

Colorado Commission on Medicaid

Docket – what the Commission has heard, for first reading on October 7

Prepared by SHG Advisors – October 6, 2026, v3.8.

How to read this

These are all the things the Commission has heard that would decrease costs or offer more value in terms of health and safety. Every line comes from the Commission’s own record (i.e., its meetings since June, the Department’s packets and fact sheets, panels, office hours, the survey, community meetings, and written testimony and public comment). None is SHG’s recommendation. The list exists so the Commission can react rather than generate.

Lines are numbered only so the room can refer to them. The number carries no meaning and never changes once published.

The dollar column is an anchor, not a costing. It is the figure the record already contains that says what is at stake on that line – the current spend, the Department’s own estimate, or a stakeholder’s estimate marked as such. Where the Department has not costed the item, the column says so and names the figure that would settle it. Amounts are general fund at the state share unless marked TF (total funds).

Lanes: Bill (statute), Budget (JBC or the Governor’s request), Department (HCPF or the Medical Services Board under existing authority), Federal (needs CMS), Oversight (reporting, transparency, audit). Horizon: Now (this fiscal year, existing authority), Session (2027), Structural (multi-year).

What October 7th Brings: A first pass, not a vote: for each line, does the Commission want to *explore it further, set it aside with no further discussion, or get more information* before deciding? SHG records the answer and what information is wanted. Lines marked “explore further” and “more information” are the agenda for the November meetings, with the Department’s costing and the requested material in hand. Counting toward the report’s recommendations happens in November, when the two meetings follow the election. A line that does not reach a majority in November is recorded as a minority position with its supporters’ reasoning, published and available to anyone who wants to carry it.

Within Parts 1 and 2, lines are ranked by one criterion: what can be acted on immediately and will produce general fund savings soonest. Tier A – existing authority, saving lands in FY26-27 or FY27-28. Tier B – can start now, saving is indirect, later, or not yet costed. Tier C – needs statute or CMS, so the earliest effect is the 2027 session or later, however large the number. Two lines in Part 2 are protections that cost money rather than save it; they sit last on this criterion and nowhere else. The ranking is a reading order, not a judgment on merit. Lines marked † are contested on the facts or carry a figure that conflicts with another in the record.

Part 3 is everything else the record produced before September 24, carried by number. Part 4 is what has been added since. Members may move any of it up.

Two horizons: long-term direction and short-term action

The tables that follow rank lines by how soon they could act. This page reads the same 96 lines the other way: six long-term questions the Commission’s record keeps returning to and, beside each, the short-term lines in the same area. Several short-term lines make sense under one long-term answer and not another – enforcing RAE loss ratios (5) matters less if behavioral health managed care ends (92), and the CFC package (23) reads differently if CFC is sunset (88) – so the working session takes the long-term questions first, then the short-term lines that fit the answer.

Long-term question	Long-term lines	Short-term lines in the same area
Who administers behavioral health, and where its funding sits	7, 18, 73, 94, 96	22, 25, 26, 28, 41, 42, 46, 81, 82, 95
Whether Medicaid keeps managed care and the ACC in their current form	19, 43, 90, 92	5, 6, 27, 44, 45, 67, 68, 71, 83
How long-term services and supports are designed and governed	31, 48, 78, 88	23, 30, 37, 38, 39, 57, 58, 59, 60, 61, 62, 66, 77, 79, 84, 86, 89, 91, 93
What the program's financing base is, beyond the general fund	11, 20, 21, 50, 51, 52, 56, 72	1, 3, 4, 10, 24, 49, 53, 54, 55
Who is covered, and for which benefits	33, 34, 85	12, 29, 32, 35, 36, 63, 64, 65, 74, 75, 76, 87
How the state knows whether a program is working	14, 15, 16, 40	2, 8, 9, 13, 17, 47, 69, 70, 80

Every line appears once. The grouping is a reading aid prepared by SHG, not a judgment on any line, and the long-term questions are the record's, not the Commission's decisions; members may move any line or reframe any question. Lines the Commission marks to explore further are summed on November's "how it adds up" page in short-term and long-term columns.

Part 1 – Structure: administration, contracts, partners, oversight, financing, integrity

No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
1	Department · Now	Proactively identify and enroll dual-eligible members already over 65 and those with qualifying conditions, not only those turning 65 or with end-stage renal disease; include Disabled Adult Child SSDI claiming for waiver members; use the RAE and MCO lists the Department now proposes, plus the health information exchange feed, to find them.	HCPF; RAEs and MCOs	HCPF (Oct 2): 5,978 members over 65 without Medicare, of whom 3,353 are immigrants under the five-year bar (mostly emergency-only coverage) and 2,625 may be eligible and unenrolled; 1,265 members with ESRD not on Medicare, whom HCPF believes dialysis providers enroll. No savings figure given; Medicare coverage of all duals avoids about \$1B a year. HCPF says it cannot apply on a member's behalf and will send lists to RAEs/MCOs and run outreach at year-end. The Disabled Adult Child pathway was not analyzed. Duals are 8.6% of Colorado Medicaid against a 10.8% national median (NCSL).	A – Existing authority and already moving; the population is smaller than the record implied, so the dollars are modest.
2	Department · Now	Restructure HCPF to reduce administrative cost: consolidate the ten offices (eight created by delegated authority since FY19) into an administration / program / operations structure; publish every office and program with dollars and FTE attached; count contractor administration in the reported admin rate; end non-mandated contract deliverables identified in the Department's own	HCPF Executive Director (existing authority); incoming administration; JBC; General Assembly if offices are placed in statute	Administration \$778M TF / \$192M GF budgeted FY26-27, up from \$603.5M TF; 1,047 authorized FTE, \$90.1M salaries; "General Professional Services" \$56.6M and "Personal Services" \$81.7M (832.6 FTE) lines FY26-27. The Department imposed a hiring, compensation and travel freeze September 21 through at least December 31 (EDD-2026-1); savings not stated.	A – Existing authority; the Department has started with a freeze and offered to help draft the rest.

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		review; show that administrative savings are exhausted before any coverage or service reduction, and apply any percentage reduction taken from provider rates to the Department, its contractors and the RAEs as well.		Classified staff 662 (June 2022) → 876 (June 2025) (State Workforce Reports); an outside analysis puts FTE growth at 72% 2018–24 against 7.6% enrollment growth (to verify). HCPF’s director: the ten-office structure “is not the most efficient” (Aug 5). Saving not costed. †	
3	Federal / Bill · Now	Preserve the higher federal draw under the hospital upper payment limit: file the per-diem demonstration the hospitals describe (a templated worksheet, no statute or CHASE Board notice, retroactive to October 1, 2025), or, if the Department’s reading is right that a larger UPL triggers the provider-fee hierarchy, amend the hierarchy so UPL room does not pull fee revenue from coverage (line 11).	HCPF; CMS; General Assembly and CHASE Board if the hierarchy must change	Two figures are in the record: up to \$569M additional federal (Denver Health memo, Sept 8) and about \$270M in additional net annual hospital payments (HCPF, Oct 2), which may describe different proposals. HCPF declined the hospitals’ methodology change because it would create ~\$270M of unfunded UPL room that, under the hierarchy, must be filled before fee revenue supports coverage for ~438,000 people, and because the IGT financing was neither sufficient nor permanent; it says it will keep exploring a path “with stakeholders and the General Assembly.” The memo’s specific claims – templated filing, no notice required, retroactivity – are not addressed. †	A/C – The largest near-term federal draw; now a hierarchy question as much as a filing.
4	Department · Now	Claim federal match on general-fund dollars now paying for Medicaid-eligible services: the H.R. 1 waiver pathway for state-only IDD services; a State Plan Amendment for behavioral health safety-net services; Medicaid administrative claiming and certified public expenditures for local public health and county mill-levy dollars; and a review of all ten state-only programs for refinancing. See line 82 for the behavioral health match reconciliation.	HCPF; CMS	State-only IDD \$21.3M GF, ~\$10M returnable (HCPF, Sept 17); BH safety-net SPA \$25–35M/yr federal (provider association estimate); state-only programs \$115.1M GF FY26-27 (HCPF inventory); school-based claiming already returns \$2.75–6.23M/yr (NCSL). The State Auditor has approved a scoping report on whether the behavioral health financing model maximizes federal match (provider association; to confirm).	A/B – Department-initiated; each pathway is a filing, not a bill.
5	Department · Now	Get accurate RAE medical loss ratios, then enforce them. First, independently validate the loss-ratio reports the RAEs have submitted – by the State Auditor or an outside actuary – and set one reporting template with fixed definitions of what counts as care (utilization-management staff, subcontractor and related-party margin, risk-corridor returns), with an officer’s attestation and validated results published by entity. Then, on validated figures: remittance with penalty when a RAE misses the floor; hold the floor at 89% unless the quality metrics that lower it to 85% are named and met; score loss ratios by population cohort; spend the SUD risk-corridor allocation rather	HCPF (contracts and template); General Assembly for the audit and publication requirement (a discussion draft exists); the State Auditor or an outside actuary for validation	BH capitation \$1.567B TF / \$375M GF FY25-26; PMPM \$97 → \$171 projected FY28-29 on flat caseload (HCPF). Provider-coalition analysis of the RAEs’ submitted filings, whose accuracy is in question – illustrative until the filings are validated: ~\$59M gap in one year across five regions; \$46.6M risk-corridor returned in SFY23 with ~\$31.9M federal lost; four quality points “worth about \$24.5M”; \$10.2M shown as owed on two filers’ own forms with no record of payment; cohort MLRs of 71–83%. Nine states publish entity-specific MLR annually; none monthly. Care-management PMPM \$149.1M	B – Validation first, under existing authority and contract; recoveries follow only on validated figures.

