternative proposed (October 20th): rather than isolated provider-fee changes, a defined, collaborative CHASE reform initiative with timelines and deliverables, in which key partners evaluate federal funding, expenditure growth, coverage and hospital reimbursement, and the legal, fiscal and access implications of changes before they advance (a hospital association). ***Suggested wording reflecting members' notes:*** *Launch a defined CHASE reform process with hospitals, the Colorado Hospital Association and the CHASE Board, with timelines and deliverables, to decide how expansion coverage and supplemental hospital payments share provider-fee reductions, holding rural and frontier hospitals harmless.* **Discuss**			

Financing beyond the general fund (continued)

Docket line and proposition	What kind of change	Members	What members wrote
20 An employer contribution to Medicaid: large employers whose workers are enrolled in Health First Colorado pay an assessment toward the cost of their coverage, with the proceeds directed to the Accountable Care Collaborative; as a first step, an annual report naming employers of Medicaid members (Nevada, New Jersey, Washington model). ***Suggested wording reflecting members' notes:*** *As a first step, require an annual report of employers whose workers are enrolled in Health First Colorado, by employer size and cost to the state, as Nevada, New Jersey and Washington do; consider any assessment only after reviewing it.* **Discuss**	Financing Acts by: bill Not yet costed	0 Proceed 4 Caution 4 Reject	Effect on employers hiring members; other states' mechanisms; objection to new revenue sources.

Financing beyond the general fund (continued)

Docket line and proposition	What kind of change	Members	What members wrote
21 A commercial payment corridor on the Washington model: cap hospital payment in state-regulated plans at a multiple of Medicare and floor primary care and non-facility behavioral health at a multiple of Medicare, starting with the state employee plan. ***Suggested wording reflecting members' notes:*** *Evaluate a payment corridor for the state employee health plan – capping hospital payment at a multiple of Medicare and setting a floor for primary care and behavioral health – and report effects on cost and access.* **Discuss**	Payment Acts by: bill Cost neutral	1 Proceed 2 Caution 5 Reject	A version for the state employee plan; possibly beyond scope.

Financing beyond the general fund (continued)

Docket line and proposition	What kind of change	Members	What members wrote
50 Certified public expenditures and intergovernmental transfers from counties, public health and government-owned providers as non-federal share; tobacco, nicotine, cannabis or lottery funds as match. ***Suggested wording reflecting members' notes:*** *Inventory local public funds not now used as federal match, show how they differ from current certified public expenditure and intergovernmental transfer financing and how TABOR treats them, and claim match where allowed.* **Discuss**	Financing Acts by: Department, bill, CMS approval Not yet costed	2 Proceed 3 Caution 3 Reject	How this differs from current CPE and IGT financing; TABOR implications.

Financing beyond the general fund (continued)

Docket line and proposition	What kind of change	Members	What members wrote
52 Raise alcohol excise taxes and dedicate revenue to SUD treatment and Medicaid. ***Suggested wording reflecting members' notes:*** *Note for the General Assembly the option of raising alcohol excise taxes with revenue dedicated statewide to substance use treatment and Medicaid, subject to TABOR.* **Discuss**	Financing Acts by: bill Not yet costed	3 Proceed 2 Caution 4 Reject	Whether this is the Commission's to propose; must serve the whole state.

