# Colorado Commission on Medicaid

## Docket – what the Commission has heard, for line-by-line review on November 10th

Prepared by SHG Advisors – October 22, 2026, v4.1. Replaces v4.0.

## What changed in this version

The docket now has 126 lines. Every line keeps its original number from previous dockets; new lines are numbered from 97.

**Long-term and short-term are now separate.** Part A lists every long-term line – the structural choices – and Part B lists every short-term action. Both are grouped under the same six areas, so the Commission can settle direction first and then take the actions that fit it.

**Ideas from Commission members come first.** Lines raised or expanded by a Commission member are marked ◆ and listed first in each group. 10 new lines come from members' written submissions since October 7th, and several existing lines were expanded at members' request.

**Lines that bundled separate ideas are split.** Lines 13, 15, 16, 72 and 73 each carried ideas the Commission may want to consider separately. Each keeps its number for its first part, and the other parts are now lines 97–106.

**New ideas from the record.** 11 new lines come from submissions received through the October 20 deadline, and 61 existing lines now carry what those submissions and the October 7 meeting added – a new mechanism, an alternative, an objection, or an updated figure.

**Links to sources.** The "Where it came from" column now links to the documents behind each line in the Commission's document library, where the document is public. Submissions from private individuals and Commission members are not linked.

**Marked as new or updated.** Each line shows whether it was on the original docket of September 24th, added after it, or new on October 22; lines updated in this version say so.

## 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 – its meetings since June, the Department's packets and fact sheets, panels, office hours, the survey, community meetings, written testimony and public comment. None is SHG's recommendation, and the Commission has made no decision on any of them. The list exists so the Commission can react rather than generate.

Lines are numbered only so the room can refer to them. Each line keeps the number it had in earlier dockets, and the number never changes once published. Because the lines are grouped by term and area, the numbers are not in sequence.

**Long-term or short-term.** A long-term line is a structural choice about how the program works. A short-term line is a specific action; several make sense under one long-term answer and not another, which is why Part A comes first.

◆ **Commission members.** A line raised or expanded by a Commission member. These are listed first in each group. No member is named.

**The lever.** Each line is tagged with the one part of Medicaid it would mainly change. Medicaid spending is, in effect, the number of people covered, times the services they use, times what is paid for each service. A line therefore works through one of those three, or through how the program is administered or paid for. The five levers are:

- **Who is covered** – who is eligible, and how people apply, enroll and renew (for example, line 107).
- **What is covered** – which benefits and services Medicaid pays for, and limits on how much of them a member can use (for example, line 112).
- **What providers and plans are paid** – rates, payment methods, and what the RAEs and other plans receive (for example, line 108).
- **How it is run** – administration, contracts, technology, oversight and program integrity, without changing who or what is covered or what is paid (for example, line 113).
- **How it is financed** – where the money comes from – provider fees, taxes, the federal match and other fund sources – rather than how much is spent (for example, line 11).

The lever shows where a line acts and which lines work through the same part of the program. It does not say whether a line saves money or how much.

**Who has to act.** Dept – HCPF or another state agency under authority it already has. MSB – the Medical Services Board by rule. Bill – statute. Budget – the Joint Budget Committee or the Governor's request. CMS – federal approval.

**Where it came from.** Member – raised by a Commission member in a meeting or interview. Agency – a state or local government body, including the Department and legislative staff. Public – individuals, through public comment, the survey, office hours or community meetings. Org – a provider, plan, association, advocacy organization or coalition. Research – national research or another state's model. Many lines came from more than one place.

**The estimate.** The dollar anchor is the figure the record already contains that says what is at stake on that line – not a costing. Department figure – HCPF, its contractors or legislative staff produced it. Stakeholder estimate only – from whoever proposed the line, not yet checked by the Department. Not yet costed. Cost neutral. Costs money – a protection rather than a saving. Amounts are general fund at the state share unless marked TF (total funds). Lines marked † carry a figure that is contested or conflicts with another in the record. *Lines not yet costed will not be costed before the Commission votes in November; a recommendation on one of them would direct the costing as its next step.*

## How to respond

By November 6th, mark every line one of three ways – please do not leave any blank. If no option fits exactly, choose the one closest to your view and use the note to explain. The information in the record is what members will decide with. Beyond the answers already requested, the Department cannot produce new analysis before the November votes. The Governor's budget, released about October 30, will give figures for the reductions it proposes, and SHG will map them to docket lines.

**Proceed.** Keep it on the list for discussion on November 10.

**Proceed with caution due to limited data.** You support pursuing it, but the data in the record is limited. Note what gives you pause or the condition you would attach – a cost limit, a protection for members, a pilot first. A recommendation can carry that condition and direct the costing as its next step.

**Reject.** You are not interested in pursuing it.

Use whichever is easiest: the boxes on the at-a-glance pages below, the Excel version, or the online form. You can text or email Summer with questions, or go through it together via a phone call or in-person meeting with Summer after October 29th. Your responses go to SHG Advisors only and are not shared with other members. On November 10th, SHG reports anonymized counts for each line – not who said what. Where most members mark Reject, SHG will propose taking the line off the list, and any member who wants to keep discussing it can say so. **Recommendations themselves still need seven of ten votes in November.**

## At a glance – Part A – Long-term direction (37 lines)

The detail for each line follows in the same order after the at-a-glance pages.

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **1. Who administers behavioral health, and where its funding sits** | | | | | | | | | |
| **7** | ◆ Consolidate care coordination | How it is run | Dept, Bill | Not yet costed | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **18** | ◆ Move BHA payment and contracting functions into HCPF | How it is run | Bill | Not yet costed | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **73** | ◆ Consider merging CDHS and HCPF | How it is run | Bill | Not yet costed | Member | Original · updated | ☐ | ☐ | ☐ |
| **106** | ◆ Move BHA block-grant dollars into HCPF | How it is financed | Bill, CMS | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **94** | Target BH safety-net and indigent care funding at highest need | How it is financed | Dept, Bill | Not yet costed | Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **96** | Re-evaluate the Behavioral Health Ombudsman Office | How it is run | Dept, Bill | Not yet costed | Org | After Sept 24 | ☐ | ☐ | ☐ |
| **121** | An Office of Recovery and a voice for people in recovery | How it is run | Dept | Not yet costed | Public, Org | New Oct 22 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **2. Whether Medicaid keeps managed care and the ACC in their current form** | | | | | | | | | |
| **19** | ◆ Reduce the number of RAEs and BHASOs † | How it is run | Dept, Bill | Not yet costed | Member, Agency, Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **108** | ◆ Pay for outcomes: more value-based purchasing | What is paid | Dept, CMS | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **43** | Shared claims payment for behavioral health | How it is run | Dept | Not yet costed | Agency, Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **90** | End or limit ACC primary care case management payments † | What is paid | Dept, Bill, CMS | Stakeholder estimate only | Agency, Public, Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **92** | End capitated managed care for behavioral health † | How it is run | Dept, Bill, CMS | Not yet costed | Public, Org | After Sept 24 · updated | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **3. How long-term services and supports are designed and governed** | | | | | | | | | |
| **31** | ◆ Individual budgets for LTSS; consolidate the waivers † | What is covered | Dept, Bill, CMS | Not yet costed | Member, Public | Original | ☐ | ☐ | ☐ |
| **48** | Area Agencies on Aging deliver older-adult services | How it is run | Dept | Not yet costed | Agency | Original | ☐ | ☐ | ☐ |
| **78** | One accountable LTSS structure in the Governor's office | How it is run | Dept, Bill | Not yet costed | Org | After Sept 24 | ☐ | ☐ | ☐ |
| **88** | Sunset Community First Choice | What is covered | Dept, Bill, CMS | Not yet costed | Agency, Public | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **125** | Prescribed pediatric extended care | What is covered | Dept, CMS | Not yet costed | Public | New Oct 22 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **4. What the program's financing base is, beyond the general fund** | | | | | | | | | |
| **11** | ◆ Amend the CHASE provider-fee hierarchy | How it is financed | Bill | Department figure | Member, Org | Original · updated | ☐ | ☐ | ☐ |
| **20** | ◆ Employer contribution to Medicaid | How it is financed | Bill | Not yet costed | Member, Research | Original | ☐ | ☐ | ☐ |
| **51** | ◆ Planned use of unclaimed property funds | How it is financed | Bill | Not yet costed | Member, Agency | Original | ☐ | ☐ | ☐ |
| **72** | ◆ Hard growth limit on the state Medicaid contribution | How it is financed | Bill | Not yet costed | Member, Public, Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **21** | Commercial payment corridor (Washington model) | What is paid | Bill | Cost neutral | Org, Research | Original | ☐ | ☐ | ☐ |
| **50** | Local public funds as federal match; dedicated taxes as match | How it is financed | Dept, Bill, CMS | Not yet costed | Agency, Public, Research | Original | ☐ | ☐ | ☐ |
| **52** | Raise alcohol excise taxes for SUD treatment and Medicaid | How it is financed | Bill | Not yet costed | Public, Org | Original | ☐ | ☐ | ☐ |
| **56** | Hospital global budgets or an AHEAD-style model | What is paid | Dept, Bill, CMS | Not yet costed | Org, Research | Original · updated | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **5. Who is covered, and for which benefits** | | | | | | | | | |
| **33** | ◆ Put CHIP, Cover All Coloradans and eligibility levels on the docket by name | Who is covered | Bill, Budget | Not yet costed | Member | Original | ☐ | ☐ | ☐ |
| **34** | ◆ Cap expansion-population benefits at the federal minimum | What is covered | Dept, Bill, CMS | Not yet costed | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **104** | ◆ Apply reductions to new enrollees only | What is covered | Bill | Not yet costed | Member, Public | New Oct 22 | ☐ | ☐ | ☐ |
| **107** | ◆ Guiding principle: cover as many people as possible | Who is covered | Dept, Bill | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **112** | ◆ Repeal post-2019 benefit additions and utilization-management limits | What is covered | MSB, Bill, CMS | Not yet costed | Member, Agency | New Oct 22 | ☐ | ☐ | ☐ |
| **85** | Smooth the eligibility cliff for people leaving Medicaid | Who is covered | Dept, Bill, CMS | Not yet costed | Org, Research | After Sept 24 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **6. How the program is run, and how the state knows whether it is working** | | | | | | | | | |
| **14** | ◆ Reconcile fiscal-note savings with actual results | How it is run | Bill, Budget | Cost neutral | Member, Org | Original · updated | ☐ | ☐ | ☐ |
| **16** | ◆ Publish forecast assumptions; dynamic budgeting | How it is run | Dept | Cost neutral | Member, Agency, Public, Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **40** | ◆ Standing legislative Medicaid oversight body | How it is run | Bill | Cost neutral | Member, Public, Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **105** | ◆ Utilization trigger requiring legislative approval | How it is run | Bill | Not yet costed | Member, Research | New Oct 22 | ☐ | ☐ | ☐ |
| **115** | ◆ Evaluate a single state-directed Pharmacy Benefit Administrator | How it is run | Dept, Bill | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **15** | An outcome measure for every program, with a wind-down rule | How it is run | Dept, Bill | Not yet costed | Public, Org | Original · updated | ☐ | ☐ | ☐ |

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# At a glance – Part B – Short-term action (89 lines)

The detail for each line follows in the same order after the at-a-glance pages.