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		than return it; tie part of the quality bonus to actual care spend; cap care-management margin and raise the PCMP pass-through floor. Line 83 is the alternative to remittance; line 45 is the related audit of capitation itself.		FY24-25, 43% passed to practices, 9.2% margin (HCPF). The Department’s written response is due in the packet. †	
6	Department · Now	Standardize what providers and members touch across the four RAEs and the BHASOs: one enrollment and credentialing process and portal, one verified provider directory, one prior-authorization standard, shared call centers and complaint lines, single case agreements and continuity of care when a member’s RAE changes or a contract ends, notice to members and providers before any reassignment, and a recoupment look-back no longer than the window in which a provider can still bill the other payer.	HCPF and BHA (contracts); General Assembly to close the 2023 recoupment law’s exception	Cost neutral to saving. HCPF’s own overlap list names call centers, credentialing, directories and complaint lines as “opportunities to explore” (Aug 5). Community meetings: 17 clients at one practice lost continuity in a day when a RAE declined single case agreements; reassignment cut payment ~\$20 a client; one RAE recouping to 2021 for other coverage found later; experiences differ sharply by RAE. Providers lose ~18% of Medicaid revenue to denials and delays nationally (Milbank). A behavioral health coalition of providers, payers and consumer advocates also proposes a single credentialing entity for RAE networks (written submission, October 5).	B – Contract amendment; saving is provider and Department time, then dollars.
7	Department · Structural	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; match intensity to complexity rather than paying across the whole population; stop paying for coordination HCBS providers already carry in their rate; give providers a channel into RAE care coordination; publish cost per engaged member against other states. Alternative proposed (written submission, October 5): complete the 2020 Blueprint’s transfer of individualized care coordination from the BHA to the BHASOs, scaled to need, and return funding not needed for an essential function to the general fund.	HCPF; General Assembly if BHA functions move	HCPF baseline (Oct 2), FY25-26: \$113.4M spent, 4.7% of MCE revenue, \$7.66 PMPM overall and \$79.28 PMPM for Tier 3; 611,369 engagements; 142,912 members with at least one (about \$793 per engaged member, \$185 per engagement); 45,739 Tier 3 care plans; delivered 44% by MCE staff, 54% by contracted providers, 2% by community organizations. No performance targets set; first evaluation 2027. Baseline outcomes: 9.4% 30-day readmission, 10.5% ED visit within 7 days, 67.3% follow-up within 30 days. No other-state comparison provided. The alternative comes from a behavioral health coalition of providers, payers and consumer advocates whose members include a RAE and a BHASO.	B – Begins under existing authority; full saving is structural.
8	Department · Now	Consolidate duplicative standard terms across vendor contracts and publish a renewal calendar; set a net-reduction target for policy memoranda and publish one indexed manual; require rulemaking rather than “policy by memo” for changes that remove or reprice a benefit, with notice before billing-manual changes; refer memos and billing manuals to the Office of	HCPF, with DPA; Medical Services Board; OLLS	Cost neutral; 116 memoranda in 2025 (65 affecting case management agencies), 66 by early September 2026, plus a 463-page rule volume and 92 job aids (provider and CMA counts). Example cited: 90-minute family-therapy encounters removed from the behavioral health manual in October 2025 without notice.	B – Cost neutral now; reduces vendor risk and staff time.

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		Legislative Legal Services for review under the Administrative Procedure Act.			
9	Oversight · Now	Transmit the recovery forecast and five years of recoveries by category to the JBC and the Commission on a standing basis; reform the recovery-audit contract so the contractor is paid on substantiated findings; commission State Auditor performance audits of the Department's largest vendor contracts; publish where recovered dollars go and what detection costs against what it recovers.	HCPF; State Auditor; General Assembly	HCPF (Oct 2) delivered five years by category. RAC recovered \$55.1M in FY23-24, \$10.6M in FY24-25 and \$11.0M in FY25-26; internal audits fell from \$14.3M to \$2.2M; recoveries excluding third-party liability fell from about \$66M to about \$18M while TPL rose to \$152M. The RAC report goes to the JBC November 1; a standing transmittal is not yet committed. Earlier anchor of "\$4–5M a year" for RAC was wrong.	B – Cost neutral; the decline in audit recoveries is the question for the room.
10	Bill · Session	Expand program-integrity extrapolation authority beyond pharmacy, non-emergency transportation and pediatric behavioral therapy (HB26-1412), and replace blanket program-wide limits with provider-specific prepayment review when a small number of providers bill inappropriately.	General Assembly; HCPF	HCPF (Oct 2) projects, under existing authority, FY26-27 recoveries and cost savings of \$36.2M TF / \$18.1M GF from prepayment review, \$13.7M TF / \$6.9M GF from HB26-1412 extrapolation (12 PBT providers, \$60M at-risk pool), and \$11.1M TF / \$5.6M GF from claim-by-claim reviews – about \$30.5M GF; FY27-28 \$33.9M TF plus extrapolation not yet estimated; NEMT extrapolation begins first quarter 2027. Cost avoidance FY25-26: \$152M TPL recoveries, \$93M TPL avoidance, \$1.77B Medicare buy-in.	C – Statute for the expansion; the Department's own forecast is the floor.
11	Bill · Session	Amend the CHASE funding hierarchy so the expansion population is not the sole absorber of provider-fee reductions, with rural and frontier hospitals held harmless as the fee ratchets down; read with line 3.	General Assembly; CHASE Board	First H.R. 1 half-point step (Oct 2027): ~\$121M in lost fees, ~\$1.1B in lost federal funds against ~\$4.1B expansion spending; replacing all fee-funded expansion state share with GF ≈ \$740M (HCPF, Sept 2). State-directed payments: \$279M in IGTs drew \$446M federal for \$725M in CHASE payments FY25-26, falling about 10% a year (~\$71.6M) from FY27-28 (Legislative Council Staff). Colorado's expansion share of enrollment is 43.7% against a 34.2% median, at \$5,860 per capita against \$8,086 (NCSL Scorecard). 11 rural hospitals at risk (Rural Futures). Modeling due before Nov 1.	C – Statute; the largest line, but the trigger hits FY27-28.
12	Bill · Session	Member cost sharing as an alternative to coverage reduction if the CHASE trigger hits.	General Assembly	Returns state share directly; federal limits apply. H.R. 1 §71120 requires cost sharing above \$0 and up to \$35 a service for expansion adults at 100–138% FPL from October 2028, exempting primary care, behavioral health and FQHC/RHC services. Collection experience elsewhere is poor: Michigan collected 26% of	C – Statute and federal limits; pairs with 11.