Who is covered, and for which benefits

No line in this bucket is consent-ready. Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
12 Member cost sharing instead of coverage reduction ***Suggested wording reflecting members' notes:*** *Consider member cost sharing only as H.R. 1 requires, with estimated savings, and convene an H.R. 1–CHASE working group with hospitals.*	Eligibility Acts by: bill Not yet costed	0 Proceed 7 Caution 2 Reject	Only as H.R. 1 requires; estimate any savings; a suggested H.R. 1–CHASE working group with hospitals.
32 Benchmark optional benefits against the national midline ***Suggested wording reflecting members' notes:*** *Review optional benefits one by one for cost and use, starting with adult dental, rather than benchmarking them against a national midline.*	Benefits Acts by: Department, budget Not yet costed	2 Proceed 5 Caution 1 Reject	Examine benefits one by one rather than against a national midline.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
64 Waitlist before new arrivals access HCBS waivers ***Suggested wording reflecting members' notes:*** *Track the residency of people using state-only programs, such as Cover All Coloradans, if HCPF confirms this is allowed; no waitlist based on length of residence, which federal law does not allow.* **HCPF legal note:** Federal law bars denying eligibility because a person has not lived in the state for a set period. Waiver enrollment limits are allowed, but not based on length of residence (42 CFR 435.403(j)(1)).	Eligibility Acts by: Department, bill, CMS approval Not yet costed	5 Proceed 2 Caution 2 Reject	Is it federally allowable under current waivers? Take after **72b**.
109 Make enrolling and re-enrolling as easy as possible	Eligibility Acts by: Department Not yet costed	6 Proceed 2 Caution 0 Reject	No comments noted.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
13c Fund appeals capacity before H.R. 1 volume arrives ***Suggested wording reflecting members' notes:*** *Prepare state appeals capacity for the volume from six-month redeterminations and work requirements, reassigning existing staff first and adding funding only where needed.*	How the program is run Acts by: budget Costs money	2 Proceed 5 Caution 1 Reject	Cost; reassign existing staff before adding.
29 Raise disability buy-in premiums, phased and income-capped ***Suggested wording reflecting members' notes:*** *Phase in higher disability buy-in premiums, rather than reducing coverage, with realistic income thresholds that protect the lowest tiers and cap premiums as a share of income.*	Eligibility Acts by: Department, bill Stakeholder estimate only	4 Proceed 5 Caution 0 Reject	Income thresholds must be realistic; some members not ready to recommend.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
35 Continuous authorization and work-requirement safeguards ***Suggested wording reflecting members' notes:*** *Ask HCPF to explain how continuous authorization and an Arizona-style 30-day corrective period would work, then recommend reducing paperwork-driven disenrollment for people with non-reversible conditions.*	Eligibility Acts by: Department, bill, CMS approval Not yet costed	4 Proceed 5 Caution 0 Reject	More information on how it works.
36 NEMT rural classification and rates ***Suggested wording reflecting members' notes:*** *Correct non-emergency medical transportation rates for all rural and frontier counties, not only the southwest, after reviewing the effect of recent rate changes, with anti-fraud controls.*	Payment Acts by: Department, budget Cost neutral	1 Proceed 7 Caution 1 Reject	Address all of rural Colorado, not one county; see the effect of recent rate changes first.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
63 Raise the $2,000 long-term care asset limit ***Suggested wording reflecting members' notes:*** *Have HCPF cost raising the $2,000 LTC asset limit with a COLA, and fix the asset-limit and buy-in interaction that causes wrongful terminations.*	Eligibility Acts by: bill Costs money	1 Proceed 7 Caution 1 Reject	Cost.
74 Fix CHP+-to-Medicaid transitions ***Suggested wording reflecting members' notes:*** *Ask HCPF for more information on the CHP+-to-Medicaid transition and out-of-network commercial coverage for Medicaid-secondary members, then recommend fixes to align effective dates.*	Eligibility Acts by: Department Not yet costed	3 Proceed 4 Caution 0 Reject	More information.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
76 One redetermination a year for waiver members ***Suggested wording reflecting members' notes:*** *Align functional and financial eligibility dates for waiver members so each faces one redetermination a year, at no added cost, and clarify what happens when SSI or SSDI is lost but disability certification stands.*	Eligibility Acts by: Department, bill Not yet costed	4 Proceed 4 Caution 0 Reject	Cost-neutral; what happens when SSI or SSDI is lost.

Who is covered, and for which benefits (continued)

Docket line	What kind of change	Members	What members wrote
87 Sliding-scale parental fee for children on waivers or CFC ***Suggested wording reflecting members' notes:*** *Do not pursue a parental-income fee, which HCPF reports federal rules do not allow; instead ask HCPF to report any cost-sharing options for families of children on HCBS waivers or CFC that federal rules permit.* **HCPF legal note:** A parental-income fee conflicts with Social Security income rules for waiver children: Colorado is a Section 1634 state, and a child at institutional level of care is a household of one, so parental income cannot be counted. For children on Community First Choice only, federal rules bar premiums below 150% of the poverty level (42 CFR 447.55). HCPF tried this under FY18 R-8 and dropped it.	Eligibility Acts by: Department, bill, CMS approval Stakeholder estimate only	2 Proceed 5 Caution 1 Reject	How fee revenue counts under TABOR; needs analysis.

Short-term · Who is covered · for discussion

Who is covered, and for which benefits

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
65 State-only coverage for qualified immigrants losing federal match	0 Proceed 4 Caution 4 Reject	No comments noted.
75 Estate recovery review	2 Proceed 4 Caution 2 Reject	No comments noted.
122 Shared dashboard on coverage loss and access under H.R. 1	4 Proceed 2 Caution 3 Reject	No comments noted.

How the program is run, and how the state knows it is working

One vote to carry the consent-ready lines. Any member may pull a line; pulled lines are taken with the conditional lines.