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **1. Who administers behavioral health, and where its funding sits** | | | | | | | | | |
| **22** | Guardrails on peer and support services † | What is covered | Dept, CMS | Not yet costed | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **25** | Right-size residential SUD and withdrawal management | What is covered | Dept | Department figure | Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **26** | Review crisis services; site-neutral behavioral health pricing | What is paid | Dept | Not yet costed | Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **28** | Outcome standards for pediatric behavioral therapy and ABA | What is covered | Dept, MSB, Bill | Department figure | Agency | Original · updated | ☐ | ☐ | ☐ |
| **41** | Any-willing-qualified-provider rule; RAE rate transparency | How it is run | Dept, Bill | Not yet costed | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **42** | Behavioral health rate floor and notice before cuts | What is paid | MSB, Bill | Not yet costed | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **46** | CCBHC prospective payment; pause the 80% payment floor | What is paid | Dept, CMS | Department figure | Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **81** | Fix peer services billing (the alternative to line 22) | What is covered | Dept, Bill | Not yet costed | Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **82** | Reconcile behavioral health federal match † | How it is financed | Dept, CMS | Stakeholder estimate only | Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **95** | Tiered payment for comprehensive safety net providers † | What is paid | Dept, CMS | Not yet costed | Agency, Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **101** | Review behavioral health pilot programs and small grants | How it is run | Dept, Bill | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |
| **116** | Reform BHA licensing and network adequacy checks | How it is run | Dept | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |
| **117** | Allow utilization review of outpatient therapy after a set number of visits | What is covered | Dept, Bill | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |
| **118** | Consistent safety-net cost definitions and earlier rates | What is paid | Dept | Stakeholder estimate only | Org | New Oct 22 | ☐ | ☐ | ☐ |
| **123** | Let behavioral health providers limit their Medicaid caseload | What is paid | Dept | Cost neutral | Public | New Oct 22 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **2. Whether Medicaid keeps managed care and the ACC in their current form** | | | | | | | | | |
| **71** | ◆ Expand shared savings and alternative payment models | What is paid | Dept | Department figure | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **111** | ◆ Standardize RAE care coordination and member tiering | How it is run | Dept | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **5** | Validate, then enforce, RAE medical loss ratios † | What is paid | Dept, Bill | Stakeholder estimate only | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **6** | One set of processes across the RAEs and BHASOs | How it is run | Dept, Bill | Cost neutral | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **27** | Incentives for integrated physical and behavioral health care | What is paid | Dept, CMS | Stakeholder estimate only | Org | Original · updated | ☐ | ☐ | ☐ |
| **44** | Cut RAE capitation for avoidable events | What is paid | Dept | Stakeholder estimate only | Org, Research | Original · updated | ☐ | ☐ | ☐ |
| **45** | Independent audit of behavioral health capitation | How it is run | Dept, Bill | Not yet costed | Agency, Public, Org, Research | Original · updated | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **67** | Community health centers as the medical home | How it is run | Dept, Budget | Stakeholder estimate only | Org | Original · updated | ☐ | ☐ | ☐ |
| **68** | Scale EMS treatment-in-place and community paramedicine | What is covered | Dept, Bill | Stakeholder estimate only | Org | Original | ☐ | ☐ | ☐ |
| **83** | Reinvest RAE surplus instead of remitting it | What is paid | Dept, Bill | Stakeholder estimate only | Org | After Sept 24 | ☐ | ☐ | ☐ |
| **99** | One or two statewide RAE quality priorities | What is paid | Dept | Department figure | Public, Org | New Oct 22 | ☐ | ☐ | ☐ |
| **119** | Primary care investment | What is paid | Dept | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **3. How long-term services and supports are designed and governed** | | | | | | | | | |
| **60** | ◆ Re-examine CES waiver eligibility | Who is covered | Dept | Not yet costed | Member, Public, Org | Original | ☐ | ☐ | ☐ |
| **23** | LTSS program-integrity package for CFC † | How it is run | Dept, Bill, CMS | Department figure | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **30** | Limit intermediary agency retention; protect caregiver pay | What is paid | Dept, MSB, Bill | Not yet costed | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **37** | Family-caregiver plan; structured family caregiving | What is covered | Dept, CMS | Stakeholder estimate only | Org | Original · updated | ☐ | ☐ | ☐ |
| **38** | Redesign or reverse PETI on the DD waiver | Who is covered | Dept, Budget | Costs money | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **39** | Hold the weekly caregiver-hour cap until failures are measured † | What is covered | Dept | Costs money | Public, Org | Original | ☐ | ☐ | ☐ |
| **57** | Evaluate CFC net of shifted services before further cuts | What is covered | Dept | Not yet costed | Public, Org | Original | ☐ | ☐ | ☐ |
| **58** | Expand family CNA tasks; a state pathway for pediatric PDN | What is covered | Dept, MSB, CMS | Not yet costed | Org | Original | ☐ | ☐ | ☐ |
| **59** | Decide the Colorado Single Assessment and support-level algorithm | What is covered | Dept | Not yet costed | Public, Org | Original | ☐ | ☐ | ☐ |
| **61** | LTSS exception and appeal reform | How it is run | Dept, Bill | Not yet costed | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **62** | Case management agency choice and performance contracts | How it is run | Dept, Bill | Not yet costed | Public, Org | Original | ☐ | ☐ | ☐ |
| **66** | Housing as a Medicaid cost lever | What is covered | Dept, CMS | Department figure | Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **77** | Remove the Class B license requirement for non-medical CFC services | How it is run | Dept, Bill | Not yet costed | Public, Org | After Sept 24 | ☐ | ☐ | ☐ |
| **79** | Connect case management to claims to see total hours | How it is run | Dept | Not yet costed | Public, Org | After Sept 24 | ☐ | ☐ | ☐ |
| **84** | Cap homemaker hours; pause the children's Community Connector | What is covered | Dept, Budget, CMS | Not yet costed | Agency, Public, Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **86** | Home health episode limits and an R-15 report-back | What is covered | Dept, Budget | Stakeholder estimate only | Org | After Sept 24 | ☐ | ☐ | ☐ |
| **89** | Cap paid parent hours per child † | What is covered | Dept, MSB, CMS | Not yet costed | Agency, Public | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **91** | Fix authorization before cutting LTSS | How it is run | Dept, Budget | Not yet costed | Public | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **93** | Restore LTSS access and rates before further cuts | What is covered | Dept, Budget | Costs money | Public | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **124** | Standards for group care of medically fragile children | What is paid | Dept, Bill | Not yet costed | Public | New Oct 22 | ☐ | ☐ | ☐ |

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| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **4. What the program's financing base is, beyond the general fund** | | | | | | | | | |
| **1** | ◆ Enroll eligible members in Medicare | How it is financed | Dept | Not yet costed | Member, Agency, Public | Original · updated | ☐ | ☐ | ☐ |
| **4** | ◆ Claim federal match on state-only spending | How it is financed | Dept, CMS | Department figure | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **24** | ◆ Pharmacy cost measures | What is covered | Dept, Bill | Not yet costed | Member, Agency | Original · updated | ☐ | ☐ | ☐ |
| **55** | ◆ Changes to the Rural Health Transformation Program | How it is financed | Dept, Bill | Not yet costed | Member, Agency, Org | Original | ☐ | ☐ | ☐ |
| **3** | Preserve the hospital upper payment limit federal draw † | How it is financed | Dept, Bill, CMS | Department figure | Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **10** | Expand program-integrity extrapolation; targeted prepayment review | How it is run | Dept, Bill | Department figure | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **49** | Administrative claiming for local public health | How it is financed | Dept, CMS | Not yet costed | Org | Original | ☐ | ☐ | ☐ |
| **53** | ABLE-account reimbursement of HCBS costs | How it is financed | Bill, CMS | Stakeholder estimate only | Public, Org | Original | ☐ | ☐ | ☐ |
| **54** | Require commercial coverage of services shifted to Medicaid | How it is financed | Bill | Not yet costed | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **126** | Durable medical equipment purchasing | What is paid | Dept, MSB | Not yet costed | Public | New Oct 22 | ☐ | ☐ | ☐ |

| No. | Line | Lever | Who has to act | Estimate | Came from | Added | Proceed | Caution | Reject |
|---|---|---|---|---|---|---|---|---|---|
| **5. Who is covered, and for which benefits** | | | | | | | | | |
| **12** | ◆ Member cost sharing instead of coverage reduction | Who is covered | Bill | Not yet costed | Member, Public | Original | ☐ | ☐ | ☐ |
| **32** | ◆ Benchmark optional benefits against the national midline | What is covered | Dept, Budget | Not yet costed | Member, Agency | Original | ☐ | ☐ | ☐ |
| **64** | ◆ Waitlist before new arrivals access HCBS waivers | Who is covered | Dept, Bill, CMS | Not yet costed | Member, Public | Original | ☐ | ☐ | ☐ |
| **109** | ◆ Make enrolling and re-enrolling as easy as possible | Who is covered | Dept | Not yet costed | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **29** | Raise disability buy-in premiums, phased and income-capped † | Who is covered | Dept, Bill | Stakeholder estimate only | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **35** | Continuous authorization and work-requirement safeguards | Who is covered | Dept, Bill, CMS | Not yet costed | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **36** | NEMT rural classification and rates | What is paid | Dept, Budget | Cost neutral | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **63** | Raise the $2,000 long-term care asset limit | Who is covered | Bill | Costs money | Public, Org | Original | ☐ | ☐ | ☐ |
| **65** | State-only coverage for qualified immigrants losing federal match | Who is covered | Bill | Costs money | Agency, Org | Original | ☐ | ☐ | ☐ |
| **74** | Fix CHP+-to-Medicaid transitions | Who is covered | Dept | Not yet costed | Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **75** | Estate recovery review | Who is covered | Dept, Bill | Not yet costed | Public | Original | ☐ | ☐ | ☐ |
| **76** | One redetermination a year for waiver members | Who is covered | Dept, Bill | Not yet costed | Public, Org | After Sept 24 | ☐ | ☐ | ☐ |
| **87** | Sliding-scale parental fee for children on waivers or CFC † | Who is covered | Dept, Bill, CMS | Stakeholder estimate only | Public | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **98** | Fund appeals capacity before H.R. 1 volume arrives | How it is run | Budget | Costs money | Agency, Org | New Oct 22 | ☐ | ☐ | ☐ |
| **122** | Shared dashboard on coverage loss and access under H.R. 1 | Who is covered | Dept | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |

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| **6. How the program is run, and how the state knows whether it is working** | | | | | | | | | |
| **2** | ◆ Restructure HCPF to cut administrative cost † | How it is run | Dept, Bill, Budget | Not yet costed | Member, Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **9** | ◆ Report and reform recovery audits | How it is run | Dept, Bill | Cost neutral | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **13** | ◆ Commission position on the HB26-1429 county transition | How it is run | Dept, Bill | Not yet costed | Member, Agency, Org | Original · updated | ☐ | ☐ | ☐ |
| **47** | ◆ Consolidate HCPF IT systems | How it is run | Dept, CMS | Not yet costed | Member, Org | Original | ☐ | ☐ | ☐ |
| **97** | ◆ Technology modernization plan that draws the enhanced federal match | How it is run | Dept, CMS | Not yet costed | Member, Agency | New Oct 22 | ☐ | ☐ | ☐ |
| **102** | ◆ Outlier list of service lines where dollars and users diverge | How it is run | Dept | Cost neutral | Member, Agency | New Oct 22 | ☐ | ☐ | ☐ |
| **110** | ◆ Disaggregate the Medical Services Premiums line | How it is run | Budget | Cost neutral | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **113** | ◆ Prevent improper payments before they are made | How it is run | Dept | Department figure | Member | New Oct 22 | ☐ | ☐ | ☐ |
| **114** | ◆ Find other insurance before Medicaid pays | How it is run | Dept | Department figure | Member, Org | New Oct 22 | ☐ | ☐ | ☐ |
| **8** | Streamline contracts, policy memos and rulemaking | How it is run | Dept, MSB | Cost neutral | Public, Org | Original | ☐ | ☐ | ☐ |
| **17** | Target reductions by acuity, not across the board | What is paid | Dept, Bill, Budget | Cost neutral | Agency, Public, Org | Original · updated | ☐ | ☐ | ☐ |
| **69** | Member explanation of benefits; real-time insurance checks | How it is run | Dept | Cost neutral | Public, Org | Original | ☐ | ☐ | ☐ |
| **70** | Pilot policy changes before statewide rollout | How it is run | Dept, MSB | Not yet costed | Public | Original · updated | ☐ | ☐ | ☐ |
| **80** | Notice and justification before benefit or eligibility changes | How it is run | Dept, MSB, Bill | Not yet costed | Public, Org | After Sept 24 · updated | ☐ | ☐ | ☐ |
| **100** | National CMS quality measures in place of state-specific ones | How it is run | Dept | Not yet costed | Public, Org | New Oct 22 | ☐ | ☐ | ☐ |
| **103** | Dynamic budgeting: track how cuts shift costs elsewhere | How it is run | Dept | Cost neutral | Public | New Oct 22 | ☐ | ☐ | ☐ |
| **120** | "Gold card" prior authorization exemptions | How it is run | Dept, Bill | Not yet costed | Org | New Oct 22 | ☐ | ☐ | ☐ |

# Part A – Long-term direction

## 1. Who administers behavioral health, and where its funding sits

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| **7** | **◆ Consolidate care coordination**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 | 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 | **Commission member, Government agency, Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>Priorities for a Sustainable, Accessible Colorado Medicaid Program |

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| | to the general fund. Also proposed (October 20): comprehensive safety net providers and CCBHCs coordinate care for the highest-need people they serve, under managed-care oversight and without financial risk, with duplicative RAE and BHASO coordination reduced and records matched against provider rosters to find duplication (a behavioral health provider association); supporters of the BHASO transfer add that the State define who does what (another behavioral health provider association). Also proposed: count pregnancy through 12 months postpartum as a high-complexity trigger and make the RAE referral channel work for birthing units (a perinatal quality collaborative). | | alternative comes from a behavioral health coalition of providers, payers and consumer advocates whose members include a RAE and a BHASO. $113.4M FY25-26 – RAE care coordination; 54% – share of RAE care coordination delivered by contracted providers (HCPF baseline, Oct 2) (a behavioral health provider association, October 20); 12 months postpartum – proposed end of the high-complexity window (a perinatal quality collaborative, October 20) | CBHC Medicaid Commission Recommendations<br>Stakeholder Comments on the Medicaid Commission's Initial Recommendations |
| **18** | **◆ Move BHA payment and contracting functions into HCPF**<br>*How it is run · Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Move the Behavioral Health Administration's payment, contracting and care-coordination functions into HCPF, leaving licensing and crisis outside the payer; consolidate the behavioral health programs scattered across nine to twelve departments that contract with the same providers. Opposed (October 20): a behavioral health provider association would keep the BHA as a cabinet-led agency with a streamlined role, review each BHA position's function, workload and statutory or federal basis, and complete the 2020 Blueprint's delegation of roles to BHASOs and providers. Members discussed consolidating administrative costs across behavioral health agencies and asked for an analysis of consolidating the behavioral health programs spread across nine to twelve departments (October 7 meeting). | 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 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. | **Commission member, Government agency, Organization**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |
| **73** | **◆ Consider merging CDHS and HCPF**<br>*How it is run · Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Consider merging CDHS and HCPF. See line 78 for the LTSS-only version and line 106 for moving BHA block-grant dollars. | General Assembly | Not costed | **Commission member**<br>Commission interviews |
| **106** | **◆ Move BHA block-grant dollars into HCPF**<br>*How it is financed · Bill, CMS · Not yet costed · New (Oct 22) · Split from line 73*<br>Move the Behavioral Health Administration's federal block-grant dollars into HCPF. Split from line 73; read with line 18. | General Assembly; SAMHSA | Not costed. The BHA is the state's designated authority for the federal substance use and mental health block grants (SAMHSA). | **Commission member** |
| **94** | **Target BH safety-net and indigent care funding at highest need**<br>*How it is financed · Dept, Bill · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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 | General Assembly; BHA; BHASOs | 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. | **Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |