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				premiums charged; Arizona spent \$15.8M to collect \$5.6M (NCSL, citing KFF). Copay removal (2023) is on HCPF's own list of cost drivers. Not costed. A related proposal heard in October – sliding-scale premiums for all members – is limited by federal rules that bar premiums at or below 150% FPL (42 CFR 447.55) and cap premiums and cost sharing together at 5% of family income (42 CFR 447.56).	
13	Oversight · Session	Take a Commission position on the HB26-1429 county-administration transition before the January 1, 2027 plan reaches the JBC: modular, multi-state IT platforms rather than further proprietary builds; enhanced federal IT match claimed; county readiness and data-matching for six-month redeterminations and work requirements so members are verified without paperwork; appeals capacity funded before volume arrives.	General Assembly; HCPF, CDHS, CDEC and counties (the 1429 work group)	County administration and IT ≈ 55% of \$778M TF admin ≈ \$430M TF (HCPF). CBMS \$97M TF / \$12.8M GF; system integrator \$389M over its term; one county processes a case ~4x faster than another (Aug 11). Appeals (HCPF, Oct 2): 2,028 pending over 90 days in July, about half delayed by the member; volume up 49% to 3,577 in FY25-26; expedited requests 119 (2019) → 610 (through Aug 10, 2026); work requirements reach ~377,283 members and a 1% appeal rate alone doubles the caseload; resources to come through supplementals. Eligibility-system changes draw 90% federal match.	C – Session; shapes county cost from 2027 onward.
14	Oversight · Session	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.	General Assembly (budget note or statute); HCPF and JBC staff produce	CFC: \$873M TF budgeted FY25-26, \$1.016B actual for 43,728 members (HCPF, per family advocates); \$43M GF savings promised, now \$75M over – a \$118M swing (HCPF, Sept 17). HB21-1021: fiscal note ~\$35,000; peer and support services now \$293M TF. CMA appeal packet \$531.60 and hearing \$490.97 per appealed denial; at least 240 denials as of July 2026 (HCPF slides, per family advocate).	C – No direct saving; disciplines every future estimate.
15	Oversight · Session	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; replace the multi-measure RAE quality program with one or two statewide priorities sustained for several years; replace state-specific hospital and provider quality measures with national CMS measures providers already report. Begin with behavioral health pilot programs and small grants, judged on outcomes, client satisfaction, sustainability, administrative burden and duplication;	General Assembly; HCPF publishes	Peer and support services \$293M TF with no published outcome; care coordination \$113.4M with no performance targets yet (HCPF, Oct 2); \$411.8M in RAE quality incentives paid over seven years, about half of what was available (HCPF). The Department's H.R. 1 outreach measures are reach and engagement, not outcomes, by its own description. Not costed – savings depend on what fails the test. Office hours (October 5) cautioned that practice-level outcome measures, including the child core set, absorb practice-support time in reporting	C – Session; saving depends on what fails the test.

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		a behavioral health coalition offers to help with the review (written submission, October 5).		rather than care – most practice coaching time was described as spent on getting the metrics right – and that some adolescent services are billed outside Medicaid for confidentiality, so they never appear in the measure.	
16	Oversight · Now	Publish the actuarial assumptions and confidence intervals behind every Medicaid forecast and fiscal note on a standing dashboard; build service-category forecasting with the all-payer claims database as an independent check; produce a normalized outlier list of service lines where dollars and utilizers diverge; show how proposed lines compound or offset one another and who carries each. Add dynamic budgeting: track how a cut or limit in one benefit shifts cost to another, using 12 months of claims data (office hours, October 5).	HCPF, with OSPB and JBC staff; CIVHC under existing contract	Cost neutral. Anchor for why: \$157.9M FY25-26 over expenditure; FY26-27 forecast revised +\$703M GF; FY27-28 +\$417M (OSPB). Adult dental \$236M → \$432M with 6,000 fewer utilizers (HCPF). Kentucky and Nevada models (NCSL).	B – Cost neutral; transparency, not savings.
17	Budget · Session	Structure any reduction so it is not across-the-board: segment services by acuity and apply a budget-neutrality factor to the least-acute tier rather than a uniform percentage; move LTSS facility, PACE and adult-day rate setting to a multi-year basis; replace the provider rate review process with actuarial rate-setting and targeted access surveys (secret-shopper pilots on the MPRRAC cycle) while keeping an independent outside view.	JBC; HCPF; MPRRAC; General Assembly	Distributional, not net. Anchor: 2% of a \$145 daily assisted-living rate against 2% of an inpatient stay (office hours); critical access hospitals ≈ 1.8% of HCPF budget. Pediatric therapy cuts of 8–24% backdated to April and five clinic closures reported (to verify). A statewide access survey would cost “millions”; MPRRAC’s draft recommendation is under \$1M GF (legislative staff).	C – Distributional; changes who bears cuts, not the total.
18	Bill · Session	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.	General Assembly	Not costed. HCPF: some efficiencies; licensing should not sit with the payer (Aug 27). For the October 7 BHA block. The BHA is the state’s designated authority for the federal substance use and mental health block grants (SAMHSA), so any consolidation keeps a unit answerable to SAMHSA as well as to CMS. Office hours (October 5) suggested mapping each agency’s functions – payment, licensing, block-grant administration, workforce, health-related social needs, the continuum of care – before deciding where each belongs. Two approaches were offered (October 5): sort the work by function – administrative, clinical, systems – or by the federal rules each function answers to, SAMHSA or CMS; each worked two ways, with the current RAE structure and without managed care for behavioral health (line 92). Contrasting view (written submission, October 5): a	C – Statute; not costed.

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				behavioral health coalition opposes moving the BHA wholesale, and proposes keeping it as a smaller cabinet agency focused on policy and regulation, reviewing every position against its function and its statutory or federal duty, and delegating to BHASOs and providers as the 2020 Blueprint directed.	
19	Bill · Structural	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.	General Assembly; HCPF procurement	Not costed. Contested: HCPF (“incredibly risky”; most states require three) and members opposed; the Milbank author said two could work (Aug 27). Manatt/MISO concluded a transition to managed care “is not likely to generate significant savings”; national reviews find little evidence of managed-care savings (NCSL). Two of four RAEs are for-profit. †	C – Procurement cycle; contested; not costed.
20	Bill · Session	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).	General Assembly; likely a referred measure under TABOR unless structured as an enterprise fee	Not costed for Colorado. Massachusetts’ 2018–19 supplement ~\$200M a year (to verify). Nevada’s report: 238,000 enrollees at employers of 50+, \$758M in 2021; Washington: \$2.27B for employed members and dependents; New Jersey enacted an employer fee in 2026 (AB 5324, to confirm). Colorado HB26-1327 was considered in 2026 and not enacted (NCSL). H.R. 1 bars new provider taxes; an employer assessment is not one. ~440,000 expansion adults are financed at 90/10.	C – Statute and probably a ballot question; a revenue line, not a saving.
21	Bill · Session	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.	General Assembly; Division of Insurance; state employee benefits	No Medicaid general fund effect; bears on commercial payers and hospitals. Washington E2SSB 5083 (2025): in-network hospitals capped at 200% of Medicare, 185% out-of-network, critical access and sole community hospitals exempt, primary care and behavioral health floored at 150% of Medicare, for ~700,000 public and school employee lives from January 2027.	C – Statute; outside Medicaid’s general fund but inside the Commission’s cost-shift question.