Docket line	What kind of change	Proceed	Caution	Reject
2 Restructure HCPF to cut administrative cost	How the program is run	8	1	0
13b Technology modernization plan that draws the enhanced federal match	How the program is run	7	1	0
47 Consolidate HCPF IT systems	How the program is run	8	1	0
110 Disaggregate the Medical Services Premiums line	How the program is run	8	0	0
113 Prevent improper payments before they are made	How the program is run	8	1	0
114 Find other insurance before Medicaid pays	How the program is run	9	0	0

How the program is run, and how the state knows it is working (continued)

Docket line	What kind of change	Proceed	Caution	Reject
8 Streamline contracts, policy memos and rulemaking	How the program is run	7	2	0

How the program is run, and how the state knows it is working

Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
9 Report and reform recovery audits	How the program is run Acts by: Department, bill Cost neutral	5 Proceed 2 Caution 0 Reject	No comments noted.
16b Outlier list of service lines where dollars and users diverge ***Suggested wording reflecting members' notes:*** *Have HCPF produce a regularly updated list for the JBC of service lines where spending grows faster than the number of members using them.*	How the program is run Acts by: Department Cost neutral	6 Proceed 1 Caution 0 Reject	Explain the proposal.

How the program is run, and how the state knows it is working (continued)

Docket line	What kind of change	Members	What members wrote
15c National CMS quality measures in place of state-specific ones ***Suggested wording reflecting members' notes:*** *Compare Colorado's state-specific quality measures with national CMS measures, explain why the state measures exist, and move to national measures where they cover the same ground.*	How the program is run Acts by: Department Not yet costed	5 Proceed 2 Caution 1 Reject	How state measures compare, and why they exist.
16c Dynamic budgeting: track how cuts shift costs elsewhere ***Suggested wording reflecting members' notes:*** *Show how proposed lines compound or offset one another and who carries each, using 12 months of claims data, with HCPF proposing the method and tools.*	How the program is run Acts by: Department Cost neutral	5 Proceed 3 Caution 0 Reject	Agree in principle; method and tools.

How the program is run, and how the state knows it is working (continued)

Docket line	What kind of change	Members	What members wrote
17 Target reductions by acuity, not across the board ***Suggested wording reflecting members' notes:*** *Discuss the ramifications of structuring any reduction by acuity rather than across the board, and of multi-year and actuarial rate setting, before recommending it.*	Payment Acts by: Department, bill, budget Cost neutral	2 Proceed 5 Caution 1 Reject	Ramifications need discussion.
69 Member explanation of benefits; real-time insurance checks ***Suggested wording reflecting members' notes:*** *Have HCPF cost a member-facing explanation of benefits and real-time third-party-liability checks before recommending them.*	How the program is run Acts by: Department Cost neutral	2 Proceed 5 Caution 1 Reject	Cost.

How the program is run, and how the state knows it is working (continued)

Docket line	What kind of change	Members	What members wrote
70 Pilot policy changes before statewide rollout ***Suggested wording reflecting members' notes:*** *Pilot policy changes where federal authority allows or is obtained, and otherwise phase them in; publish a rule-change calendar, and space changes so each is absorbed before the next, recognizing immediate budget actions may not allow a pilot.* **HCPF legal note:** Pilots cannot override federal statewideness and comparability requirements without federal waiver authority (42 U.S.C. 1396a(a)(1), (a)(10)(B)).	How the program is run Acts by: Department, Medical Services Board Not yet costed	2 Proceed 6 Caution 1 Reject	When possible; immediate budget changes may not allow pilots.

How the program is run, and how the state knows it is working (continued)

Docket line	What kind of change	Members	What members wrote
80 Notice and justification before benefit or eligibility changes ***Suggested wording reflecting members' notes:*** *Before benefit reductions or eligibility changes take effect, provide 60–90 days' member notice and public input when possible, confirming what is already required so the recommendation adds only what is not.*	How the program is run Acts by: Department, Medical Services Board, bill Not yet costed	6 Proceed 3 Caution 0 Reject	May already be required; when possible.
120 "Gold card" prior authorization exemptions ***Suggested wording reflecting members' notes:*** *Pilot, in dental first, letting providers with consistently high prior-authorization approval rates skip prior authorization on those procedures, aligned with HB24-1149 for commercial carriers.*	How the program is run Acts by: Department, bill Not yet costed	3 Proceed 4 Caution 1 Reject	Align with commercial prior-authorization law; question whether it is a Commission priority.

How the program is run, and how the state knows it is working

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
13a Commission position on the HB26-1429 county transition	4 Proceed 2 Caution 1 Reject	No comments noted.