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| | flexible BHASO funding rather than siloed streams. A behavioral health provider association would preserve early intervention while focusing on the highest-need people, have funding follow the obligation by contract to the designated provider, CSNP or ESNP, and, as BHA develops no-refusal enforcement, clarify who follows up after assessment and referral so that a CSNP that is not the primary treating provider does not automatically take on placement responsibility (October 20). Another behavioral health provider association offers statutory language. | | | CBHC Medicaid Commission Recommendations |
| **96** | **Re-evaluate the Behavioral Health Ombudsman Office**<br>*How it is run · Dept, Bill · Not yet costed · Added after Sept 24*<br>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 | 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. | **Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |
| **121** | **An Office of Recovery and a voice for people in recovery**<br>*How it is run · Dept · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>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. | Governor; HCPF; BHA | Not costed. | **Public, Organization**<br>Coalition 2045: A Peer-Led Plan for a Sustainable Colorado Peer Workforce |

## 2. Whether Medicaid keeps managed care and the ACC in their current form

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| **19** | **◆ Reduce the number of RAEs and BHASOs †**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Reduce the number of RAEs and BHASOs – to two, or one with regions – or, in the alternative, standardize them (line 6); a further alternative heard: bar for-profit entities from behavioral health managed care contracts, as Minnesota does. Alternatives proposed (October 20): prioritize Colorado-based companies for behavioral health managed care contracts while keeping federal consumer-choice compliance, and pilot two or more MCOs for physical health managed care in one county to test payer choice (a behavioral health provider association); consider approaches other states use to preserve community-rooted nonprofit plans and local accountability (a RAE). A behavioral health provider asks whether a for-profit managed care organization that cannot administer Medicaid responsibly should continue to do so; BHA lists targeted regional contracting among its focus areas. | 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. | **Commission member, Government agency, Organization, Research / other states**<br>Managed Care as Medicaid's Administrative Architecture: Does It Still Provide Value to Sta<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026)<br>Medicaid Managed Care 101<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>COA Recommendations for Savings |
| **108** | **◆ Pay for outcomes: more value-based purchasing**<br>*What providers and plans are paid · Dept, CMS · Not yet costed · New (Oct 22) · Added from a Commission member submission*<br>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 99. | HCPF; RAEs; CMS for some payment models | Not costed. Maternity bundle $6.7M over five years (line 71). $411.8M in RAE quality incentives paid over seven years (line 99). | **Commission member** |
| **43** | **Shared claims payment for behavioral health**<br>*How it is run · Dept · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Move behavioral health claims payment onto shared or state-administered infrastructure, keeping RAEs for network and coordination; standardize prior | HCPF | 4.5M capitated BH claims FY24-25 | **Government agency, Organization, Research / other states** |

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| | authorization statewide and integrate with provider records. Opposed (October 20): a RAE. HCPF reports strengthened monitoring and retroactive review of outpatient psychotherapy, with RAEs directed to explore utilization management for outlier billing and to apply targeted prior authorization in FY 2026-27; prior authorization for outpatient psychotherapy is constrained by SB22-156 (HCPF, October 20). | | | Managed Care as Medicaid's Administrative Architecture: Does It Still Provide Value to Sta<br>COA Recommendations for Savings<br>Behavioral Health Cost Growth |
| **90** | **End or limit ACC primary care case management payments †**<br>*What providers and plans are paid · Dept, Bill, CMS · Stakeholder estimate only · Added after Sept 24 · Updated Oct 22*<br>End the Accountable Care Collaborative's primary care case management and care coordination payments, or limit them to adults and fund a pediatric primary care payment model from the children's share – care coordination, team-based care and preventive care, paid when delivered rather than on outcome metrics, with the AAP PACK report and Commission testimony on pediatric payment as the reference – keeping a per-member payment for pediatric primary care practices. Relates to 7, 15, 19 and 71. Opposed (October 20): a RAE. HCPF reports it will reduce provider incentive payments, not yet specified (HCPF, October 20). | General Assembly; HCPF (procurement and contracts); CMS | 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. | **Government agency, Public, Organization**<br>COA Recommendations for Savings<br>Current Fiscal Year Action Plans |
| **92** | **End capitated managed care for behavioral health †**<br>*How it is run · Dept, Bill, CMS · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>End capitated managed care for behavioral health: pay behavioral health services fee-for-service or through an administrative-services contract, keeping network and care-coordination functions where they add value; first, have HCPF cost the administrative saving at constant utilization. Relates to 5, 19, 43 and 45; line 18 asks the agency question with and without it. Opposed (October 20): a behavioral health provider association, which asks that any move proceed through analysis, stakeholder engagement and targeted pilots, and a RAE. Another behavioral health provider association is neutral on managed-care structure (lines 19 and 92) provided cost-based safety-net payment first has a defined home and high-acuity and no-refusal responsibility is assigned. | General Assembly; HCPF; CMS (waiver and state plan amendments) | 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. | **Public, Organization**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations<br>COA Recommendations for Savings |

## 3. How long-term services and supports are designed and governed

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| **31** | **◆ Individual budgets for LTSS; consolidate the waivers †**<br>*What is covered · Dept, Bill, CMS · Not yet costed · Original (Sept 24)*<br>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. | **Commission member, Public** |

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| 48 | **Area Agencies on Aging deliver older-adult services**<br>*How it is run · Dept · Not yet costed · Original (Sept 24)*<br>Contract Area Agencies on Aging to deliver community-based services for older adults, as other states do. | HCPF; CDHS | AAA state senior services ~$46M | **Government agency**<br>Regional council of governments |
| 78 | **One accountable LTSS structure in the Governor's office**<br>*How it is run · Dept, Bill · Not yet costed · Added after Sept 24*<br>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 | Not costed. Eight CMAs "interpret differently"; surveys 2.5 years late; ~100,000 LTSS members, 15 agencies, 2M+ actions a year (CMA estimate) | **Organization**<br>Case management agency; provider agencies; home health owner – one session and talking points |
| 88 | **Sunset Community First Choice**<br>*What is covered · Dept, Bill, CMS · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>Sunset Community First Choice and return personal care, homemaker and health maintenance services to the HCBS waivers, phased over more than one year. The larger alternative to the CFC package in line 23; read with 57. HCPF is evaluating removing personal care for children from Community First Choice; a forwarder of the proposal asks whether families encouraged to move from CNA services to personal care can return without a reduction in hours or a reassessment (HCPF roundtable proposal, October 20). | General Assembly; HCPF; CMS (State Plan Amendment ending the 1915(k) option; waiver amendments) | 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. $17 million Gen Fund – savings; Current 48 hour soft cap to Zero – change; 5500 children - 100% of those receiving personal care – affected (HCPF roundtable proposal, October 20) | **Government agency, Public**<br>Parent of an adult with IDD – written submission (October) |
| 125 | **Prescribed pediatric extended care**<br>*What is covered · Dept, CMS · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>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. | HCPF; CMS (state plan or waiver amendment) | Not costed. Private duty nursing ~$4–6K a day in the hospital against ~$1,500 at home (line 58). | **Public** |

## 4. What the program's financing base is, beyond the general fund

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| 11 | ◆ **Amend the CHASE provider-fee hierarchy**<br>*How it is financed · Bill · Department figure · Original (Sept 24) · Updated Oct 22*<br>Amend the CHASE funding hierarchy so the expansion population is not the sole absorber of provider-fee reductions, with rural and frontier hospitals, and Denver Health, held harmless as the fee ratchets down; read with line 3. Alternative proposed (October 20): rather than isolated provider-fee changes, a defined, collaborative CHASE reform initiative with timelines and deliverables, in which key partners evaluate federal funding, expenditure growth, coverage and hospital reimbursement, and the legal, fiscal and access implications of changes before they advance (a hospital association). | 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. approximately $11 billion – CHA | **Commission member, Organization**<br>H.R. 1 – Hospital Provider Fees & State Directed Payments<br>Colorado Medicaid's State Directed Payment Program<br>Medicaid Enrollment, Expenditure and Outcomes Data<br>From Vision to Action: A Roadmap to Strengthen and Sustain Rural Hospitals in Colorado |

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| | | | estimate of cumulative federal funding reductions over five years under H.R. 1 absent replacement financing; more than 438,000 Coloradans – coverage financed by the hospital provider fee; 51% – share of hospital Medicaid reimbursement statewide from supplemental payments (a hospital association, October 20) | Recommendations to the 2026 Colorado Medicaid Commission |
| **20** | ◆ **Employer contribution to Medicaid**<br>*How it is financed · Bill · Not yet costed · Original (Sept 24)*<br>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. | **Commission member, Research / other states** |
| **51** | ◆ **Planned use of unclaimed property funds**<br>*How it is financed · Bill · Not yet costed · Original (Sept 24)*<br>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 | Fund ~$2.3B; drawn ~$200–300M/yr | **Commission member, Government agency**<br>Unclaimed Property and Disposition of Funds Statutes |
| **72** | ◆ **Hard growth limit on the state Medicaid contribution**<br>*How it is financed · Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>A hard growth limit: the state Medicaid contribution grows at inflation only, within TABOR's band. Parts of the earlier line are now lines 104 and 105. Opposed (October 20): a behavioral health provider association, because health costs outpace inflation and triggers could delay responses to emerging needs. | General Assembly | Not costed | **Commission member, Public, Organization, Research / other states**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |
| **21** | **Commercial payment corridor (Washington model)**<br>*What providers and plans are paid · Bill · Cost neutral · Original (Sept 24)*<br>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. | **Organization, Research / other states** |
| **50** | **Local public funds as federal match; dedicated taxes as match**<br>*How it is financed · Dept, Bill, CMS · Not yet costed · Original (Sept 24)*<br>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 | Not costed; Utah HB 599 (2026) nicotine fund as match | **Government agency, Public, Research / other states**<br>Advanced Deliverables for Sept 2 Commission Meeting |
| **52** | **Raise alcohol excise taxes for SUD treatment and Medicaid**<br>*How it is financed · Bill · Not yet costed · Original (Sept 24)*<br>Raise alcohol excise taxes and dedicate revenue to SUD treatment and Medicaid. | General Assembly (likely referred) | 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 | **Public, Organization**<br>Physician testimony; medical society |
| **56** | **Hospital global budgets or an AHEAD-style model**<br>*What providers and plans are paid · Dept, Bill, CMS · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 | General Assembly; HCPF; CMS | Maryland: 16% fewer admissions 16 percent – Maryland reduction in admissions cited in the proposal (a perinatal quality collaborative, October 20) | **Organization, Research / other states**<br>Medicaid Growth, Financing, Relationship to Commercial Costs and Prices, and Other Demogra |

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| | districts operating within a global budget. Also proposed (October 20): voluntary, locally designed regional rural collaboratives under the RHTP that share staff, infrastructure, data and service capacity, piloted and scaled if successful, and alignment of RHTP, the Hospital Improvement Program and CHASE under one rural performance framework within an all-payer strategy (a rural health advocacy group). A perinatal quality collaborative supports the obstetrics pilot, asking how baselines avoid locking in underservice and what happens to HQIP quality funding. | | | A Template for Rural Health System Sustainability in Colorado<br>Leveraging the Rural Health Transformation Program to Strengthen Rural Health Through Regi<br>From Vision to Action: A Roadmap to Strengthen and Sustain Rural Hospitals in Colorado<br>Stakeholder Comments on the Medicaid Commission's Initial Recommendations |

## 5. Who is covered, and for which benefits

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| **33** | **◆ Put CHIP, Cover All Coloradans and eligibility levels on the docket by name**<br>*Who is covered · Bill, Budget · Not yet costed · Original (Sept 24)*<br>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. | **Commission member**<br>Data Requests for Sept 2 Commission Meeting<br>Optional Medicaid Services, Fiscal Years 2008-09, 2018-19 and 2025-26 |
| **34** | **◆ Cap expansion-population benefits at the federal minimum**<br>*What is covered · Dept, Bill, CMS · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Cap benefits for the expansion population: set the alternative benefit plan at the federal minimum essential health benefits with annual limits on optional services (adult dental, vision, non-emergency transportation where permitted), rather than reducing eligibility, if the CHASE trigger hits. Opposed (October 20): a behavioral health provider association, because the cap would fall disproportionately on people with mental health and substance use conditions; a dental association opposes further limiting the adult dental benefit, citing recent rate cuts, the reinstated annual cap and emergency department cost shifts in other states. | 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. ~20% – Colorado Access expansion members at risk of losing coverage under work requirements who have a substance use disorder; 72% – share of Colorado Medicaid beneficiaries treated for SUD in 2021 who were in the adult expansion group (federal Medicaid analysis) (a behavioral health provider association, October 20); approximately 3.3% – dental share of total Medicaid spending in SFY25-26; about 1.2% – adult dental share of total state Medicaid budget; 15% – 2025 targeted rate cuts to selected Medicaid dental codes; $3,000 – annual maximum adult dental benefit reinstated in 2026; 65% – federal match rate for adult dental; $400 to $1,500 – ED visit for dental pain, versus $90 to $200 for a routine dental visit; | **Commission member, Government agency, Organization**<br>Medicaid Enrollment, Expenditure and Outcomes Data<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>Colorado Dental Association Input to Legislative Medicaid Commission |