Part 2 – What we buy: eligibility, benefits, rates, LTSS and behavioral health service design

No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
22	Department · Now	Limit allowable place of service and provider types for peer and support services, require clinical oversight, and seek CMS approval to pause enrollment of new unlicensed behavioral health providers; test whether	HCPF (rule); RAEs; CMS for the moratorium	Peer and support services \$293M TF FY24-25, +59% in one year; PMPM \$5.86 → \$20.87 since FY20-21; three support codes +286% 2022–24 (HCPF). Peer organizations say nearly all peer	A – Rule under existing authority; HCPF already

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		peer and support services can be delivered through primary care and integrated settings rather than as standalone billed services. Line 81 is the alternative peer providers propose. A specific mechanism (written submission, October 5): an aggregate annual limit of 200 hours across 18 support and rehabilitation codes – peer, psychosocial rehabilitation, clubhouse, community psychiatric support, supported employment and targeted case management among them – so that services do not shift from one code to another; and a cap of about eight participants on peer-led groups, or group peer support only within a treatment plan. The same coalition opposes removing the peer benefit.		services bill under one code, so spend by setting is invisible, and that fraud reported in 2023 went unaddressed; a reported average of ~\$8,000 per person per year (to verify). Public comment and community meetings defended the service and asked for oversight rather than cuts. † The proposed limit reaches beyond the peer and support line, since its code list includes targeted case management and supported employment; the coalition states HCPF has independently reached similar policies – HCPF to confirm.	limiting place of service; largest fast-growing line.
23	Department · Now	LTSS program-integrity package: provider accountability for CFC homemaker and personal care agencies – enrollment growth caps or a financial-strength threshold for enrollment, regulation of direct-to-consumer advertising and of inducements to switch agencies, stronger CMA authorization and monitoring, a guardrail so remote supports cannot approach a residential rate – short of pausing CFC; if a reduction is made, make it once rather than in annual steps. Lines 79 and 84 carry the related visibility and benefit-design items.	HCPF; General Assembly for advertising authority; CMS for any enrollment cap	Homemaker \$346M paid FY25-26 (+101%, 22,571 participants); personal care \$727M (+30%); CFC \$1.016B TF actual against \$873M budgeted, 43,728 members; CBLTC forecast +\$244.6M GF over appropriation FY26-27 (HCPF). Manatt/MISO costed the package at \$121–148M GF over five years. HCPF: growth “almost entirely agency-driven”; providers at the September 28 session volunteered that some authorizations are excessive and the calculator has produced more hours than there are in a week. †	A – Accountability rules just adopted; the \$244.6M over-appropriation sits here; the only five-year costing on the docket.
24	Department · Now	Pharmacy: prefer generics where they are cheaper net of rebate; report 340B’s effect on state cost; state what the PBM contract returns; report other states’ cost sharing; when the statutory prohibition sunsets in July 2027, restore step therapy for new antipsychotic starts and allow prior authorization on select HIV drugs.	HCPF; General Assembly for the 2027 items	Drug cost ~\$2.1B against rebates plateaued ~\$1.0B; specialty \$910M, PMPM \$32 → \$71 since FY18-19; pharmacy drove \$38.5M of the FY25-26 over expenditure (HCPF). Antipsychotic spend +\$14.5M in the year after the 2024 law (Manatt/MISO).	A – PBM and preferred-drug decisions are the Department’s.
25	Department · Now	Have BHA or HCPF determine how many residential SUD facilities the state needs and limit participation to that number with quality oversight; align withdrawal management with ASAM 4th edition and shift opioid, stimulant and cannabis withdrawal management to outpatient; condition the residential benefit on the 1115 waiver’s own evaluation.	HCPF; BHA; RAEs	Residential SUD \$356M TF FY24-25, +76%; participants +14%, PMPM +102% (HCPF). Withdrawal-management alignment \$20–24M GF over five years (Manatt/MISO). HCPF’s interim waiver evaluation found engagement not improved and ED and inpatient use rising. The residential breakout and per-day table requested for the packet are still owed.	A/B – Department and BHA can set need and limit participation; PMPM doubled in a year.

No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
26	Department · Now	Review standalone walk-in crisis centers and crisis stabilization units – utilization, outcomes and cost against alternatives – and move to tiered, site-neutral pricing for crisis stabilization, outpatient therapy and inpatient mental health by acuity and geography; pay routine pediatric behavioral health assessments at a community-practice rate wherever they are done.	HCPF; BHA (crisis system)	Not costed. Manatt/MISO found crisis stabilization is often paid more than hospitalization and outpatient therapy is 41% of BH capitation growth; HCPF describes 988/crisis as a “public utility” outside Medicaid. A hospital pediatric assessment billed at ~\$3,200 after a year’s wait (one practice’s account). The crisis-system data requested for the packet are still owed.	A/B – Review under existing authority; pricing change by contract.
27	Department · Session	Create incentives for integrated physical and behavioral health care: combine FQHCs and comprehensive safety net providers where both operate in the same community; integrated accountability within RAE contracts; expand the existing fully capitated PRIME model within its enrollment cap before deciding on broader capitation.	HCPF (contracts); RAEs; CMS for rate changes	RAEs indicated willingness to combine (Sept 17). PRIME reports 6.2% state savings (\$17.6M/yr average) and 17% more provider groups at top-tier integration in capitated counties; 35,000 enrolled against a 60,000 cap (plan letter; HCPF). Not independently costed.	B – Contract and procurement; savings claimed by the plan, not yet verified by HCPF.
28	Department · Session	Require a standardized outcome assessment for pediatric behavioral therapy and applied behavior analysis, tighten provider qualifications and individual licensure, apply HCBS-style conflict-of-interest rules, and amend the medical-necessity definition so high-hour authorizations are tied to measured improvement.	HCPF (rule); Medical Services Board; General Assembly for the definition	\$47–58M GF over five years (Manatt/MISO). Pediatric behavioral therapy \$287M SFY25, +471%; share above 40 hours a week 23% → 34%. Nebraska’s autism payments rose ~2,000% 2020–24 (NCSL).	B – Rule now, statute for the definition; the second-largest costed line in Part 2.
29	Bill · Session	Raise disability buy-in premiums rather than reduce coverage – phased, protecting the lowest tiers, capped as a share of income, and factoring household wealth – particularly for members on an HCBS waiver who are working. Not a doubling. Also heard: count more of earned income when setting the premium (not eligibility) – about half of earned income is disregarded today, so a member with gross earnings of about \$11,000 a month can qualify and pay the \$200 top tier.	General Assembly; HCPF	~25,000 members, ~\$6.7M collected today, 13% of the \$51.4M the schedule could yield (stakeholder analysis); doubling would add ~\$6.66M (public comment); buy-in members cost ~\$20,000 a year against ~\$85,000 for the traditional disability population (HCPF). Current tiers \$0 / \$25 / \$90 / \$130 / \$200 a month; a disability organization states the \$200 top tier is already the highest federally allowable premium. Federal rules cap working-disabled premiums as a share of income – no more than 7.5% of income for members between 250% and 450% FPL (42 CFR 447.55; Colorado’s rule repeats the 7.5% cap) – rather than at a dollar amount, so \$200 does not appear to be the federal ceiling; HCPF to confirm which buy-in group Colorado uses before this line is costed. A parent’s submission (October) estimates \$6M a year if the average premium rose from \$20 to \$40 a month and \$15M from \$50 to \$100	B – Premium change by rule or statute; the ceiling and the earned-income disregard decide how much is available.

No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
				(gross; the state keeps roughly half of collections). Earned-income disregard: HCPF's 2026 premium guide (OM 26-023). †	
30	Department · Session	Set a standard for the share of reimbursement an intermediary agency may retain against what reaches the direct-care worker, by provider type; differentiate rates for agencies that pay full benefits; enforce that family caregivers are W-2 employees under the IRS and DOL tests already in force; require any rate reduction to be absorbed by the agency rather than passed to the caregiver; use HB26-1235 cost reporting as the first hard data on overhead.	HCPF (rule); Medical Services Board; CDLE; General Assembly if by statute	Retention reported at 5–10% against 30–60% (office hours; community meetings); family caregivers paid through payrolling companies report receiving 70% (non-live-in) to 80% (live-in) of the rate; CFC homemaker rate ~\$21–22 an hour against a \$19–20 wage before overhead; family caregiver spend over \$800M SFY25 (Manatt/MISO). Misclassification as contractors also costs payroll tax (union). Not costed.	B – Rule; saving is indirect – more of each dollar reaches the worker.
31	Bill · Structural	Move LTSS toward an individual budget model: each member receives a stated budget derived from assessed need and chooses services from a menu with a support broker – self-direction extended beyond CDASS and beyond the three services now allowed – with a defined “stacking” framework and, over time, the nine waivers consolidated into one. A narrower version (office hours, October 5): one adult waiver and one children’s waiver, each with a menu of services subject to authorization; the combining of the CLLI and CHCBS children’s waivers is cited as precedent (to confirm).	General Assembly; HCPF; CMS (waiver amendment)	Not costed. 11% of LTSS members use CDASS today (HCPF); the supported living services waiver ran on individual budgets (SPALs) about 25 years ago; a fiscal intermediary handles payroll for under \$200 a month (client-led organization). Federal CFC rules require any self-directed budget method to be objective and in the State Plan (42 CFR 441.560). Participants in two community meetings independently proposed acuity at entry tied to a budget; panelists said need fluctuates too much for a fixed budget. †	C – Waiver redesign; multi-year; contested.
32	Budget · Session	Benchmark every optional benefit against the national midline and cost what adjusting to the midline would save, before any benefit decision is taken; model adult dental first, since it is already capped.	HCPF to cost; JBC to act	Adult dental \$215M TF / \$75M state share / 206,233 members (FY25-26); rates cut 15.5% Oct 2025 (HCPF). Adult vision eliminated entirely returns ~\$700,000 GF because expansion reductions return a dime on the dollar. Dental was defended in three community sessions on system-savings grounds, without a cited study.	B – Costing step now; benefit decisions follow at meeting 11.
33	Bill / Budget · Session	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.	General Assembly; JBC	CHIP 75,000–95,000 members at 65% match; Cover All Coloradans \$100.5M FY25-26, \$72.7M GF appropriated FY26-27 (children: general fund, no federal match; pregnant group 65% under CHIPRA 214); targeted case management \$147M TF / \$73M state / 81,346 members (HCPF). HCPF's funding-source chart (Oct 2) marks which populations can change by state law – the vehicle check for this Part. Not costed as reductions.	C – Statute; the largest What-we-buy decisions, but session-dependent.