Managed care and the ACC

No line in this bucket is consent-ready. Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
111 Standardize RAE care coordination and member tiering ***Suggested wording reflecting members' notes:*** *Standardize core care coordination practices across the RAEs, based on the most successful RAEs, while allowing regional variation where urban and rural needs differ.*	How the program is run Acts by: Department Not yet costed	3 Proceed 5 Caution 0 Reject	One standard may not fit urban and rural regions.
5 Validate, then enforce, RAE medical loss ratios ***Suggested wording reflecting members' notes:*** *Independently validate RAE medical loss ratio reports with one reporting template and fixed definitions, and report why validation is not happening today; decide with line **83** what happens to recouped funds.*	Payment Acts by: Department, bill Stakeholder estimate only	4 Proceed 4 Caution 0 Reject	What is done today, and why validation isn't happening already; take with **83**.

Managed care and the ACC (continued)

Docket line	What kind of change	Members	What members wrote
6 One set of processes across the RAEs and BHASOs ***Suggested wording reflecting members' notes:*** *Standardize what providers and members touch across the RAEs and BHASOs – enrollment, credentialing, directory, prior authorization and continuity of care – phased as current systems can support it, with HCPF reporting what systems changes are needed.*	How the program is run Acts by: Department, bill Cost neutral	4 Proceed 4 Caution 0 Reject	Can current systems support it?
27 Incentives for integrated physical and behavioral health care	Payment Acts by: Department, CMS approval Stakeholder estimate only	5 Proceed 3 Caution 0 Reject	No comments noted.

Managed care and the ACC (continued)

Docket line	What kind of change	Members	What members wrote
45 Independent audit of behavioral health capitation ***Suggested wording reflecting members' notes:*** *Commission an independent audit that tests whether behavioral health capitation actually transfers financial risk to the RAEs or only reprices last year's costs, and report the results to the JBC.*	How the program is run Acts by: Department, bill Not yet costed	2 Proceed 6 Caution 0 Reject	Explain what the audit would test.
67 Community health centers as the medical home ***Suggested wording reflecting members' notes:*** *Ask HCPF to report how community health centers are used today as medical homes and for enrollment help, then recommend building on what works for redeterminations and work-requirement compliance.*	How the program is run Acts by: Department, budget Stakeholder estimate only	1 Proceed 6 Caution 1 Reject	Is this already happening? More information.

Managed care and the ACC (continued)

Docket line	What kind of change	Members	What members wrote
68 Scale EMS treatment-in-place and community paramedicine ***Suggested wording reflecting members' notes:*** *Using data from last session's EMS changes, report the savings from treatment-in-place and community paramedicine, and scale statewide where savings are shown.*	Benefits Acts by: Department, bill Stakeholder estimate only	2 Proceed 5 Caution 0 Reject	Use data from last session's EMS changes first; show savings.
83 Reinvest RAE surplus instead of remitting it ***Suggested wording reflecting members' notes:*** *Take with line **5**: where RAE surplus falls below the MLR floor, consider reinvesting it through a restricted account under a Department-approved plan instead of remitting it, since most recouped expansion funds return to the federal government.*	Payment Acts by: Department, bill Stakeholder estimate only	1 Proceed 6 Caution 1 Reject	Take with **5**.

Managed care and the ACC

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
71 Expand shared savings and alternative payment models	2 Proceed 4 Caution 2 Reject	No comments noted.
15b One or two statewide RAE quality priorities	0 Proceed 5 Caution 3 Reject	No comments noted.
44 Cut RAE capitation for avoidable events	0 Proceed 6 Caution 1 Reject	No comments noted.
119 Primary care investment	3 Proceed 3 Caution 2 Reject	No comments noted.

Short-term · Behavioral health · consent group

Behavioral health: who administers it, and where its funding sits

One vote to carry the consent-ready lines and set aside **41** (Any-willing-qualified-provider rule; RAE rate transparency). Any member may pull a line; pulled lines are taken with the conditional lines.

Docket line	What kind of change	Proceed	Caution	Reject
15d Review behavioral health pilot programs and small grants	How the program is run	7	1	0
22 Guardrails on peer and support services	Benefits	8	1	0
28 Outcome standards for pediatric behavioral therapy and ABA	Benefits	7	2	0
41 Any-willing-qualified-provider rule; RAE rate transparency	How the program is run	0	1	7

Seven or more Reject – set aside

Behavioral health: who administers it, and where its funding sits

Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
7b Pay for care coordination by member complexity ***Suggested wording reflecting members' notes:*** *Tier RAE care coordination by member complexity using one standard tiering method and risk adjustment across the RAEs, starting only when HCPF confirms it can be administered on time; publish cost per engaged member against other states.*	Payment Acts by: Department Not yet costed	3 Proceed 5 Caution 1 Reject	Can it be administered on time? Consider risk adjustment across RAEs and standard tiering.