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| | | | 48%, 100%, 128% – increases in ED visits, surgical interventions and hospital admissions after Illinois's 2012 cutback (a dental association, October 20) | |
| **104** | ◆ **Apply reductions to new enrollees only**<br>*What is covered · Bill · Not yet costed · New (Oct 22) · Split from line 72*<br>Grandfather current rates and apply any reductions to new enrollees only. Split from line 72. | General Assembly | Not costed. | **Commission member, Public** |
| **107** | ◆ **Guiding principle: cover as many people as possible**<br>*Who is covered · Dept, Bill · Not yet costed · New (Oct 22) · Added from a Commission member submission*<br>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. | Commission; General Assembly; HCPF | A principle rather than a costed change. Most members who spoke on October 7 favored keeping coverage over cutting eligibility. | **Commission member** |
| **112** | ◆ **Repeal post-2019 benefit additions and utilization-management limits**<br>*What is covered · MSB, Bill, CMS · Not yet costed · New (Oct 22) · Added from a Commission member submission*<br>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. | General Assembly; Medical Services Board; CMS where approval is needed | Not costed as a package. HCPF's list of state-driven eligibility and benefit expansions, 2017–2026, gives the cost of each (September 17). Members cited about $40 million for the outpatient utilization-management prohibition (October 7). | **Commission member, Government agency** |
| **85** | **Smooth the eligibility cliff for people leaving Medicaid**<br>*Who is covered · Dept, Bill, CMS · Not yet costed · Added after Sept 24*<br>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. | General Assembly; HCPF; CMS | 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) | **Organization, Research / other states**<br>Medicaid Coverage Transitions & Economic Mobility<br>CBHC Medicaid Commission Recommendations |

## 6. How the program is run, and how the state knows whether it is working

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| **14** | ◆ **Reconcile fiscal-note savings with actual results**<br>*How it is run · Bill, Budget · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>Require a reconciliation of every major Medicaid policy change's fiscal-note savings claim against actual results, transmitted to the JBC annually, beginning with Community First Choice, HB21-1021 peer services, Cover All Coloradans and the nurse assessor program that sunset December 2025; count downstream appeal, administrative and workforce costs in every savings estimate, and present each reduction in state-share and total-funds terms. Require every major administrative-efficiency proposal to show current spending, implementation cost, projected savings and actual results, separating General Fund, total funds, additional federal revenue and costs shifted to counties or providers, so the same saving is not counted twice across lines. | 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). | **Commission member, Organization**<br>State Driven Eligibility and Benefit Expansions 2017-2026<br>Advanced Deliverable: Medicaid Growth Trends<br>Recommendations to the 2026 Colorado Medicaid Commission<br>CBHC Medicaid Commission Recommendations |
| **16** | ◆ **Publish forecast assumptions; dynamic budgeting**<br>*How it is run · Dept · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>Publish the actuarial assumptions and confidence intervals behind every Medicaid forecast and fiscal note on a standing dashboard, and build service-category forecasting with the all-payer claims database as an independent check. Parts of the earlier line are now lines 102 and 103. HCPF will refine the fund-source part of the forecast after the FY 2025-26 General Fund overexpenditure and will revise | HCPF, with OSPB and JBC staff; CIVHC under existing contract | Cost neutral. Anchor for why: $157.9M FY25-26 overexpenditure; FY26-27 forecast revised +$703M GF; FY27-28 +$417M (OSPB). Kentucky and Nevada models (NCSL). approximately 80% – share of CES members accessing Community Connector (HCPF figure); 508 in FY2018-19 – average monthly Community Connector users; more than 3,000 in FY2024-25 – average monthly | **Commission member, Government agency, Public, Organization, Research / other states**<br>Medicaid Budget<br>OSPB and HCPF Follow Up from September 17 Meeting |

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| | the FY 2026-27 General Fund estimate in its November 1, 2026 budget submission (HCPF and OSPB, October 20). | | Community Connector users (a member of the public, October 20); $157.9 million – FY 2025-26 General Fund overexpenditure, about 2.7% above final spending authority; $71.5M GF – forecast assumptions vs. actual experience; $31.8M GF – Medicaid Drug Rebate Program unit rebate offset amounts; $39.7M GF – overestimated expenditure for expansion populations (same figure also cited for the fund-source error; source does not explain); $86.4M GF – remaining overexpenditure (utilization changes, accounting adjustments, recoveries shortfall); $703M (12.7%) – estimated FY 2026-27 GF spending above FY 2025-26 spending authority; $442M GF – preliminary FY 2026-27 forecast increase ($443M in the OSPB data section); 37.8% – HCPF share of state General Fund, FY 2027-28 (24.3% in FY 2012-13; 37.0% in FY 2026-27); Behavioral Health $496M (FY 2027-28) to $1,511M (FY 2037-38) – ten-year GF projection; Community-Based Long-Term Care $1,876M (FY 2027-28) to $7,454M (FY 2037-38) – ten-year GF projection (OSPB and HCPF, October 20) | The Medicaid Balancing Act – NCSL Summit 2026<br>Colorado's All Payer Claims Database (HCPF Final Package for Meeting 6)<br>CBHC Medicaid Commission Recommendations |
| **40** | **◆ Standing legislative Medicaid oversight body**<br>*How it is run · Bill · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>A standing legislative Medicaid oversight body to carry unresolved items past December 11 (Connecticut, Kentucky, North Carolina); sequence LTSS structural recommendations with the externally convened LTSS Work Group reporting September 2027. Opposed in part (October 20): a behavioral health provider association, citing risk of political influence and frequent policy shifts and a preference for a stable, evidence-informed policy environment. | General Assembly | Cost neutral | **Commission member, Public, Organization, Research / other states**<br>LTSS Work Group One Pager for Legislators<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations |
| **105** | **◆ Utilization trigger requiring legislative approval**<br>*How it is run · Bill · Not yet costed · New (Oct 22) · Split from line 72*<br>Require legislative approval when a service category grows more than a set percentage in a year (Idaho SB 1108). Split from line 72. | General Assembly | Not costed. Idaho SB 1108 (NCSL). | **Commission member, Research / other states** |
| **115** | **◆ Evaluate a single state-directed Pharmacy Benefit Administrator**<br>*How it is run · Dept, Bill · Not yet costed · New (Oct 22) · Added from Commission member submissions*<br>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. | HCPF; General Assembly if statute is needed | Not costed for Colorado. Drug cost ~$2.1B against rebates plateaued ~$1.0B (HCPF; line 24). Ohio has reported savings from its single PBM. | **Commission member** |
| **15** | **An outcome measure for every program, with a wind-down rule**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>A defined outcome measure for every Medicaid program and contract, published annually, with a rule that a program the data show is not delivering is wound down. Parts of the earlier line are now lines 99, 100 and 101. Also proposed (October 20): rural-appropriate measures using multi-year trends and regional | 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). The Department's H.R. 1 outreach measures are reach and engagement, not outcomes, by its own description. Not costed – savings depend on what | **Public, Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |

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| | 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. | | fails the test. nearly two dozen – programs in other state agencies identified as consolidation candidates; $5.2M to $7.9M – estimated cost savings from transferring programs from BHA to BHASOs, with FTE reduction (a behavioral health provider association, October 20); three measures – CMS Hospital IQR maternal set (a perinatal quality collaborative, October 20) | Leveraging the Rural Health Transformation Program to Strengthen Rural Health Through Regi<br>Stakeholder Comments on the Medicaid Commission's Initial Recommendations<br>Peer Support & Medicaid Brief |

# Part B – Short-term action

## 1. Who administers behavioral health, and where its funding sits

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| 22 | **Guardrails on peer and support services †**<br>*What is covered · Dept, CMS · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Limit allowable place of service and provider types for peer and support services, require clinical oversight, and seek CMS approval to pause enrollment of new unlicensed behavioral health providers; test whether peer and support services can be delivered through primary care and integrated settings rather than as standalone billed services. 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. Also proposed (October 20): disallow peer-led groups in Recovery Community Organizations and Recovery Support Services Organizations while keeping them in treatment and facility-based settings (a behavioral health provider association), and tighten the coding manual for non-clinical skills training (a health plan association). Opposed (October 20): the aggregate cap across 18 codes, which would reach case management and rehabilitation that people with serious mental illness depend on (a behavioral health provider association), and clinical oversight and place-of-service limits, in favor of peer-competent supervision under SAMHSA standards and a comparison of delivery models on disaggregated data (a peer-support organization). HCPF reports provider, credentialing, group-scope, daily (CO MUE) and same-day billing limits phased in from July 1, 2025 to October 1, 2026, with limits on services not connected to clinical care as the next step, and said it found a couple of thousand cases of peer or supportive services with no connected clinical care (October 7 meeting). | 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 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. 9.25 (FY 2022-23) to 24.75 (FY 2025-26) – supportive service hours per person; 286% – growth in H0038, H0023 and H2014 billing between FY2022 and FY2024; $8.8 million (FY2022) to $51.8 million (FY2025) – H0038 spend (HCPF, October 20) | **Government agency, Public, Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Peer Support & Medicaid Brief<br>Peer Support & Medicaid Brief – Questions from Commission on Medicaid Answered by CMWN<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>Priorities for a Sustainable, Accessible Colorado Medicaid Program |
| 25 | **Right-size residential SUD and withdrawal management**<br>*What is covered · Dept · Department figure · Original (Sept 24) · Updated Oct 22*<br>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 | 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 | **Government agency, Organization**<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026) |

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| | 1115 waiver's own evaluation. Also proposed (October 20): a behavioral health Certificate of Need process in which BHA establishes need, providers show alignment with it before licensure for public contracts, and providers repeatedly failing quality standards lose contracts, covering residential, crisis, inpatient and withdrawal management services (a behavioral health provider association); placement based on need rather than facility counts, with ambulatory withdrawal management at a sustainable rate (another behavioral health provider association). HCPF is implementing ASAM 4th edition and will end free-standing withdrawal management on July 1, 2027 (HCPF, October 20). | | residential breakout and per-day table requested for the packet are still owed. thirty-five states – have a certificate of need program as of 2025 (a behavioral health provider association, October 20); July 1, 2027 – end of free-standing withdrawal management (HCPF, October 20); SUD residential spending at about twice its 2018 estimate (HCPF, October 7 meeting) | Behavioral Health Accountability Map: BHASOs as Contractors; 1115 Waiver Demonstrations<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations<br>Behavioral Health Cost Growth |
| **26** | **Review crisis services; site-neutral behavioral health pricing**<br>*What providers and plans are paid · Dept · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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. Opposed (October 20): two behavioral health provider associations would pay walk-in centers and crisis stabilization units for 24/7 standby capacity rather than per-visit or site-neutral pricing, with CSU payment rewarding overnight referrals and complex clients; one would also fix walk-in center and CSU licensing and service expectations and bring them under a Certificate of Need process. HCPF stopped directing cost-based CSU and ATU payments on July 1, 2026, moving to a fee schedule (HCPF, October 20). | 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. 20 hours – care in a facility that must operate 24/7, compared with a single outpatient encounter (a behavioral health provider association, October 20); about twice a hospital daily rate – average cost-based ATU/CSU rate before July 2024 (HCPF, October 20) | **Government agency, Organization**<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations<br>Behavioral Health Cost Growth |
| **28** | **Outcome standards for pediatric behavioral therapy and ABA**<br>*What is covered · Dept, MSB, Bill · Department figure · Original (Sept 24) · Updated Oct 22*<br>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 reports it will implement new regulations and national clinical guidelines for pediatric behavioral therapy (HCPF, October 20). | 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). | **Government agency**<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026)<br>Current Fiscal Year Action Plans |
| **41** | **Any-willing-qualified-provider rule; RAE rate transparency**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 how they set provider rates and how they determine that a rate change will not harm access – information plans otherwise treat as proprietary. Also proposed (October 20): publish the standards RAEs and BHASOs use to set rates and to award, renew or end provider contracts, with written reasons and a way to challenge decisions (a behavioral health provider association); restore 90-day enrollment, interest on erroneously denied or delayed claims and access to covered codes in RAE contracts (a behavioral health provider consultancy). Opposed (October 20): another behavioral health provider association proposes a Certificate of Need approach instead (line 25), and HCPF reports it will end any-willing-provider contracting for RAEs and terminate contracts with outlier billing. | General Assembly; HCPF | Not costed; 52 credentialing/contracting concerns in HCPF's FY24-25 escalation process 90-day – enrollment timeframe formerly required (a behavioral health provider consultancy, October 20) | **Government agency, Public, Organization**<br>Interim Commission Testimony – Seven Structural Issues Requiring the Commission's Attentio<br>Written Testimony for the Medicaid Interim Commission<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations<br>Behavioral Health |
| **42** | **Behavioral health rate floor and notice before cuts**<br>*What providers and plans are paid · MSB, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22* | General Assembly; Medical Services Board | "One GF dollar buys $10 of BH care" for expansion adults; 77% of CSNPs at break-even or loss (association survey, March 2026) 2 per | **Public, Organization**<br>Interim Commission Testimony – Seven Structural Issues |