No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
34	Bill / Federal · Session	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.	General Assembly; HCPF (state plan amendment); CMS	Expansion reductions return roughly a dime on the dollar to the general fund because the population is financed at 90/10; adult vision eliminated entirely returns ~\$700,000 GF; the alternative benefit plan must stay actuarially equivalent to its commercial benchmark (HCPF, Sept 2). Expansion per-capita spend \$5,860 against an \$8,086 national median (NCSL). MAGI adult caseload is forecast to fall 21.8% in FY27-28 under H.R. 1 (HCPF forecast, per provider network). Not costed.	C – Statute and CMS; small general fund return per dollar cut, which is the point the arithmetic makes.
35	Bill · Session	Continuous authorization in place of annual redetermination for people with certified non-reversible conditions; a documentation framework and 30-day corrective-action period before disenrollment under the H.R. 1 work requirement (Arizona model); monthly eligibility-status sharing with safety-net systems and the health information exchange so exemptions are found without paperwork; housing and homeless providers as first-line navigators; an optional voluntary workforce-support program for expansion adults (Montana, New Hampshire models).	General Assembly; HCPF; CDLE; counties; CMS	Administrative saving not costed. 52% of one safety-net system's expansion adults have a potential exemption, 76% among people experiencing homelessness; exempt-eligible members cost a median \$302 PMPM against \$207 for the population (Denver Health research, 2021 data). HIE data cut disability-determination time from eight months to 38 days (vendor-reported). Appeals and admin growth for H.R. 1 are the anchor (HCPF, Oct 2; line 13). Montana's program: 63% employed the following quarter (NCSL).	C – Statute; administrative saving from 2027.
36	Department · Now	Classify Montezuma County and the southwest corner as rural for non-emergency medical transportation; publish a dated rollout schedule beyond the nine metro counties; restore the two NEMT rates to a cost-covering level with anti-fraud controls rather than the across-the-board cuts of 2025 and 2026.	HCPF; JBC for the rates	Cost neutral to low on classification. Rates: passenger-mile cut ~55% July 2025, base rate ~66% July 2026 (rural provider alliance; to verify against fee schedules); providers warn of ambulance and ED substitution. Four unconnected reports since August.	A – Existing authority and cost neutral – access, not savings.
37	Department · Session	A comprehensive family-caregiver plan, including whether structured family caregiving as used in ten states fits Colorado, and a consumer-directed option for the DD-waiver family caregiver rate so caregivers can be W-2 without agency retention.	HCPF; incoming administration; CMS	Vendor fiscal analysis: \$1.78M saving year one, \$6.89M year two, EBD waiver only, 560 then 1,196 participants, built on Indiana's rate (\$99.71 a day against \$109.44 for 16 units). HCPF: existing models cover it. Not independently costed.	C – Session; saving is small and stakeholder-estimated.
38	Budget · Now	Redesign or reverse PETI on the DD waiver: replace the flowchart with an income sliding scale; exempt members with no earned income and members living in their own or a family home; widen the employment exemption beyond job coaching; cap the contribution at the buy-in maximum (\$200) so a non-working member does not pay more than a working	JBC; HCPF (rule)	HCPF's phased estimate: \$6.3M GF FY26-27, \$13.1M GF full year FY27-28; ~3,100 members; the state retains roughly half of collections. Member examples in the record: ~\$400 a month on \$1,800 SSDI; \$855 a month for one non-working member against \$90 for a buy-in member at similar income; a 23% cut in living	– – A protection, not a saving: reversing PETI costs up to \$13.1M GF a year. Ranked last on this criterion only.

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No.	Lane · Horizon	Proposition	Who acts	Dollar anchor (source)	Tier · why ranked here
		one; correct the locked worksheet; require the savings figure to be recalculated net of exemptions.		funds. Advocates report a worksheet error of nearly \$10,000 a year per member in agency reimbursement and that the estimate used other waivers' income assumptions (to verify). PETI on this waiver was ended in 2009. A case manager reports 2 of 25 clients paying.	
39	Department · Now	Do not advance the weekly caregiver cap further until arrangement failure is measured; correct the field application (it applies to the caregiver, not the member); define who finds the second worker when authorized hours exceed the cap; track nursing-facility admissions among members whose paid hours were reduced.	HCPF	Record conflict on timing: the docket has read "from 70 to 56 hours in July 2027"; a caregiver organization's corrected supplement says the 56-hour cap took effect July 1, 2026 with no phase-in (OM 26-043) and exceptions run through May 2027 – HCPF to confirm. Corrected figures: saving \$2.2M TF / \$1.1M GF year one, \$3.1M TF / \$1.5M GF ongoing (JBC staff); at the Department's \$40,712 differential (647 nursing-facility transitions), 54 failed arrangements erase year one and 76 ongoing. 2,300+ members above 84 hours; 176 exceptions, 80% approved (HCPF). †	– – A protection, not a saving: holding the cap forgoes ~\$1.1M GF unless failures exceed 54. Ranked last on this criterion only.

The five lines that carry the money, and how to use them on October 7

If members want to know where the general fund actually sits before they start: line 11 (the CHASE hierarchy, ~\$740M GF to hold expansion harmless), line 23 (community-based long-term care, +\$244.6M GF over appropriation next year), lines 5, 22 and 25 (behavioral health capitation, \$375M GF and nearly doubling PMPM), line 3 (the UPL, \$270M–\$569M federal depending on whose figure holds), and line 2 (administration, \$192M GF). The only lines with a five-year costing are 23, 28 and the withdrawal-management piece of 25, all from the Department's Manatt/MISO work; line 10 now carries the Department's own one-year forecast. Everything else is smaller than \$25M GF or is not yet costed.

Part 3 – Also heard before September 24, carried by number

Everything else the record produced through September 24th, in one line each. Not ranked. Anchors updated where the October record adds to them.