Behavioral health: who administers it, and where its funding sits (continued)

Docket line	What kind of change	Members	What members wrote
25 Right-size residential SUD and withdrawal management ***Suggested wording reflecting members' notes:*** *Have BHA and HCPF report how many residential SUD beds the state needs, with the data behind it, and align withdrawal management with ASAM 4th edition; consider limiting participation only after that report.*	Benefits Acts by: Department Department figure	5 Proceed 4 Caution 0 Reject	Limited data; members want more detail.
46 CCBHC prospective payment; pause the 80% payment floor ***Suggested wording reflecting members' notes:*** *Move comprehensive safety net providers that can meet CCBHC standards to CCBHC prospective payment, with a separate path for those that cannot; confirm whether the 80% state-directed payment floor is already paused before acting on it.*	Payment Acts by: Department, CMS approval Department figure	1 Proceed 6 Caution 1 Reject	Not every CMHC can become a CCBHC; confirm whether the 80% floor is already paused.

Behavioral health: who administers it, and where its funding sits (continued)

Docket line	What kind of change	Members	What members wrote
81 Fix peer services billing (the alternative to line **22**) ***Suggested wording reflecting members' notes:*** *Take lines **22** and **81** together: fix peer services by splitting the billing code by setting and function, setting credentialing and supervision standards and acting on fraud reports, with any limits from line **22** applied only where those fixes fall short.*	Benefits Acts by: Department, bill Not yet costed	6 Proceed 3 Caution 0 Reject	Members are split on **22** versus **81** as the fix; take the two together.
82 Reconcile behavioral health federal match	Financing Acts by: Department, CMS approval Stakeholder estimate only	6 Proceed 2 Caution 0 Reject	No comments noted.

Behavioral health: who administers it, and where its funding sits (continued)

Docket line	What kind of change	Members	What members wrote
95 Tiered payment for comprehensive safety net providers ***Suggested wording reflecting members' notes:*** *Have HCPF cost a tiered payment method for comprehensive safety net providers, test it as a pilot, and protect rural and small providers in any design.*	Payment Acts by: Department, CMS approval Not yet costed	2 Proceed 6 Caution 1 Reject	Cost the tiered method first, perhaps as a pilot; protect rural and small providers.
116 Reform BHA licensing and network adequacy checks ***Suggested wording reflecting members' notes:*** *Ask the BHA to report how licensing site visits could measure quality of care rather than process, and how network adequacy reports would verify access, before recommending specific licensing changes.*	How the program is run Acts by: Department Not yet costed	3 Proceed 4 Caution 0 Reject	More information needed.

Behavioral health: who administers it, and where its funding sits (continued)

Docket line	What kind of change	Members	What members wrote
117 Allow utilization review of outpatient therapy after a set number of visits ***Suggested wording reflecting members' notes:*** *Allow clinical-appropriateness review of outpatient therapy above a visit threshold set by HCPF on clinical evidence – narrower than the Governor's R-06.I proposal to lift the prior-authorization ban outright – confirmed compliant with mental health parity, and designed so current treatment is not interrupted.*	Benefits Acts by: Department, bill Department figure	2 Proceed 7 Caution 0 Reject	Who sets the visit threshold, and on what basis; parity compliance; avoid disrupting care.
118 Consistent safety-net cost definitions and earlier rates	Payment Acts by: Department Stakeholder estimate only	4 Proceed 4 Caution 0 Reject	No comments noted.

Short-term · Behavioral health · for discussion

Behavioral health: who administers it, and where its funding sits

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
26 Review crisis services; site-neutral behavioral health pricing	6 Proceed 0 Caution 3 Reject	No comments noted.
42 Behavioral health rate floor and notice before cuts	0 Proceed 6 Caution 3 Reject	No comments noted.
123 Let behavioral health providers limit their Medicaid caseload	1 Proceed 3 Caution 3 Reject	No comments noted.

Long-term services and supports: design and governance

One vote to carry the consent-ready lines and set aside **93** (Restore LTSS access and rates before further cuts). Any member may pull a line; pulled lines are taken with the conditional lines.

Docket line	What kind of change	Proceed	Caution	Reject
23 LTSS program-integrity package for CFC	How the program is run	7	2	0
93 Restore LTSS access and rates before further cuts	Benefits	0	0	9

Seven or more Reject – set aside

Long-term services and supports: design and governance

Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
60 Re-examine CES waiver eligibility ***Suggested wording reflecting members' notes:*** *Re-examine CES waiver eligibility, including the validity of the evaluator tool, and give aging caregivers priority for adult DD waiver slots, with implementation details worked out by HCPF and stakeholders.*	Eligibility Acts by: Department Not yet costed	4 Proceed 4 Caution 0 Reject	Implementation detail.
30 Limit intermediary agency retention; protect caregiver pay	Payment Acts by: Department, Medical Services Board, bill Not yet costed	6 Proceed 3 Caution 0 Reject	No comments noted.