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| | 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. Alternative proposed (October 20): tie payment to quality rather than a uniform floor, with notice periods scaled to the size of the change (a behavioral health provider association). Also proposed: an independent parity review of a RAE's behavioral health reimbursement (a behavioral health provider); notice before payment-method, claims-rule and enrollment-type changes (a behavioral health provider); and treating unit and code limits, including new Medically Unlikely Edits on H0005, H2014 and T1017, as material changes requiring 90-day notice under state law, with parity applied to service limits (a behavioral health provider consultancy). | | session to 1 – H0005 group units; 6 hours per fiscal year – new H2014 limit; 16 hours per fiscal year – T1017 case management limit; 1 hour per day – T1017 daily limit (a behavioral health provider consultancy, October 20); PT25 to PT77 – required provider-type change on July 1 (a behavioral health provider, October 20) | Requiring the Commission's Attentio<br>Written Testimony for the Medicaid Interim Commission<br>Colorado's Behavioral Health Safety Net: What's Happening and What You Can Do<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>$6K+ Clawback for Anthem/CCHA Medicaid Claims from 2024 and 2025 |
| **46** | **CCBHC prospective payment; pause the 80% payment floor**<br>*What providers and plans are paid · Dept, CMS · Department figure · Original (Sept 24) · Updated Oct 22*<br>Move comprehensive safety net providers to CCBHC prospective payment and pause the 80% state-directed payment floor until metrics are defined. Also proposed (October 20): evaluate CCBHC fit during the demonstration and design prospective payment with temporary innovation rate adjustments and flexible service areas (a behavioral health provider association); keep cost-based payment until CCBHC payment has a permanent home in the state plan and replace the 80–105% corridor that took effect October 1 with a stable, published methodology (another behavioral health provider association); reconsider the 80% CSNP payment model in light of the no-refusal obligation (a behavioral health provider consultancy). HCPF secured the CCBHC demonstration and, from July 1, 2026, no longer sets a minimum rate for essential safety net services in bedded facilities, while continuing directed rates for CSNPs and other named services (HCPF, October 20). | HCPF; CMS | 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 three-year – FQHC cost-reporting average used to set rates (a behavioral health provider association, October 20); 80–105% – corridor that took effect October 1 (a behavioral health provider association, October 20); 80% of the current rate – CSNP payment as of 7/1/2026; approximately 25-30% higher – promised ESNP directed rates; 6 months or more – ESNP licensing time (a behavioral health provider consultancy, October 20) | **Government agency, Organization**<br>Medicaid Financing: Considerations for Colorado's Behavioral Health Safety Net<br>Comprehensive Safety Net Providers: Answers to the Commission's October 7 Questions<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations<br>Behavioral Health Cost Growth |
| **81** | **Fix peer services billing (the alternative to line 22)**<br>*What is covered · Dept, Bill · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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.” Also proposed (October 20): disaggregate growth in the H0038, H0023 and H2014 codes by service, provider type and billing entity before attributing it to peer support, and protect role fidelity so peer staff are not required to drug test, conduct room checks or enforce treatment compliance (a peer-support organization). Panelists warned that limiting peer services alone may shift billing to staff who also hold the qualified behavioral health assistant credential, and that there is no cap on the number of peers billing under one rendering provider (October 7 meeting). | HCPF; BHA; General Assembly if a licensing framework | 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 $293 million – FY24-25 'peer & support services' spending presented by HCPF; 286 percent in two years – growth in the three support-service codes (a peer-support organization, October 20) | **Organization**<br>Colorado Peer Provider Oversight, Medicaid Integrity, and a Path Forward<br>Peer Support & Medicaid Brief<br>Peer Support & Medicaid Brief – Questions from Commission on Medicaid Answered by CMWN<br>Coalition 2045: A Peer-Led Plan for a Sustainable Colorado Peer Workforce<br>CBHC Medicaid Commission Recommendations |
| **82** | **Reconcile behavioral health federal match †**<br>*How it is financed · Dept, CMS · Stakeholder estimate only · Added after Sept 24 · Updated Oct 22*<br>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 | HCPF; JBC staff; CMS | 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 about | **Organization**<br>Ten Cents on the Dollar: Why Behavioral Health Cuts Cost Colorado More Than They Save – Ma<br>CBHC Medicaid Commission Recommendations |

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| | 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. A perinatal quality collaborative asks HCPF to name the federal authority, expected match rate and services covered for the replacement prenatal behavioral health match (October 20). | | $2.3 million – value of replacement authority cited in the proposal (a perinatal quality collaborative, October 20) | Stakeholder Comments on the Medicaid Commission's Initial Recommendations |
| **95** | **Tiered payment for comprehensive safety net providers †**<br>*What providers and plans are paid · Dept, CMS · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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. A behavioral health provider association is open to paying more for the hardest-to-serve through the federal CCBHC options with special population rates and outlier payments (PPS-2 and PPS-4), which Colorado's daily PPS-1 lacks (October 20). HCPF reports cost transparency and allowable-cost limits in CSNP prospective payment from July 2025, value-based payments from October 2026 and RAE use of capitated CSNP arrangements (October 20); it said CSNP indirect costs are not capped and prospective payment spending is rising significantly, and claims of 33 to 44 percent overhead were left unresolved (October 7 meeting). | HCPF; BHA; RAEs and BHASOs (contracts); CMS for the rate methodology | 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. 50% – federal match for non-expansion members under the CSNP rate; 65% – federal match during the CCBHC demonstration; 2 providers in year one; up to 8 under consideration for year two – Colorado CCBHC participants (a behavioral health provider association, October 20); 24 percent – federal indirect rate one provider stated it uses (October 7 meeting) | **Government agency, Organization**<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>CBHC Medicaid Commission Recommendations<br>Comprehensive Safety Net Providers: Answers to the Commission's October 7 Questions<br>Behavioral Health Cost Growth |
| **101** | **Review behavioral health pilot programs and small grants**<br>*How it is run · Dept, Bill · Not yet costed · New (Oct 22) · Split from line 15*<br>Review behavioral health pilot programs and small grants on outcomes, client satisfaction, sustainability, administrative burden and duplication, and wind down those that are not delivering. A behavioral health coalition offered to help with the review (written submission, October 5). Split from line 15. Also proposed (October 20): consolidate or eliminate behavioral health pilots and small grants duplicated across agencies and transfer multiple BHA programs to the BHASOs (a behavioral health provider association). | BHA; HCPF; General Assembly | Not costed. | **Organization** |
| **116** | **Reform BHA licensing and network adequacy checks**<br>*How it is run · Dept · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>Reform Behavioral Health Administration licensing so site visits measure quality of care rather than process compliance, and require network adequacy reports that verify hours of operation, appointment availability for Medicaid members no less favorable than for other patients, after-hours access and whether quality standards are met. Before BHA licensing and designation rules take effect – including ASAM 4th edition and walk-in crisis center licensure – assess their effects on access, administrative burden, capacity and state cost, especially in rural and frontier areas where one provider may carry the full continuum. | BHA; HCPF; BHASOs and RAEs (reporting) | Not costed. ASAM 4th edition alignment takes effect July 1, 2027 (behavioral health provider association). Relates to lines 25 and 26. | **Organization**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CBHC Medicaid Commission Recommendations |
| **117** | **Allow utilization review of outpatient therapy after a set number of visits**<br>*What is covered · Dept, Bill · Not yet costed · New (Oct 22) · Added from submissions received October 6–21* | General Assembly (the 2022 prohibition is in statute); HCPF; RAEs | Not costed. Members cited about $40 million for the outpatient utilization-management prohibition (October 7). | **Organization**<br>Priorities for a Sustainable, Accessible Colorado Medicaid Program |

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| | Allow clinical-appropriateness review of outpatient therapy once a member reaches a set number of visits in a year; the threshold was not specified. Read with lines 41, 42 and 112. | | | |
| **118** | **Consistent safety-net cost definitions and earlier rates**<br>*What providers and plans are paid · Dept · Stakeholder estimate only · New (Oct 22) · Added from submissions received October 6–21*<br>Use HCPF's existing Accounting and Auditing Committee, with provider cost-reporting experts, to set consistent cost definitions for comprehensive safety net providers and publish a stable, multi-year payment methodology, with decisions made in public with written reasons. Define and report overhead the same way for every provider and compare providers on cost per unit of service and access among peers of similar size, geography and services rather than on overhead share. Set prospective payment rates early enough for providers to budget. Relates to lines 46 and 95. | HCPF; Accounting and Auditing Committee (C.R.S. 25.5-4-403(2)) | FY27 daily rates for the 17 comprehensive providers: $286.92 to $501.73, median $346.26; overhead 11% to 43% of total cost, median 24% (FY25 cost reports); median cost per outpatient unit $117 for providers above 25% overhead and $112 at or below it (behavioral health provider association, October 8). Rates now rest on two-year-old costs and arrive in April for July. | **Organization**<br>CBHC Medicaid Commission Recommendations<br>Comprehensive Safety Net Providers: Answers to the Commission's October 7 Questions |
| **123** | **Let behavioral health providers limit their Medicaid caseload**<br>*What providers and plans are paid · Dept · Cost neutral · New (Oct 22) · Added from submissions received October 6–21*<br>Allow enrolled behavioral health providers to limit the number of Medicaid clients or weekly hours they serve, or wind down Medicaid participation gradually while keeping current clients, without breaching their RAE contracts. Relates to lines 6 and 41. | HCPF; RAEs (contracts) | Not costed. | **Public** |

## 2. Whether Medicaid keeps managed care and the ACC in their current form

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| **71** | **◆ Expand shared savings and alternative payment models**<br>*What providers and plans are paid · Dept · Department figure · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): payment methodologies on the PRIME model that center primary care and share savings with high-performing primary care providers (a community health center association); before statewide expansion of the maternity bundle, a review of independent data on methodology, risk adjustment, administrative cost, savings and quality, including evidence that savings did not come from less care (a perinatal quality collaborative). | HCPF | Maternity bundle $6.7M over five years $6.7 million in savings over five years – HCPF's own projection for the maternity bundle; 23 percent – NTSV cesarean rate benchmark (a perinatal quality collaborative, October 20) | **Commission member, Government agency, Organization**<br>Colorado's All Payer Claims Database (HCPF Final Package for Meeting 6)<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>CCHN Recommendation to Medicaid Commission<br>Stakeholder Comments on the Medicaid Commission's Initial Recommendations |
| **111** | **◆ Standardize RAE care coordination and member tiering**<br>*How it is run · Dept · Not yet costed · New (Oct 22) · Added from a Commission member submission*<br>Standardize care coordination across the RAEs on the practices of the most successful RAEs, including one method for tiering members by need. Relates to lines 6 and 7. | HCPF (RAE contracts) | Care coordination $113.4M FY25-26, $7.66 PMPM overall and $79.28 PMPM for Tier 3; no performance targets set (HCPF, Oct 2). | **Commission member** |