No.	Proposition	Who acts	Source	Dollar anchor
40	A standing legislative Medicaid oversight body to carry unresolved items past December 11 (Connecticut, Kentucky, North Carolina); sequence LTSS structural recommendations with the externally convened LTSS Work Group reporting September 2027.	General Assembly	NCSL; public comment; Commission interviews; disability coalition	Cost neutral
41	Any-willing-qualified-provider rule for behavioral health: enrolled providers admitted to every RAE and CHP+ network within 60 days, written denials, state appeal; publish the metrics by which RAEs declare networks adequate. Require RAEs, through their contracts, to disclose	General Assembly; HCPF	Provider testimony; provider listening session; clinician letter via a member; office hours (October 5)	Not costed; 52 credentialing/contracting concerns in HCPF's FY24-25 escalation process

No.	Proposition	Who acts	Source	Dollar anchor
	how they set provider rates and how they determine that a rate change will not harm access – information plans otherwise treat as proprietary.			
42	A statewide behavioral health rate floor at the fee-for-service schedule with a cost-of-living index, 120-day notice before reductions or manual changes, annual cross-RAE rate comparison, parity analysis before BH-only cuts; notice and a dispute process before cost-report audit changes produce retroactive adjustments.	General Assembly; Medical Services Board	Provider testimony; provider association	“One GF dollar buys \$10 of BH care” for expansion adults; 77% of CSNPs at break-even or loss (association survey, March 2026)
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.	HCPF	Milbank review	4.5M capitated BH claims FY24-25
44	Cut RAE capitation for potentially avoidable events (ER visits, readmissions), as Pennsylvania did.	HCPF (contracts)	Milbank author; NCSL	Pennsylvania: \$1.8B over five years
45	Independent audit of whether behavioral health capitation transfers risk or merely reprices prior-year cost; a dedicated managed-care oversight unit.	General Assembly; HCPF	Milbank review; HCPF’s own ACC assessment	BH margin –0.4% FY24-25
46	Move comprehensive safety net providers to CCBHC prospective payment and pause the 80% state-directed payment floor until metrics are defined.	HCPF; CMS	Provider association	CCBHC waivers –\$6.5M GF (HCPF); SDP change delayed to Oct 1, 2026; CCBHC application filed March 2026; outpatient BH directed payments ended July 1, 2025
47	Consolidate HCPF IT systems (MMIS, PBMS, CCM, not only CBMS) onto modular, multi-state platforms; make CBMS, CCM, interChange, PEAKPro and the Bridge interoperable; pursue a multi-state consortium.	HCPF; CMS	Commission discussion (Aug 5); CMA talking points	CCM contract \$35.3M, 39% underspent; 90% federal match for modernization, 75% ongoing
48	Contract Area Agencies on Aging to deliver community-based services for older adults, as other states do.	HCPF; CDHS	Regional council of governments	AAA state senior services ~\$46M
49	Medicaid administrative claiming, a provider designation and billing hubs for local public health agencies; a payment path for care coordination they absorb from RAEs.	HCPF; CMS	Local public health association	Not costed
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.	General Assembly; HCPF; CMS	NCSL; public input; community meetings; HCPF money map	Not costed; Utah HB 599 (2026) nicotine fund as match
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.	General Assembly; Treasurer	Commission interview; JBC staff research	Fund ~\$2.3B; drawn ~\$200–300M/yr
52	Raise alcohol excise taxes and dedicate revenue to SUD treatment and Medicaid.	General Assembly (likely referred)	Physician testimony; medical society	AUD members cost \$12,879 vs \$7,194; 35,813 alcohol-related ED visits, \$6.5M TF (FY22-23); spirits tax second-lowest in the nation

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No.	Proposition	Who acts	Source	Dollar anchor
53	Voluntary ABLE-account reimbursement of the state share of HCBS direct-service costs after a federal amendment.	Congress; General Assembly	Disability planning consultants; public comment	Proponents: \$14–18M/yr at 1% participation, assuming \$1M accounts – illustration only
54	Require commercial insurers to cover private duty nursing, long-term home health, and life-sustaining medications and equipment now shifted to Medicaid, as Minnesota has since 2010.	General Assembly; DOI	Home care provider; parents	20–30% of PDN members have commercial coverage; one buy-in member’s two injectables exceed \$1M a year
55	Use RHTP principal as a revolving loan fund; remove state-added RHTP restrictions beyond federal law (five-site cap, \$3M limit, a county test that excludes a federally designated CAH); transmit RHTP outcomes and obligation status to the Commission and JBC.	HCPF; General Assembly	Commission interview; hospital association; HCPF fact sheet	RHTP \$200.1M year one, ~\$1B over five
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.	General Assembly; HCPF; CMS	NCSL; Independent Rural Advocates; Rural Futures report	Maryland: 16% fewer admissions
57	Test whether Community First Choice can be evaluated net of services that shifted from waivers and long-term home health, before further reductions; before any pause, name the authority that will carry each member’s existing hours so there is no gap.	HCPF	Family advocates; eight family impact letters	EBD waiver spend fell 87% as CFC rose; CFC \$873M budgeted, \$1.016B actual FY25-26
58	Expand delegable skilled tasks (tracheostomy, ventilator) for family CNAs; replace the federal home-health conditions of participation for pediatric PDN agencies with a PDN-specific state pathway by State Plan Amendment and rule.	HCPF; State Board of Nursing; Medical Services Board; CMS	Home care providers and association (crosswalk offered)	PDN ~\$4–6K/day in hospital vs ~\$1,500 at home; ~900 PDN members; parent CNA 7,994 (2023) → 10,766 (2025); Colorado 44th in PDN rates (to verify)
59	Decide the Colorado Single Assessment and support-level algorithm: publish the instrument and pilot results before go-live, or discontinue resource-allocation tools in favor of a case-manager services guide (19 states use none); deploy the funded acuity tools before any acuity-premised reduction; account for the nurse assessor program that sunset December 15, 2025.	HCPF	Case manager testimony; disability planning consultants; pediatric home nursing provider	\$6.2M GF FY26-27 request; contractors \$4.7M spent
60	Re-examine CES waiver eligibility – the evaluator tool’s validity, a waitlist or acuity gate – given enrollment roughly doubled 2023–25; give aging caregivers priority for adult DD waiver slots.	HCPF	Technical advisor; Commission discussion; September 28 session	CES 4,971 enrolled; ~\$11,137/month total cost of care
61	LTSS exception and appeal reform: credentialed reviewers, no expansion of a review beyond what was requested, resolve the CMA conflict at hearing, publish how often assessments differ from authorizations; separate utilization review from case management; report CMA appeal units paid so appeal costs are netted against savings.	HCPF (rule); General Assembly	Family caregivers; HCPF due-process fact sheet; CMA	320 open appeals; 209 pending over 90 days; appeal packet \$531.60, hearing \$490.97
62	Member choice of case management agency or performance-based CMA contracts with accountability for missed PARs; remove CMAs that fail after state intervention, with enforcement shared with the Attorney General; publish the time study behind CMA rates.	HCPF (contracts); General Assembly	Public input; client-led organization; CMA	\$161.2M to CMAs FY25-26 (or \$157.4M actual against \$171.5M appropriated – reconcile); 72

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No.	Proposition	Who acts	Source	Dollar anchor
				required activities, 9 paid; 1:65 caseloads
63	Raise the \$2,000 LTC asset limit (frozen 30 years) with a COLA; fix the asset-limit and buy-in interaction that produces wrongful terminations.	General Assembly	Disability planning consultants; survey	11 states above \$2,000
64	Waiting period or waitlist before new arrivals access HCBS waivers; track residency of state-only program users (HCPF: waiting periods are not federally allowed; waitlists are).	General Assembly; HCPF; CMS	Public comment; survey; Commission discussion	Counter-data: enrollment -8.5% 2016–25 while spend +75%; migration shows no consistent relationship
65	State-only coverage for the ~7,000 qualified immigrants losing federal match October 1, or the ~250 receiving LTSS; stabilize Cover All Coloradans and OmniSalud as the landing place – a protection, not a saving.	General Assembly	HCPF fact sheet; advocacy organizations	\$32.8M GF all, or \$26M GF LTSS only (HCPF); ~16,000 lose coverage by January 2027 counting APTC; OmniSalud slots 12,000 → 6,700
66	Housing as a Medicaid cost lever: supportive housing and housing supports for high utilizers and HCBS members; restore an “SLS-plus” step with a housing voucher as the alternative to the DD waiver.	HCPF; DOLA; CMS	Safety-net hospital; HCPF budget request; HCBS provider	S-10 housing vouchers –\$8.9M GF (HCPF)
67	Community health centers as the primary-care medical home; use their enrollment staff for redeterminations and work-requirement compliance.	HCPF; JBC	Community health network	CHCs 1.6% of spend, 25% of members; ~\$900/member/yr saving claimed
68	Scale EMS treatment-in-place and community paramedicine statewide.	HCPF; General Assembly (rates)	Technical advisor; plan letter	Paramedicine 33% cheaper than ED
69	A member-facing explanation of benefits so members can dispute what is billed in their name; the service plan shows the full rate and the agency’s share; real-time third-party-liability checks for providers.	HCPF	Public input; CMA; parents	Cost neutral
70	Pilot policy changes before statewide rollout; publish a rule-change calendar; finish absorbing one change before starting the next. See line 80 for notice.	HCPF; Medical Services Board	Survey (several independent respondents)	Not costed
71	Expand shared-savings and alternative payment models (maternity bundle, chronic conditions) statewide and report savings annually; pay against an absolute benchmark, not only year-over-year improvement, and release savings to providers; extend value-based purchasing to hospitals and specialists. A safety-net reinvestment version (written submission, October 5): qualifying safety-net providers keep a defined share of verified efficiency savings, only where quality, access and outcomes hold, most of the people served have significant needs, the savings are measurable and attributable to better operations, part is reinvested in care, and the use is publicly reported.	HCPF	HCPF’s ACC assessment; Commission discussion; community health center; behavioral health coalition (October 5)	Maternity bundle \$6.7M over five years
72	A hard growth limit: state Medicaid contribution grows at inflation only, within TABOR’s band; grandfather current rates and apply reductions to new enrollees only; or a utilization trigger requiring legislative approval when a service category grows more than a set percentage in a year (Idaho SB 1108).	General Assembly	Commission interviews; a clinician; NCSL	Not costed