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
37 Family-caregiver plan; structured family caregiving ***Suggested wording reflecting members' notes:*** *Develop a family-caregiver plan that compares structured family caregiving and a consumer-directed W-2 option for family caregivers outside agencies, with costs and supports for consumer direction.*	Benefits Acts by: Department, CMS approval Stakeholder estimate only	5 Proceed 2 Caution 1 Reject	Flesh out both approaches; W-2 status for family caregivers outside agencies; support for consumer direction.
38 Redesign or reverse PETI on the DD waiver ***Suggested wording reflecting members' notes:*** *Redesign PETI across all waivers, not only the DD waiver, so it is applied equitably, using other states' practice and an income-based sliding scale.*	Eligibility Acts by: Department, budget Costs money	3 Proceed 5 Caution 1 Reject	Redesign PETI across all waivers, not only DD; apply it equitably; use other states' practice.

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
58 Expand family CNA tasks; a state pathway for pediatric PDN ***Suggested wording reflecting members' notes:*** *Evaluate expanding delegable skilled tasks for family CNAs and a PDN-specific state pathway, with a fiscal estimate, safety safeguards for unsupervised tasks and other states' experience, before adoption.*	Benefits Acts by: Department, Medical Services Board, CMS approval Not yet costed	0 Proceed 8 Caution 1 Reject	Fiscal impact; safety of expanding unsupervised CNA tasks; other states' experience.
59 Decide the Colorado Single Assessment and support-level algorithm ***Suggested wording reflecting members' notes:*** *Publish the Colorado Single Assessment instrument and pilot results before go-live, and report options – including a case-manager services guide – before any acuity-based reduction.*	Benefits Acts by: Department Not yet costed	2 Proceed 5 Caution 0 Reject	Support for parts; more information.

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
61 LTSS exception and appeal reform ***Suggested wording reflecting members' notes:*** *Ask HCPF to report how LTSS exceptions and appeals work today, how often assessments differ from authorizations and what appeals cost, before recommending specific reforms.*	How the program is run Acts by: Department, bill Not yet costed	2 Proceed 6 Caution 0 Reject	More information.
62 Case management agency choice and performance contracts ***Suggested wording reflecting members' notes:*** *Ask HCPF to report on case management agency performance and the time study behind CMA rates, then recommend member choice or performance-based contracts based on what it shows.*	How the program is run Acts by: Department, bill Not yet costed	2 Proceed 6 Caution 0 Reject	More information.

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
66 Housing as a Medicaid cost lever ***Suggested wording reflecting members' notes:*** *Clarify with HCPF what happens to housing supports when the 1115 demonstration ends December 31st, 2026, and cost options for supportive housing for high utilizers before recommending an extension.*	Benefits Acts by: Department, CMS approval Department figure	2 Proceed 6 Caution 0 Reject	Could be costly; clarify whether this extends the demonstration or reflects its end.
79 Connect case management to claims to see total hours ***Suggested wording reflecting members' notes:*** *Connect case management and claims systems so overlapping LTSS hours are flagged before payment, as IT systems can support it, with HCPF reporting the systems changes and timeline needed.*	How the program is run Acts by: Department Not yet costed	6 Proceed 2 Caution 0 Reject	Can IT systems support it?

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
84 Cap homemaker hours; pause the children's Community Connector ***Suggested wording reflecting members' notes:*** *Consider limits on homemaker services and a pause of the children's Community Connector benefit only after reviewing the effect on families and on care.*	Benefits Acts by: Department, budget, CMS approval Not yet costed	4 Proceed 5 Caution 0 Reject	Effect on families and on care.
86 Home health episode limits and an R-15 report-back ***Suggested wording reflecting members' notes:*** *Ask HCPF why the earlier rule on back-to-back home health episodes was withdrawn, and require a JBC update before January 2027 on the pending R-15 home-care changes.*	Benefits Acts by: Department, budget Stakeholder estimate only	2 Proceed 5 Caution 0 Reject	Why the earlier rule was withdrawn.

Long-term services and supports: design and governance (continued)

Docket line	What kind of change	Members	What members wrote
89 Cap paid parent hours per child ***Suggested wording reflecting members' notes:*** *Discuss capping total paid hours from legally responsible persons at 56 a week per child, read with line **39**.*	Benefits Acts by: Department, Medical Services Board, CMS approval Not yet costed	1 Proceed 6 Caution 1 Reject	Open to discussion.
124 Standards for group care of medically fragile children ***Suggested wording reflecting members' notes:*** *Require an HCPF evaluation, including cost, when five or more unrelated medically fragile children routinely receive care in one residence, without classifying biological, adoptive or foster families as group homes.*	Payment Acts by: Department, bill Not yet costed	4 Proceed 4 Caution 0 Reject	Cost.