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| 5 | **Validate, then enforce, RAE medical loss ratios †**<br>*What providers and plans are paid · Dept, Bill · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>Get accurate RAE medical loss ratios, then enforce them. First, independently validate the loss-ratio reports the RAEs have submitted – by the State Auditor or an outside actuary – and set one reporting template with fixed definitions of what counts as care (utilization-management staff, subcontractor and related-party margin, risk-corridor returns), with an officer's attestation and validated results published by entity. Then, on validated figures: remittance with penalty when a RAE misses the floor; hold the floor at 89% unless the quality metrics that lower it to 85% are named and met; score loss ratios by population cohort; spend the SUD risk-corridor allocation rather than return it; tie part of the quality bonus to actual care spend; cap care-management margin and raise the PCMP pass-through floor. Line 83 is the alternative to remittance; line 45 is the related audit of capitation itself. HCPF and BHA report that RAEs must direct at least 85% of funds to behavioral health services and that all exceeded it in FY24-25, and that BHASOs direct 93.1%; the figures are as reported by the entities (October 20). A RAE reported that HCPF built a 6 percent reduction into Region 1 rates this year (October 7 meeting). | 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 FY24-25, 43% passed to practices, 9.2% margin (HCPF). The Department's written response is due in the packet. 85% – minimum share of RAE funds that must go directly to behavioral health services; 99% – highest RAE share reported, FY24-25; 93.1% – share of BHASO funds going directly to behavioral health services; 6.9% – cumulative BHASO administrative rate; $46,160,302 – BHASO spend on emergency and crisis services; $41,231,431 – BHASO spend on outpatient services; $23,145,490 – BHASO spend on residential treatment; $16,242,621 – BHASO spend on recovery support services (HCPF and BHA, October 20); 6 percent reduction in Region 1 rates this year – about $17 million, or more than $100 million if extrapolated statewide (panelist estimate) (a RAE, October 7 meeting) | **Government agency, Public, Organization**<br>Nine Ways the Numbers Get Bent: What We Found in Colorado's Mental Health Spending Reports<br>Why RAE Spending Less than MLR Is a Free Bet<br>Outpatient Behavioral Health Is a Revenue Engine for the State of Colorado<br>Behavioral Health Cost Growth<br>CBHC Medicaid Commission Recommendations |
| 6 | **One set of processes across the RAEs and BHASOs**<br>*How it is run · Dept, Bill · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): a fixed RAE recoupment limit (for example, 12 months), a six-month provider appeal window and recovery from the member's primary insurer (a provider coalition), with a public accounting of recoupments and their treatment in the loss ratio (a behavioral health provider); and one credentialing process across HCPF and the dental administrator using CAQH (a dental association). Also proposed: an escalation path for provider enrollment, denial and coding disputes (a behavioral health provider consultancy), and continuity-of-care review before a pending RAE termination of a provider contract takes effect (a SUD treatment provider). | 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). 12 months – proposed RAE recoupment time limit; six-month – proposed provider appeal window; up to 5 years ago – age of services subject to clawbacks seen by [the coalition's] members (a provider coalition, October 20); $6,346.17 – recoupment demand received by the clinic; more than two years – age of claims being recouped (a behavioral health provider, October 20); $619 – | **Government agency, Public, Organization**<br>Managed Care as Medicaid's Administrative Architecture: Does It Still Provide Value to Sta<br>Commission on Medicaid Recommendation: Strengthening Clawback Limits<br>$6K+ Clawback for Anthem/CCHA Medicaid Claims from 2024 and 2025<br>Medicaid Commission Recommendations (People First Behavioral Health Alliance)<br>CBHC Medicaid Commission Recommendations |

Docket v4.1 – line numbers never change. ◆ = raised by a Commission member. Mark each line Proceed, Proceed with caution due to limited data or Reject and return to SHG Advisors by November 6. † = a figure on the line is contested or conflicts with another in the record.

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| | | | amount recouped from one check for services paid in the first quarter of 2026; up to 2 years-worth of payments, nearly $10,000 – potential recoupment; at least $3,500 – lost income in 2026 from these issues (a behavioral health provider, October 20); August 14, 2026 – date of termination notice; February 15, 2027 – contract termination effective date (a SUD treatment provider, October 20) | |
| **27** | **Incentives for integrated physical and behavioral health care**<br>*What providers and plans are paid · Dept, CMS · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): before broader integration, a RAE-administered demonstration pilot integrating physical and behavioral health with set outcome measures (a behavioral health provider association); any organizational combination community-chosen rather than mandated (another behavioral health provider association). A health plan association and a RAE propose expanding fully capitated integrated care with the managed care entity rather than the state holding financial risk. | 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. | **Organization**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance<br>Priorities for a Sustainable, Accessible Colorado Medicaid Program<br>CBHC Medicaid Commission Recommendations<br>COA Recommendations for Savings |
| **44** | **Cut RAE capitation for avoidable events**<br>*What providers and plans are paid · Dept · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>Cut RAE capitation for potentially avoidable events (ER visits, readmissions), as Pennsylvania did. Opposed (October 20): a behavioral health provider association proposes incentives for RAEs, providers and hospitals that reduce avoidable events instead. | HCPF (contracts) | Pennsylvania: $1.8B over five years | **Organization, Research / other states**<br>Medicaid Commission Recommendations – People First Behavioral Health Alliance |
| **45** | **Independent audit of behavioral health capitation**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Independent audit of whether behavioral health capitation transfers risk or merely reprices prior-year cost; a dedicated managed-care oversight unit. Also proposed (October 20): legislative examination of RAE administration before small behavioral health providers leave the network (a behavioral health provider), and investigation of RAE and HCPF behavioral health payment reform with restored HCPF oversight of managed care contracts (a behavioral health provider consultancy). HCPF projects behavioral health capitation at $2.289 billion by 2029 with no action, driven mainly by service cost and utilization per person rather than enrollment, and reports RAE FY 2026-27 negotiations producing a 6–10% rate reduction (HCPF, October 20). | General Assembly; HCPF | BH margin −0.4% FY24-25 $2.289 billion total fund by 2029 – projected BH capitation spend with no action; $112.00 (FY 2025-26) to $171.48 (FY 2028-29) – average weighted PMPM paid to RAEs; 241,345 – members accessing capitated BH services in FY 2024-25; 14% to 20% – share of all members accessing capitated BH services; about 6,000 to over 14,000 – Medicaid-accepting BH providers, 2018 to 2025; 6-10% – reduction in RAE rates from FY 2026-27 negotiations (HCPF, October 20) | **Government agency, Public, Organization, Research / other states**<br>Managed Care as Medicaid's Administrative Architecture: Does It Still Provide Value to Sta<br>Colorado's All Payer Claims Database (HCPF Final Package for Meeting 6)<br>Behavioral Health Cost Growth Behavioral Health |
| **67** | **Community health centers as the medical home**<br>*How it is run · Dept, Budget · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>Community health centers as the primary-care medical home; use their enrollment staff for redeterminations and work-requirement compliance. Also proposed (October 20): direct state investment, including any newly identified funding, to safety-net primary care through the Provider Stabilization Fund, and work with RAEs to raise primary care incentive payments through | HCPF; JBC | CHCs 1.6% of spend, 25% of members; ~$900/member/yr saving claimed at least $900 less per year – HCPF analysis of total cost per Medicaid member with an FQHC as primary care medical home versus other providers; 306,000 unique Medicaid members (25% of Colorado's Medicaid population) – served by CHCs in calendar year 2025; 144,000 uninsured | **Organization**<br>CCHN Letter to Medicaid Commissioners<br>2026 CCHN One-Pager, Medicaid Highlight<br>CCHN Recommendation to Medicaid Commission |

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| | per-member-per-month or other methods (a community health center association). | | Coloradans (40% of uninsured Coloradans) – served by CHCs in 2025 (a community health center association, October 20) | |
| **68** | **Scale EMS treatment-in-place and community paramedicine**<br>*What is covered · Dept, Bill · Stakeholder estimate only · Original (Sept 24)*<br>Scale EMS treatment-in-place and community paramedicine statewide. | HCPF; General Assembly (rates) | Paramedicine 33% cheaper than ED | **Organization**<br>Technical advisor; plan letter |
| **83** | **Reinvest RAE surplus instead of remitting it**<br>*What providers and plans are paid · Dept, Bill · Stakeholder estimate only · Added after Sept 24*<br>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 | FY25-26 "Risk Corridor Payment and MLR Recoupment" line $21.6M (HCPF Exhibit B, per network); 46% of BH capitation matched at 90% | **Organization**<br>Ten Cents on the Dollar: Why Behavioral Health Cuts Cost Colorado More Than They Save – Ma<br>Outpatient Behavioral Health Is a Revenue Engine for the State of Colorado |
| **99** | **One or two statewide RAE quality priorities**<br>*What providers and plans are paid · Dept · Department figure · New (Oct 22) · Split from line 15*<br>Replace the multi-measure RAE quality program with one or two statewide priorities sustained for several years. Split from line 15. Also proposed (October 20): make perinatal health one of the statewide priorities (a perinatal quality collaborative). | HCPF (RAE contracts) | $411.8M in RAE quality incentives paid over seven years, about half of what was available (HCPF). | **Public, Organization** |
| **119** | **Primary care investment**<br>*What providers and plans are paid · Dept · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>Seek recommendations from the Colorado Primary Care Payment Reform Collaborative (Division of Insurance) and other primary care stakeholders on increasing access to and investment in primary care. Relates to lines 67 and 108. | HCPF; Division of Insurance | Not costed. | **Organization**<br>CCHN Recommendation to Medicaid Commission |

## 3. How long-term services and supports are designed and governed

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| **60** | **◆ Re-examine CES waiver eligibility**<br>*Who is covered · Dept · Not yet costed · Original (Sept 24)*<br>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 | CES 4,971 enrolled; ~$11,137/month total cost of care | **Commission member, Public, Organization**<br>HCPF Response to Children's Extensive Supports Waiver Questions |
| **23** | **LTSS program-integrity package for CFC †**<br>*How it is run · Dept, Bill, CMS · Department figure · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): bar parents and legally responsible caregivers from owning or financially controlling an agency that bills Medicaid for their own children's care absent substantial independent oversight, with disclosure of financial relationships among agencies, caregivers, owners and recipients (a pediatric nurse). HCPF is evaluating lowering | 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. $9 million State General Fund – savings; 48 hrs/wk to 40 hrs/wk – soft cap change; 11% of those using personal | **Government agency, Public, Organization**<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026)<br>Advanced Deliverable: Medicaid Growth Trends<br>Medicaid Buy-In for Working Adults with Disabilities<br>Current Fiscal Year Action Plans |

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| | the CFC personal care soft cap from 48 to about 40 hours a week and will restrict consumer-directed provider marketing (October 20); it agreed to add Community First Choice growth to its current-year action list (October 7 meeting). | | care, 3800 members – affected (HCPF roundtable proposal, October 20) | |
| **30** | **Limit intermediary agency retention; protect caregiver pay**<br>*What providers and plans are paid · Dept, MSB, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): require that a portion of targeted PDN reimbursement increases reach direct-care nurses as wages, benefits and retention incentives (a pediatric nurse). | 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. | **Public, Organization**<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026) |
| **37** | **Family-caregiver plan; structured family caregiving**<br>*What is covered · Dept, CMS · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>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. Alternative wording proposed (October 20): that the next administration evaluate family caregiving models used in other states but not available in Colorado – with predictable payment, professional supports and a difficulty-of-care payment – for their effect on nursing facility placement, personal care and homemaker use, caregiver finances and oversight (a family caregiving organization). | 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. | **Organization**<br>Executive Summary: Fiscal Analysis of Structured Family Caregiving in Colorado<br>Careforth – Letter to Commission on Medicaid |
| **38** | **Redesign or reverse PETI on the DD waiver**<br>*Who is covered · Dept, Budget · Costs money · Original (Sept 24) · Updated Oct 22*<br>Redesign or reverse PETI on the DD waiver: replace the flowchart with an income sliding scale; exempt members with no earned income and members living in their own or a family home; widen the employment exemption beyond job coaching; cap the contribution at the buy-in maximum ($200) so a non-working member does not pay more than a working one; correct the locked worksheet; require the savings figure to be recalculated net of exemptions. Also proposed (October 20): replace PETI with sliding-scale premiums for all members – nothing at or below FPL, a nominal fee near 300% FPL (a member of the public); repeal PETI by rule on civil rights and Olmstead grounds, and stop counting court-ordered child support for an unemancipated adult child as the member's income (a disability advocate). | 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 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. $15/mo – nominal fee at 300% FPL; $36 MIL – estimated savings (a member of the public, October 20); approx. 8% – recovery rate based on recent case manager reporting; 3,100 out of 9,000+ – DD waiver members targeted for PETI (per HCPF testimony 09/17/26); $550/month each – PETI amount; $150 – income change that triggers a new PETI calculation; 300% of SSI ($2,982) – LTC and waiver income limit (a disability advocate, October 20) | **Public, Organization**<br>HCPF OM 26-059 August 2026 DD Waiver Update: Implementation of Post-Eligibility Treatment<br>Colorado LTSS Fact Sheet Package (September 2026) |
| **39** | **Hold the weekly caregiver-hour cap until failures are measured †**<br>*What is covered · Dept · Costs money · Original (Sept 24)* | 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 | **Public, Organization**<br>Corrected Supplement to the Record: Caregiver Workforce and the 56-Hour Cap |

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| | 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. | | 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). | Colorado LTSS Fact Sheet Package (September 2026)<br>Written Submission to the Colorado Commission on Medicaid<br>The Commission's Unmeasured Risk – Caring Costs Survey v5.4 |
| **57** | **Evaluate CFC net of shifted services before further cuts**<br>*What is covered · Dept · Not yet costed · Original (Sept 24)*<br>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 | EBD waiver spend fell 87% as CFC rose; CFC $873M budgeted, $1.016B actual FY25-26 | **Public, Organization**<br>Notes re LTSS Services |
| **58** | **Expand family CNA tasks; a state pathway for pediatric PDN**<br>*What is covered · Dept, MSB, CMS · Not yet costed · Original (Sept 24)*<br>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 | PDN ~$4–6K/day in the hospital vs ~$1,500 at home; ~900 PDN members; parent CNA 7,994 (2023) → 10,766 (2025); Colorado 44th in PDN rates (to verify) | **Organization**<br>Protect Patients with PDN-Specific Oversight (Private Duty Nursing Policy Fact Sheet)<br>Colorado Medicaid Ideas (Team Select Home Care)<br>Fact Sheet: Policy Suggestions for Medicaid Commission |
| **59** | **Decide the Colorado Single Assessment and support-level algorithm**<br>*What is covered · Dept · Not yet costed · Original (Sept 24)*<br>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 | $6.2M GF FY26-27 request; contractors $4.7M spent | **Public, Organization**<br>Case manager testimony; disability planning consultants; pediatric home nursing provider |
| **61** | **LTSS exception and appeal reform**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): independent review by professionals with pediatric clinical expertise before significant service reductions for high-acuity children, with clear information on appeal rights and continuation of services (a pediatric nurse). HCPF reports an internal sprint to clear its appeals backlog (HCPF, October 20). | HCPF (rule); General Assembly | 320 open appeals; 209 pending over 90 days; appeal packet $531.60, hearing $490.97 | **Government agency, Public, Organization**<br>Colorado LTSS Fact Sheet Package (September 2026)<br>Current Fiscal Year Action Plans |
| **62** | **Case management agency choice and performance contracts**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24)*<br>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 | $161.2M to CMAs FY25-26 (or $157.4M actual against $171.5M appropriated – reconcile); 72 required activities, 9 paid; 1:65 caseloads | **Public, Organization**<br>Long-Term Services and Supports (LTSS) Sustainability Challenges – CMA Perspective<br>Medicaid Buy-In for Working Adults with Disabilities |
| **66** | **Housing as a Medicaid cost lever**<br>*What is covered · Dept, CMS · Department figure · Original (Sept 24) · Updated Oct 22* | HCPF; DOLA; CMS | S-10 housing vouchers −$8.9M GF (HCPF) | **Government agency, Organization** |