No.	Proposition	Who acts	Source	Dollar anchor
73	Consider merging CDHS and HCPF; move BHA block-grant dollars into HCPF. See line 78 for the LTSS-only version.	General Assembly	Commission interviews	Not costed
74	Fix the CHP+--to-Medicaid transition so effective dates align; reinstate acceptance of out-of-network commercial status for Medicaid-secondary members.	HCPF; counties	Public input; family advocate	Low
75	Estate recovery review: whether rules deter people from accepting home care they need.	General Assembly; HCPF	Survey	Not costed

Part 4 – Added since September 24th

From the four community meetings, the written submissions received since September 18, and the Department’s October 2 package. Not ranked. Where a line extends an earlier one, it says so.

No.	Lane	Proposition	Who acts	Source	Dollar anchor
76	Department / Bill	Align functional and financial eligibility dates for waiver members so a person faces one redetermination a year, not two; no denial before the review period closes; six months’ notice with case-manager support; no suspension of Medicaid when SSI or SSDI is lost for a member whose disability certification stands.	HCPF; counties; General Assembly	Case management agency, host-home and home health providers, parents – two sessions	Not costed. One provider’s write-offs tripled in 2025 and it carries seven residents at ~\$77,000 with two benefits specialists on payroll; aligning dates costs “a few months of service” once (provider estimate)
77	Bill / Department	Remove the Class B home care agency license requirement for non-medical CFC personal care and homemaker services, and write a regulatory subset for IDD and TBI group homes that fits their residents rather than a medical setting.	General Assembly; CDPHE; HCPF	Provider agencies, group home operator, parents – two sessions	Not costed. License cost cited at \$1,500–1,700 to “thousands every year” (to verify); one operator spends half its time on rule interpretation
78	Bill	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.	Governor; General Assembly	Case management agency; provider agencies; home health owner – one session and talking points	Not costed. Eight CMAs “interpret differently”; surveys 2.5 years late; ~100,000 LTSS members, 15 agencies, 2M+ actions a year (CMA estimate)
79	Department	Connect the case management system to claims so a member’s total authorized and billed hours across CFC, waiver, long-term home health and PDN are visible before authorization and overlapping service days are flagged before payment, not recouped a year later; publish cross-program LTSS utilization and total cost of care. Extends 23 and 59.	HCPF	Provider agency executive; CMA director; LTSS provider association	Not costed. The calculator produced more personal care hours than there are in a week for one member; overlaps found six to twelve months later and docked from agencies

No.	Lane	Proposition	Who acts	Source	Dollar anchor
80	Bill / Department	Before any benefit reduction or eligibility change takes effect: 60–90 days’ member notice; service-plan changes batched rather than issued one at a time; public input before rollout; and a four-part statement with every cost-containment proposal – stakeholder work done, federal engagement, member-impact data, and why less restrictive measures were insufficient. Extends 8, 14 and 70.	General Assembly; HCPF; Medical Services Board	Parents and family caregivers; provider agencies; pediatric home nursing provider – two sessions and a fact sheet	Not costed; cites the nurse assessor, caregiver cap and discharge-summary changes as savings that did not materialize
81	Department / Oversight	Peer services, the alternative to line 22: break the single peer-services code into codes by setting and function (recovery housing, hospital, justice, harm reduction, community), publish what each may bill, set a credentialing and supervision standard for individual peer providers, add early-warning checkpoints, and act on fraud reports – “fix the pipes instead of turning off the water.”	HCPF; BHA; General Assembly if a licensing framework	Peer-run organizations and recovery providers – the September 28 session, two letters, Panel B	Not costed against the \$293M line. One organization lost ~\$150,000 to a provider it reported in 2023 with no action; peer documentation training first offered in 2025
82	Department / Oversight	Behavioral health federal match reconciliation: reconcile the budget’s fund splits to actual CMS-64 claiming; claim RAE incentive payments at the FMAP of the populations they serve rather than a flat 50%; validate the 75/25 proxy that shifts capitation into the 80% “non newly eligible” cell; seek replacement authority for the enhanced prenatal match lost in July 2025; present every reduction in state-share and total-funds terms. Extends 4.	HCPF; JBC staff; CMS	Behavioral health provider network report	Provider estimates: ~\$14M more federal in FY26-27 on incentive payments (\$37M over three years); ~\$13.8M a year on the reclassification; ~\$2.3M a year prenatal BH. All unverified against the CMS-64 and possibly a presentation convention rather than a claiming error †
83	Department / Bill	RAE surplus reinvestment instead of remittance: because about ninety cents of every dollar recouped from a RAE on expansion-population capitation returns to the federal government, require surplus below the MLR floor to go to a restricted account spent under a Department-approved plan (Pennsylvania HealthChoices model). The alternative to the remittance mechanism in line 5.	HCPF (contracts); General Assembly	Behavioral health provider network report	FY25-26 “Risk Corridor Payment and MLR Recoupment” line \$21.6M (HCPF Exhibit B, per network); 46% of BH capitation matched at 90%
84	Department / Budget	Benefit design within CFC and the children’s waivers: cap homemaker services at 5–7 hours a week for all HCBS members, with needs above that met through long-term home health; pause the children’s Community Connector benefit for two to three years while its structure is re-examined. Proposed by a client-led disability organization. Extends 23.	HCPF (rule and waiver amendment); JBC	Disability-rights, client-led organization; families named CES extras, homemaker and respite as the hours they could spare	Not costed; homemaker \$346M TF FY25-26 (+101%) is the line it would act on; Colorado’s Community Connector structure is said to differ from other states’
85	Bill / Federal	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	General Assembly; HCPF; CMS	Behavioral health practice owners (October 1 session); NCSL memo to the Chairs	Not costed. 38 states offer premium assistance; 20 and D.C. use 12-month TMA (NCSL). Clients turning down hours to keep coverage (provider accounts)

Reminder: **Tier A** – existing authority, saving lands in FY26-27 or FY27-28. **Tier B** – can start now, saving is indirect, later, or not yet costed. **Tier C** – needs statute or CMS