Long-term services and supports: design and governance

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
39 Hold the weekly caregiver-hour cap until failures are measured	2 Proceed 4 Caution 3 Reject	No comments noted.
57 Evaluate CFC net of shifted services before further cuts	3 Proceed 1 Caution 3 Reject	No comments noted.
77 Remove the Class B license requirement for non-medical CFC services	2 Proceed 4 Caution 1 Reject	No comments noted.
91 Fix authorization before cutting LTSS	2 Proceed 3 Caution 2 Reject	No comments noted.

Short-term · Financing · consent group

Financing beyond the general fund

One vote to carry the consent-ready lines. Any member may pull a line; pulled lines are taken with the conditional lines.

Docket line	What kind of change	Proceed	Caution	Reject
1 Enroll eligible members in Medicare	Financing	9	0	0
4 Claim federal match on state-only spending	Financing	9	0	0
24 Pharmacy cost measures	Benefits	8	0	0
3 Preserve the hospital upper payment limit federal draw	Financing	9	0	0

Suggested wording reflecting members' notes: *Ask HCPF to keep working with the Colorado Hospital Association and hospitals, prospectively, on a hospital upper payment limit methodology that maximizes federal funds, and to report the amount CMS will approve; if a larger limit triggers the provider-fee hierarchy, amend the hierarchy so payment-limit room does not pull fee revenue from coverage (line **11**).*

Short-term · Financing · conditional

Financing beyond the general fund

Conditional lines, one at a time: confirm the conditions – who acts, what must be shown, by when – then vote with them attached.

Docket line	What kind of change	Members	What members wrote
55 Changes to the Rural Health Transformation Program ***Suggested wording reflecting members' notes:*** *Confirm how much RHTP principal the federal government allows to be used as a revolving loan fund, design repayment terms rural hospitals can meet, and remove state-added restrictions beyond federal law.*	Financing Acts by: Department, bill Not yet costed	6 Proceed 2 Caution 1 Reject	How much the federal government will allow; rural hospitals may be unable to repay a revolving loan.

Financing beyond the general fund

Lines for discussion: is there a version that gets to seven – narrower scope, a pilot, a study first? If not, record a minority position, defer or set aside.

Docket line	Members	What members wrote
10 Expand program-integrity extrapolation; targeted prepayment review	2 Proceed 3 Caution 3 Reject	No comments noted.
49 Administrative claiming for local public health	0 Proceed 4 Caution 4 Reject	No comments noted.

Financing beyond the general fund (continued)

Docket line	Members	What members wrote
53 ABLE-account reimbursement of HCBS costs ***Suggested wording reflecting members' notes:*** *Add to the Commission's requests to Colorado's congressional delegation: amend federal law to allow voluntary ABLE-account reimbursement of HCBS costs, split between the federal and state shares.* **HCPF legal note:** Not allowed under current federal law: Congress would need to amend the ABLE and Medicaid statutes, and any reimbursement would be split between the federal and state shares (26 U.S.C. 529A; 42 U.S.C. 1396p).	1 Proceed 5 Caution 3 Reject	No comments noted.
54 Require commercial coverage of services shifted to Medicaid	0 Proceed 4 Caution 5 Reject	No comments noted.
126 Durable medical equipment purchasing	0 Proceed 5 Caution 2 Reject	No comments noted.

Report back, and the road to December 11th

Today

SHG reads back every vote: lines carried with their conditions, lines set aside, and minority positions. Members correct the record in the room.

November 18th

Lines not reached today. What the carried set adds up to, short and long term. [Other items – confirm.]

December 11th

Legislation-ready recommendations, each naming who is responsible, how success is measured, how results are reported, and milestones for course correction.

Public comment

Two minutes each. Written comments can also be submitted to the Commission.

Appendix (if needed)

Each item, and how members marked the related docket lines

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
A	Cuts HCPF operating spending 4% – travel, training and hardware.	−150 TF −450	Line **2** – Restructure HCPF to cut administrative cost	8	1	0
			Line **8** – Streamline contracts, policy memos and rulemaking	7	2	0
B	Cancels or trims contracts and deliverables state and federal law do not require – one piece of docket line **2**.	−1,180 TF −2,070	Line **2** – Restructure HCPF to cut administrative cost	8	1	0
C	Trims claims-system operating spending about 4% for two years, then restores it; the system draws a 75–90% federal match.	−1,480 TF −5,830	Line **13b** – Technology modernization plan that draws the enhanced federal match	7	1	0
			Line **47** – Consolidate HCPF IT systems	8	1	0