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| | 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 anticipates that Medicaid payment for housing interventions with room and board will end when the 1115 demonstration period closes December 31, 2026, and will phase out up to six months of rental assistance for members newly matched with a housing voucher (HCPF, October 20). | | | Behavioral Health Accountability Map: BHASOs as Contractors; 1115 Waiver Demonstrations |
| **77** | **Remove the Class B license requirement for non-medical CFC services**<br>*How it is run · Dept, Bill · Not yet costed · Added after Sept 24*<br>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 | 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 | **Public, Organization**<br>Provider agencies, group home operator, parents – two sessions |
| **79** | **Connect case management to claims to see total hours**<br>*How it is run · Dept · Not yet costed · Added after Sept 24*<br>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 | 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 | **Public, Organization**<br>Notes re LTSS Services |
| **84** | **Cap homemaker hours; pause the children's Community Connector**<br>*What is covered · Dept, Budget, CMS · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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. Opposed (October 20): a member of the public holds that high Community Connector use in a highly screened population is not evidence of overuse and asks that inappropriate billing, provider rates, administrative layers, program design and duplication be examined before access is reduced. HCPF is evaluating lowering the homemaker soft cap from 21 to about 7 hours a week (HCPF roundtable proposal, October 20). | HCPF (rule and waiver amendment); JBC | 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' $12 million Gen. Fund – savings; 21 hrs/wk to 7 hrs/wk – soft cap change; 34,000 members about 79% of the people now getting homemaker – affected (HCPF roundtable proposal, October 20) | **Government agency, Public, Organization**<br>Medicaid Buy-In for Working Adults with Disabilities |
| **86** | **Home health episode limits and an R-15 report-back**<br>*What is covered · Dept, Budget · Stakeholder estimate only · Added after Sept 24*<br>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 | ~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 | **Organization**<br>Fact Sheet: Policy Suggestions for Medicaid Commission |
| **89** | **Cap paid parent hours per child †**<br>*What is covered · Dept, MSB, CMS · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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 is evaluating limiting paid homemaker by any family caregiver to 7 hours a week, extending the limit for legally responsible persons to all relatives, and limiting paid personal care by parents and legal guardians of children from 48 to 7 hours a week (HCPF roundtable proposals, October 20). | HCPF (rule; Medical Services Board); CMS (CFC State Plan Amendment and waiver amendments) | 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). 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, | **Government agency, Public**<br>Parent of an adult with IDD – written submission (October) |

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| | | | with the same arrangement-failure risk as line 39. $29 million from Gen Fund – savings; 7 hrs/wk – limit, extended from LRPs to all family caregivers; 34,000 members about 79% of the people getting homemaker – affected; $11 million Gen Fund – savings; 48 hrs/wk to 7 hours/wk – limit for legally responsible persons; 4150 members which is 76% of those currently getting this service – affected (HCPF roundtable proposals, October 20); 9 hrs/day, or 63 hrs/wk – remaining for paid care (a member of the public, October 20) | |
| **91** | **Fix authorization before cutting LTSS**<br>*How it is run · Dept, Budget · Not yet costed · Added after Sept 24 · Updated Oct 22*<br>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. Also proposed (October 20): a hospital-to-home pathway for children with complex medical needs – expedited or provisional PDN authorization, discharge planning before the expected discharge date, prioritized equipment approval, and tracking of hospital days caused by authorization, equipment or nursing delays (a pediatric nurse). | HCPF (vendor contracts); JBC | 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). | **Public**<br>Colorado LTSS Fact Sheet Package (September 2026) |
| **93** | **Restore LTSS access and rates before further cuts**<br>*What is covered · Dept, Budget · Costs money · Added after Sept 24 · Updated Oct 22*<br>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. Also proposed (October 20): raise PDN reimbursement to reflect competitive nursing wages, with enhanced rates for high-acuity children on objective clinical criteria rather than cutting hours for all (a pediatric nurse). | HCPF; JBC | Costs money; not costed. Private duty nursing ~$4–6K a day in the 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. $10 less an hour – home health nurse pay versus hospital nurses (a pediatric nurse, October 20) | **Public**<br>Office hours (October 5) |
| **124** | **Standards for group care of medically fragile children**<br>*What providers and plans are paid · Dept, Bill · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>Require an HCPF evaluation when five or more unrelated medically fragile children routinely receive Medicaid-funded care in one residence, with pediatric medical group-home licensing standards and group reimbursement rates for congregate settings, without classifying biological, adoptive or foster families as group homes. Relates to lines 58 and 86. | HCPF; CDPHE; General Assembly if licensing is in statute | Not costed. | **Public** |

## 4. What the program's financing base is, beyond the general fund

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| **1** | **◆ Enroll eligible members in Medicare**<br>*How it is financed · Dept · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 | 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 | **Commission member, Government agency, Public**<br>Medicaid Enrollment, Expenditure and Outcomes Data |

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| | 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. Track how many potentially eligible members are identified, how many enroll, and the net Medicaid savings once Medicare becomes the primary payer; explore more data sharing with federal agencies and proactive enrollment assistance so eligible members reach Medicare sooner. | | 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). | |
| **4** | **◆ Claim federal match on state-only spending**<br>*How it is financed · Dept, CMS · Department figure · Original (Sept 24) · Updated Oct 22*<br>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. A behavioral health provider association supports analysis of added federal match on General Fund behavioral health safety-net spending on condition that resulting state savings are reinvested first in BHA and BHASO capacity for uninsured and non-covered care, replacement payment is in place before existing funding is reduced, local mill-levy dollars already sustaining safety-net capacity are not redirected as state match, and savings that depend on the CCBHC demonstration's time-limited enhanced match do not become a permanent General Fund base reduction (October 20). | 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). | **Commission member, Government agency, Organization**<br>Department Materials, Packet 1 of 2<br>CALPHO Letter to Medicaid Commission<br>CBHC Medicaid Commission Recommendations |
| **24** | **◆ Pharmacy cost measures**<br>*What is covered · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 reports new prior authorization requirements for certain prescription drugs, not named, and is exploring the federal 'GENEROUS model' supplemental rebate program and use of its PBM contractor to maximize rebates (HCPF, October 20). | 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). | **Commission member, Government agency**<br>Advanced Deliverable: Medicaid Growth Trends<br>Joint Budget Committee Hearing – Health Care Policy & Financing (January 5, 2026)<br>Current Fiscal Year Action Plans |
| **55** | **◆ Changes to the Rural Health Transformation Program**<br>*How it is financed · Dept, Bill · Not yet costed · Original (Sept 24)*<br>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 | RHTP $200.1M year one, ~$1B over five | **Commission member, Government agency, Organization**<br>Rural Health Transformation Program (RHTP) Memo<br>Colorado Rural Health Transformation Program – Project Narrative |
| **3** | **Preserve the hospital upper payment limit federal draw †**<br>*How it is financed · Dept, Bill, CMS · Department figure · Original (Sept 24) · Updated Oct 22*<br>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 is working with a hospital association on a new upper payment limit | 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, | **Government agency, Organization**<br>Proposed Medicaid UPL Model Restructure to Enhance Revenue to Colorado Hospitals<br>Current Fiscal Year Action Plans |

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| | methodology for hospital supplemental payments, to be explored prospectively (October 7 meeting). | | 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. | |
| **10** | **Expand program-integrity extrapolation; targeted prepayment review**<br>*How it is run · Dept, Bill · Department figure · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): a moratorium on new provider contracts in areas with high fraud, waste and abuse and where billing is materially outside peer norms (a health plan association). HCPF reports RAE billing controls for FY 2026-27 (procedure-code changes, encounter limits, audits, coding reviews and targeted monitoring), revalidation of high-risk providers and action on enrolled 'ghost providers', and claims-system changes for 'medically unlikely' billing in high-cost growth areas (HCPF, October 20). | 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. 100% by May 2028 – revalidation target for high-risk providers (HCPF, October 20) | **Government agency, Public, Organization**<br>Priorities for a Sustainable, Accessible Colorado Medicaid Program<br>CBHC Medicaid Commission Recommendations<br>Behavioral Health Cost Growth<br>Current Fiscal Year Action Plans |
| **49** | **Administrative claiming for local public health**<br>*How it is financed · Dept, CMS · Not yet costed · Original (Sept 24)*<br>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 | Not costed | **Organization**<br>CALPHO Letter to Medicaid Commission |
| **53** | **ABLE-account reimbursement of HCBS costs**<br>*How it is financed · Bill, CMS · Stakeholder estimate only · Original (Sept 24)*<br>Voluntary ABLE-account reimbursement of the state share of HCBS direct-service costs after a federal amendment. | Congress; General Assembly | Proponents: $14–18M/yr at 1% participation, assuming $1M accounts – illustration only | **Public, Organization**<br>Disability planning consultants; public comment |
| **54** | **Require commercial coverage of services shifted to Medicaid**<br>*How it is financed · Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): make commercial coverage of peer recovery support services a priority (a peer-led coalition). | General Assembly; DOI | 20–30% of PDN members have commercial coverage; one buy-in member's two injectables exceed $1M a year | **Public, Organization**<br>Colorado Medicaid Ideas (Team Select Home Care)<br>Coalition 2045: A Peer-Led Plan for a Sustainable Colorado Peer Workforce |
| **126** | **Durable medical equipment purchasing**<br>*What providers and plans are paid · Dept, MSB · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>Reform durable medical equipment purchasing: a statewide recovery and refurbishment program, repair before replacement, competitive and bulk purchasing with price transparency, augmentative communication devices priced with hardware separate from specialized software and services, and itemized costs for high-cost equipment. | HCPF; Medical Services Board | Not costed. | **Public** |

## 5. Who is covered, and for which benefits

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| **12** | **◆ Member cost sharing instead of coverage reduction**<br>*Who is covered · Bill · Not yet costed · Original (Sept 24)* | 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 | **Commission member, Public**<br>Medicaid Cost-Sharing (NCSL research response) |

Docket v4.1 – line numbers never change. ◆ = raised by a Commission member. Mark each line Proceed, Proceed with caution due to limited data or Reject and return to SHG Advisors by November 6. † = a figure on the line is contested or conflicts with another in the record.

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| | Member cost sharing as an alternative to coverage reduction if the CHASE trigger hits. | | primary care, behavioral health and FQHC/RHC services. Collection experience elsewhere is poor: Michigan collected 26% of 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). | |
| **32** | **◆ Benchmark optional benefits against the national midline**<br>*What is covered · Dept, Budget · Not yet costed · Original (Sept 24)*<br>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. | **Commission member, Government agency**<br>Optional Medicaid Services, Fiscal Years 2008-09, 2018-19 and 2025-26 |
| **64** | **◆ Waitlist before new arrivals access HCBS waivers**<br>*Who is covered · Dept, Bill, CMS · Not yet costed · Original (Sept 24)*<br>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 | Counter-data: enrollment −8.5% 2016–25 while spend +75%; migration shows no consistent relationship | **Commission member, Public**<br>Public comment; survey; Commission discussion |
| **109** | **◆ Make enrolling and re-enrolling as easy as possible**<br>*Who is covered · Dept · Not yet costed · New (Oct 22) · Added from Commission member submissions*<br>Streamline state eligibility and enrollment IT, rules and processes so members can enroll and keep coverage. Share verified income information both ways between Medicaid and SNAP where federal rules allow; compare Colorado's renewal questionnaire with simpler versions in other states, including Maryland; remove unneeded questions, prepopulate information already on file and offer a short, mobile-friendly renewal; set targets for automatic renewals, processing time and cost. | HCPF; CDHS; counties; CMS and USDA rules | Not costed. The State Auditor's FY2025 Single Audit found errors in 7 of 125 Medicaid case files tested. Relates to lines 13, 35, 47 and 97. | **Commission member** |
| **29** | **Raise disability buy-in premiums, phased and income-capped †**<br>*Who is covered · Dept, Bill · Stakeholder estimate only · Original (Sept 24) · Updated Oct 22*<br>Raise disability buy-in premiums rather than reduce coverage – phased, protecting the lowest tiers, capped as a share of income, and factoring household wealth – particularly for members on an HCBS waiver who are working. Not a doubling. Also heard: count more of earned income when setting the premium (not eligibility) – about half of earned income is disregarded today, so a member with gross earnings of about $11,000 a month can qualify and pay the $200 top tier. A behavioral health provider association would raise premiums at the highest and lowest levels and hold or modestly raise the middle levels (October 20). HCPF is exploring higher member cost sharing, such as enrollment fees and premiums, where programs allow it (HCPF, October 20). | 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 | **Government agency, Public, Organization**<br>Colorado's Medicaid Buy-In for Working Adults with Disabilities (WAwD)<br>Medicaid Buy-In for Working Adults with Disabilities<br>Medicaid Commission Recommendations – People First<br>Behavioral Health Alliance<br>Current Fiscal Year Action Plans |