No.	Lane	Proposition	Who acts	Source	Dollar anchor
		limit so a dollar more in earnings does not end coverage. Relates to 12 and 29 but for the expansion population.			
86	Department / Budget	Home health: reinstate the withdrawn rule limiting back-to-back 60-day acute home health episodes; require the Department to return to the JBC before January 2027 on the pending R-15 home-care changes (blended PDN/CNA per diem, unit changes, acute PDN limits) with federal approval status, deviations from the approved concept and whether the savings remain valid. Extends 58.	HCPF; JBC	Pediatric home nursing provider fact sheet	~700 members with back-to-back acute episodes, \$4.33M TF July 2024 – July 2025 (HCPF's own rule notice, per provider); why the rule was withdrawn is unknown
87	Federal / Bill	A sliding-scale parental fee for children who receive Medicaid through an HCBS waiver or CFC, where eligibility does not count parental income: no fee for low-income families, rising with family income (the submitter's illustration: about \$200 a month at \$150,000 a year, about \$500 for high-income families). Relates to 29 and 38.	General Assembly; HCPF; CMS (State Plan or waiver amendment)	Parent of an adult with IDD – written submission (October)	Submitter's estimate: \$12M a year if 5,000 families pay \$200 a month, \$30M at \$500 (gross; the state keeps roughly half of collections). Not costed. Precedent: Minnesota charged parents of children on its TEFRA option and waivers a sliding-scale fee from 1990 (up to 7.49% of adjusted gross income at the top) and repealed it in July 2023 over affordability. Whether federal premium rules (42 CFR 447.55–447.56) allow a fee based on parents' income for a child whose eligibility disregards it is the threshold question for HCPF and CMS. †
88	Federal / Bill	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.	General Assembly; HCPF; CMS (State Plan Amendment ending the 1915(k) option; waiver amendments)	Parent of an adult with IDD – written submission (October)	Not costed. CFC \$1.016B TF actual FY25-26 against \$873M budgeted, 43,728 members (line 23). A state may end the 1915(k) option, but CFC draws a 6-point federal match increase the waivers do not, so the same services moved back to waivers cost more general fund unless enrollment or hours fall. Waivers can cap enrollment and keep waitlists; CFC must serve everyone who meets institutional level of care. Services moved out of the waivers and long-term home health when CFC began (line 57), so a sunset needs a named home for every member's hours.
89	Department / Federal	Cap the total paid hours from all legally responsible persons for a child at 56 a week per member, not per caregiver, so a two-parent household cannot be paid for more parent hours than a single-parent household. Adults are unaffected (at most one legally responsible person). Read with 39.	HCPF (rule; Medical Services Board); CMS (CFC State Plan Amendment and waiver amendments)	Parent of an adult with IDD – written submission (October)	Not costed; the figure that would settle it is the number of children with two paid legally responsible persons and their combined weekly hours. The 56-hour limit applies per caregiver per member across personal care, homemaker and health maintenance; homemaker by a legally responsible person is already capped at 5 hours a week from April 1, 2026 (OM 26-004).

No.	Lane	Proposition	Who acts	Source	Dollar anchor
					Hours must still follow assessed need under federal CFC and HCBS rules, so the cap moves hours to non-family workers rather than removing them, with the same arrangement-failure risk as line 39. †
90	Bill / Department	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.	General Assembly; HCPF (procurement and contracts); CMS	Office hours (October 5)	Stakeholder estimate \$205.6M a year (contract PMPMs × caseload), primary care case management only; to reconcile with HCPF’s \$113.4M care coordination baseline (line 7) and \$149.1M care-management figure (line 5). Children’s share not known – HCPF to supply. Manatt/MISO and national reviews find little durable cost difference between managed care and fee-for-service (line 19). Pediatric practices depend on the per-member payment, so a carve-out without a replacement cuts primary care funding. Not costed. † Open questions: whether claims data support keeping the ACC for adults, and whether it is the only route to avoiding preventable hospitalizations. Children’s federal entitlement to all medically necessary care (EPSDT) makes a pediatric capitation hard to set.
91	Department / Budget	Fix authorization before cutting: set performance standards and strengthen contract oversight for the prior-authorization and utilization-review vendors for private duty nursing, long-term home health and LTSS; measure how often authorizations are changed on appeal or exception; hold further across-the-board LTSS limits until that error rate is known. The JBC’s lever is declining reductions and conditioning funding on authorization accuracy. Relates to 23, 39, 61, 79 and 80.	HCPF (vendor contracts); JBC	Office hours (October 5)	Not costed; the figure that would settle it is the share of authorizations changed on appeal or exception. 320 open HCBS and CFC appeals, 209 pending over 90 days; of 51 with a recorded outcome, 49 resolved without a decision on the merits (HCPF). Private duty nursing and long-term home health authorization problems recur across the record (lines 58, 61, 86).
92	Bill / Department	End capitated managed care for behavioral health: pay behavioral health services fee-for-service or through an administrative-services contract, keeping network and care-coordination functions where they add value; first, have HCPF cost the administrative saving at constant utilization. Relates to 5, 19, 43 and 45; line 18 asks the agency question with and without it.	General Assembly; HCPF; CMS (waiver and state plan amendments)	Office hours (October 5)	Not costed. Behavioral health capitation \$1.567B TF / \$375M GF FY25-26 (line 5); RAE behavioral health margin –0.4% FY24-25 (line 45). Manatt/MISO and national reviews find little durable cost difference between managed care and fee-for-service (line 19). Whether any federal financing the state now receives depends on managed care – state-directed payments under H.R. 1, for example – is the threshold question for HCPF. †

No.	Lane	Proposition	Who acts	Source	Dollar anchor
93	Department / Budget	Restore before cutting in LTSS: reverse several recent CFC changes, restore access to private duty nursing and long-term home health under the state plan, and restore direct-care rates that attract and keep a workforce, on the premise that hospital and institutional diversion offsets the cost. A protection, not a saving; the reverse of 23, 84 and 89; read with 58 and 91.	HCPF; JBC	Office hours (October 5)	Costs money; not costed. Private duty nursing ~\$4–6K a day in hospital against ~\$1,500 at home (line 58). Some CFC changes are described as already being reversed – HCPF to say which before this line is read.
94	Bill / Budget	Target behavioral health safety-net and indigent care funding at the highest need: keep the statutory “no refusal” requirement for comprehensive safety net providers but focus it on the highest-acuity people; redefine “priority populations” in statute; let indigent care funding follow the person to any eligible provider – including specialty, essential and substance use treatment providers – through flexible BHASO funding rather than siloed streams.	General Assembly; BHA; BHASOs	Written submission, behavioral health coalition of providers, payers and consumer advocates whose members include a RAE and a BHASO (October 5)	Not costed; mostly BHA funding rather than Medicaid. The coalition expects the uninsured and underinsured population to grow with H.R. 1 and the end of enhanced Marketplace subsidies. BHASOs, which would hold the flexible funding, are among its members.
95	Department / Budget	Tiered payment for comprehensive safety net providers: replace the uniform prospective payment rate with rates tiered by the complexity and intensity of the population served (people cycling through hospitals, crisis services, jail or homelessness; serious mental illness; severe substance use disorder; children at risk of out-of-home placement), with an obligation to serve everyone and outcome accountability; correct incentives that spread routine services across several days with lower-cost staff or shift complex clients to other providers; direct RAEs and BHASOs to reward providers that serve the highest-need clients. Relates to 17, 26 and 46.	HCPF; BHA; RAEs and BHASOs (contracts); CMS for the rate methodology	Written submission, behavioral health coalition of providers, payers and consumer advocates whose members include a RAE and a BHASO (October 5)	Not costed; distributional before it saves. The figure that would settle it is provider cost by client tier against the current rate; HCPF to describe how the current rate is set. †
96	Bill / Budget	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.	General Assembly; BHA	Written submission, behavioral health coalition of providers, payers and consumer advocates whose members include a RAE and a BHASO (October 5)	Not costed; the office’s budget and FTE are the anchor – BHA to supply. Contested: community meetings asked for an independent member ombuds office (summary of October 1), which is not yet a docket line.

Heard, and not carried as a line

Raised in community meetings or submissions without a Medicaid general fund mechanism, or outside the Commission’s charge; recorded so that all ideas are reflected. A universal or public-option primary care benefit, or merging the exchange with Medicaid (raised in three rooms; outside the general fund question). A “right to request” flexible-work standard for employed family caregivers (Title 8; no appropriation). A graduate practice authorization for mental health professions (workforce, not Medicaid). Raising DD-waiver room-and-board and personal needs allowances (a cost). Publishing or capping community mental health center

executive pay. Consumer seats on Department committees. Rolling back universal preschool and school meals (outside Medicaid). Protecting LTSS ahead of behavioral health if cuts must be made (a priority, not a proposal). Durational residency requirements (federally barred; line 64 carries the lawful version). Premiums for all members on a sliding scale above poverty, in place of PETI (federal rules bar premiums at or below 150% FPL, which covers most members, and cap premiums and cost sharing together at 5% of family income above it; line 12 carries cost sharing and line 38 the PETI sliding scale).