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
D	Delays four CHP+ health services initiatives (home visiting, safety supplies, Reach Out and Read, food pantries) to FY 2028-29. *Needs a bill.*	−3,470 TF −9,930	None	–	–	–
E	Sets All Payer Claims Database funding to current cost, shifts more to other funds, then cuts the contract 25%.	−1,090 TF −1,520	None	–	–	–
F	Reduces six line items that have underspent; no change to programs.	−550 TF −1,760	Line **110** – Disaggregate the Medical Services Premiums line	8	0	0
			Line **14** – Reconcile fiscal-note savings with actual results	7	1	1

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
G	Cuts the RAE per-member care management payment 4% from March 2027 and halves the ACC incentive program.	−11,300 TF −33,000	Line **90** – End or limit ACC primary care case management payments	1	6	2
			Line **7a** – Consolidate care coordination	6	3	0
			Line **7b** – Pay for care coordination by member complexity	3	5	1
			Line **111** – Standardize RAE care coordination and member tiering	3	5	0
			Line **19** – Reduce the number of RAEs and BHASOs	2	5	2

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
H	Ends the maternity bundled payment and the Prescriber Tool payment model, saving the administering contract.	−80 TF −200	Line **71** – Expand shared savings and alternative payment models	2	4	2
			Line **108** – Pay for outcomes: more value-based purchasing	3	5	0

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
I	Reinstates prior authorization for outpatient psychotherapy at 13, 25, 37 and 48 visits, at each RAE's discretion; needs a bill. *Needs a bill.*	−14,500 TF −65,000	Line **117** – Allow utilization review of outpatient therapy after a set number of visits	2	7	0
			Line **112** – Repeal post-2019 benefit additions and utilization-management limits	1	6	1
			Line **120** – “Gold card” prior authorization exemptions	3	4	1

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
J	Limits stand-alone billing of peer, skills training and case management to safety net providers and FQHCs; elsewhere paid only inside programs.	−37,800 TF −169,100	Line **22** – Guardrails on peer and support services	8	1	0
			Line **81** – Fix peer services billing (the alternative to line **22**)	6	3	0
			Line **95** – Tiered payment for comprehensive safety net providers	2	6	1

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
K	Ends the Behavioral Health Incentive Program, which pays RAEs for engagement, follow-up and screening results.	−18,600 TF −78,800	Line **15b** – One or two statewide RAE quality priorities	0	5	3
			Line **108** – Pay for outcomes: more value-based purchasing	3	5	0
			Line **27** – Incentives for integrated physical and behavioral health care	5	3	0
L	Cuts the teaching-hospital add-on 80% and ends separate graduate medical education payments in managed care. *Needs a bill.*	−25,400 TF −87,700	None	–	–	–

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
M	Ends Cover All Coloradans for children from January 2028 (emergency-only after); savings matched into the Primary Care Fund. *Needs a bill.*	−10,100 TF +2,120	Line **33** – Put CHIP, Cover All Coloradans and eligibility levels on the docket by name	1	2	4
			Line **107** – Guiding principle: cover as many people as possible	6	1	2
			Line **65** – State-only coverage for qualified immigrants losing federal match	0	4	4

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
N	Ends optional adult dental except emergencies from July 2027; $10M TF to safety-net dental clinics. *Needs a bill.*	−39,800 TF −214,800	Line **32** – Benchmark optional benefits against the national midline	2	5	1
			Line **34** – Cap expansion-population benefits at the federal minimum	1	2	5
			Line **112** – Repeal post-2019 benefit additions and utilization-management limits	1	6	1
O	Ends acute home health physical, occupational and speech therapy for adults 21+; outpatient therapy remains. *Needs a bill.*	−840 TF −2,900	Line **86** – Home health episode limits and an R-15 report-back	2	5	0

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
P	Ends the Children's Hospital specialty payment, the Senior Dental grant program and SBIRT training grants.	−6,810 TF −16,670	Line **15d** – Review behavioral health pilot programs and small grants	7	1	0
			Line **15a** – An outcome measure for every program, with a wind-down rule	2	6	0

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.

Each item, and how members marked the related docket lines (continued)

	What it does	GF ($K)	Docket line	Proceed	Caution	Reject
Q	Raises primary care rates in primary care practices; same services elsewhere set at 80% of Medicare.	+6,900 TF +22,900	Line **119** – Primary care investment	3	3	2
			Line **17** – Target reductions by acuity, not across the board	2	5	1
			Line **67** – Community health centers as the medical home	1	6	1
			Line **108** – Pay for outcomes: more value-based purchasing	3	5	0
R	Raises the school health services federal withhold from 2.5% to 10% and uses the increase to offset GF. *Needs a bill.*	−7,330 TF 0	None	–	–	–

Dollars in thousands, FY 2027-28; negative is a reduction. Proceed, Caution, Reject: members marking each docket line (9 of 10 responded). Source: SHG crosswalk, Nov 3rd, 2026.