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| | | | premium rose from $20 to $40 a month and $15M from $50 to $100 (gross; the state keeps roughly half of collections). Earned-income disregard: HCPF's 2026 premium guide (OM 26-023). roughly 60% – share of member income counted in the premium calculation; $12,000/mo – earnings that can still qualify; 25,000 members on the Buy-In; $20 to $40 – average payment increase, would save $6 MIL; $50 to $100 – average payment increase, would save $15 MIL (a member of the public, October 20) | |
| **35** | **Continuous authorization and work-requirement safeguards**<br>*Who is covered · Dept, Bill, CMS · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Continuous authorization in place of annual redetermination for people with certified non-reversible conditions; a documentation framework and 30-day corrective-action period before disenrollment under the H.R. 1 work requirement (Arizona model); monthly eligibility-status sharing with safety-net systems and the health information exchange so exemptions are found without paperwork; housing and homeless providers as first-line navigators; an optional voluntary workforce-support program for expansion adults (Montana, New Hampshire models). Also proposed (October 20): give RAEs timely member-level renewal and redetermination data, including ex parte verification status for work requirements, for targeted outreach (a RAE); longer service authorization periods and a unified pediatric assessment across PDN, CNA and HCBS for children with permanent conditions (a pediatric nurse). HCPF reports that CMS denied continuous eligibility for youth and reentry populations (HB 23-1300) and has indicated verbally that it will not approve presumptive eligibility for people needing LTSS (HB 24-1229) (HCPF, October 20). | 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). | **Government agency, Public, Organization**<br>Minimizing H.R.1-related Medicaid coverage disruptions for high-risk patients<br>Medicaid Coverage Transitions & Economic Mobility<br>CBHC Medicaid Commission Recommendations<br>COA Recommendations for Savings<br>Behavioral Health Accountability Map; BHASOs as Contractors; 1115 Waiver Demonstrations |
| **36** | **NEMT rural classification and rates**<br>*What providers and plans are paid · Dept, Budget · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>Classify Montezuma County and the southwest corner as rural for non-emergency medical transportation; publish a dated rollout schedule beyond the nine metro counties; restore the two NEMT rates to a cost-covering level with anti-fraud controls rather than the across-the-board cuts of 2025 and 2026. Also proposed (October 20): extend the rural correction to all rural and frontier counties through a rural modifier on procedure codes or new rural-access codes, paid for from fraud-prevention savings under the NEMT broker (a transportation association). | 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. | **Public, Organization**<br>Medicaid Commission: NEMT & The Colorado Transportation Alliance |
| **63** | **Raise the $2,000 long-term care asset limit**<br>*Who is covered · Bill · Costs money · Original (Sept 24)*<br>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 | 11 states above $2,000 | **Public, Organization**<br>Disability planning consultants; survey |
| **65** | **State-only coverage for qualified immigrants losing federal match**<br>*Who is covered · Bill · Costs money · Original (Sept 24)*<br>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 | $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 | **Government agency, Organization**<br>Data Requests for Sept 2 Commission Meeting<br>Written Testimony for Commission on Medicaid Sustainability from COLOR |

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| | | | | Recommendations to the Commission on Medicaid (COLOR) |
| **74** | **Fix CHP+-to-Medicaid transitions**<br>*Who is covered · Dept · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Fix the CHP+-to-Medicaid transition so effective dates align; reinstate acceptance of out-of-network commercial status for Medicaid-secondary members. Also proposed (October 20): Medicaid payment for in-office dental anesthesia when the provider is out of network with a commercial plan that does not cover the service (a dental association), and prompt RAE disenrollment when a member moves to other coverage, with payment for services delivered while the member remained enrolled (a behavioral health provider). | HCPF; counties | Low often thousands of dollars more – hospital or surgical center cost versus in-office dental anesthesia (a dental association, October 20); $800 – unpaid sessions during the overlap (a behavioral health provider, October 20) | **Public, Organization**<br>Colorado Dental Association Input to Legislative Medicaid Commission |
| **75** | **Estate recovery review**<br>*Who is covered · Dept, Bill · Not yet costed · Original (Sept 24)*<br>Estate recovery review: whether rules deter people from accepting home care they need. | General Assembly; HCPF | Not costed | **Public**<br>Survey |
| **76** | **One redetermination a year for waiver members**<br>*Who is covered · Dept, Bill · Not yet costed · Added after Sept 24*<br>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 | 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) | **Public, Organization**<br>Case management agency, host-home and home health providers, parents – two sessions |
| **87** | **Sliding-scale parental fee for children on waivers or CFC †**<br>*Who is covered · Dept, Bill, CMS · Stakeholder estimate only · Added after Sept 24 · Updated Oct 22*<br>A sliding-scale parental fee for children who receive Medicaid through an HCBS waiver or CFC, where eligibility does not count parental income: no fee for low-income families, rising with family income (the submitter's illustration: about $200 a month at $150,000 a year, about $500 for high-income families). Relates to 29 and 38. Also proposed (October 20): tier pay for paid parental caregivers by household income, resources, the child's medical complexity and the family's ability to stay employed, keeping authorized care based on clinical need, with income verification by participating agencies and random HCPF audits where HCPF cannot verify (a pediatric nurse). | General Assembly; HCPF; CMS (State Plan or waiver amendment) | 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. 5,000 – half of children on waivers assumed in this income group; $30 MIL – estimated savings; $12 MIL – savings if only $200 a month collected from that half (a member of the public, October 20) | **Public**<br>Parent of an adult with IDD – written submission (October) |
| **98** | **Fund appeals capacity before H.R. 1 volume arrives**<br>*How it is run · Budget · Costs money · New (Oct 22) · Split from line 13*<br>Fund state appeals capacity before the volume from six-month redeterminations and work requirements arrives. Split from line 13. | JBC; HCPF; Office of Administrative Courts | 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. | **Government agency, Organization** |
| **122** | **Shared dashboard on coverage loss and access under H.R. 1**<br>*Who is covered · Dept · Not yet costed · New (Oct 22) · Added from submissions received October 6–21* | HCPF; CDHS; hospital, clinic and provider associations; could be privately funded | Not costed. | **Organization**<br>Save Our Safety Net Memo to Medicaid Commission re Final Report |

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

## 6. How the program is run, and how the state knows whether it is working

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| 2 | ◆ **Restructure HCPF to cut administrative cost †**<br>*How it is run · Dept, Bill, Budget · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>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 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. Review all administrative and vendor contracts across HCPF, the RAEs, pharmacy benefit managers and other contractors for duplicated functions – credentialing, provider enrollment, claims administration, care coordination and member services – and consolidate them rather than adding another layer of administration. Also proposed (October 20): tie HCPF FTE, personal services, operating expenses and contractor spending to the programs and functions they support in the Long Bill, with year-over-year reporting; a 'build vs. buy' analysis before a major contract is entered, materially expanded or renewed; and a periodic independent review of HCPF's organizational structure and administrative spending (a coalition of providers and advocates). HCPF reported a hiring, compensation, travel and discretionary-spending freeze from September 21 through at least December 31, 2026, and the ending of non-essential contracts (October 7 meeting). | 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. 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. | **Commission member, Government agency, Public, Organization**<br>FY 2021-22 State of Colorado Workforce Report – Classified Employee June Snapshot by Depar<br>State of Colorado Workforce Report FY 2024-25 – Classified Employees by Department, June S<br>Department Materials, Packet 1 of 2<br>Recommendations to the Commission on Medicaid (COLOR)<br>Recommendations to the 2026 Colorado Medicaid Commission |
| 9 | ◆ **Report and reform recovery audits**<br>*How it is run · Dept, Bill · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): a consolidated public inventory of HCPF contracts over $5 million a year, with annual performance reporting and, for recovery or savings contracts, net benefit to the state (a coalition of providers and advocates). HCPF will adjust Recovery Audit Contract recovery expectations after recoveries fell short of forecast, a shortfall it attributes to changes to the RAC audit process and third-party liability recoveries under SB 25-314, whose fiscal note assumed no change in recoveries (HCPF and OSPB, October 20). | 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. $5 million annually – threshold for a major contract (a coalition of providers and advocates, October 20); $33.1M – recoveries shortfall in FY 2025-26 (OSPB and HCPF, October 20) | **Commission member, Government agency, Organization**<br>Save Our Safety Net Memo to Medicaid Commission re Final Report<br>OSPB and HCPF Follow Up from September 17 Meeting |
| 13 | ◆ **Commission position on the HB26-1429 county transition**<br>*How it is run · Dept, Bill · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Take a Commission position on the HB26-1429 county-administration transition before the January 1, 2027 plan reaches the JBC: county readiness and | General Assembly; HCPF, CDHS, CDEC and counties (the 1429 work group) | County administration and IT ≈ 55% of $778M TF admin ≈ $430M TF (HCPF). One county processes a case ~4x faster than another (Aug 11). Work requirements reach ~377,283 members (HCPF, Oct 2). The HB26-1429 work group's transition | **Commission member, Government agency, Organization**<br>HB26-1429 Overview |

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| | data-matching for six-month redeterminations and work requirements, so members are verified without paperwork. The technology and appeals parts of this line are now lines 97 and 98. Also proposed (October 20): examine the status and testing of CBMS changes for the January 1, 2027 work requirements and whether the CBMS replacement stays staffed, funded and on schedule through the gubernatorial transition, and monitor county eligibility staffing, workloads, processing times and backlogs (a RAE). CDHS, HCPF and CDEC report that the transition plan due to the JBC January 1, 2027 will recommend a cohort or statewide shared-services model, with performance-based county contracts by July 1, 2027, 12 or fewer cohorts from July 1, 2028 and a centralized member integrity service operational by July 1, 2027; cohort and governance options, including a county proposal to align cohorts with the six CHSDA regions, remain open, and the agencies report schedule risk (October 20). | | report is due November 30 and its dashboard January 1. January 1, 2027 – start of federal Medicaid work requirements (a RAE, October 20); $134,990,813 – current HCPF Medical Assistance county administration allocation; about 53.1% – five-year growth from the FY 2020-21 appropriation of $88.2M; about 8.9% – compounded annual growth rate; about 75% / about 60% – automation for MAGI / non-MAGI; 12 or fewer – cohorts in the streamlined model from July 1, 2028 (CDHS, HCPF and CDEC, October 20); six CHSDA regions – proposed cohort alignment; Nov 4 (previously Oct 2) – revised Cohort Models target date; November 30, 2026 – contractual deadline for core deliverables (CDHS, HCPF and CDEC, October 20) | H.B. 26-1429 Implementation Work Group Legislative Report – September 2026<br>COA Recommendations for Savings |
| **47** | ◆ **Consolidate HCPF IT systems**<br>*How it is run · Dept, CMS · Not yet costed · Original (Sept 24)*<br>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 | CCM contract $35.3M, 39% underspent; 90% federal match for modernization, 75% ongoing | **Commission member, Organization**<br>HCPF Contractor Systems List<br>Long-Term Services and Supports (LTSS) Sustainability Challenges – CMA Perspective |
| **97** | ◆ **Technology modernization plan that draws the enhanced federal match**<br>*How it is run · Dept, CMS · Not yet costed · New (Oct 22) · Split from line 13, with additions from Commission members*<br>Ask HCPF for a modernization plan that names which eligibility, claims and data systems qualify for the 90% federal match for development and the 75% match for ongoing operations, the added federal dollars available beyond what is drawn today, and the administrative savings. Prefer modular, multi-state platforms to further proprietary builds, and build a shared, modular data and analytics architecture across health and human services – with SNAP payment accuracy and Medicaid payment-error (PERM) reduction as first uses – that automates eligibility verification and data sharing and keeps administrative cost from shifting to counties. Split from line 13; relates to line 47. | HCPF; CDHS; OIT; CMS (advance planning documents) | CBMS $97M TF / $12.8M GF; system integrator $389M over its term (HCPF, Aug 11). Eligibility-system changes draw 90% federal match; ongoing operations 75%. Not costed. | **Commission member, Government agency** |
| **102** | ◆ **Outlier list of service lines where dollars and users diverge**<br>*How it is run · Dept · Cost neutral · New (Oct 22) · Split from line 16*<br>Produce a normalized outlier list of service lines where spending and the number of members using them diverge, updated regularly for the JBC. Split from line 16. | HCPF; JBC staff | Adult dental $236M → $432M with 6,000 fewer utilizers (HCPF). | **Commission member, Government agency** |
| **110** | ◆ **Disaggregate the Medical Services Premiums line**<br>*How it is run · Budget · Cost neutral · New (Oct 22) · Added from a Commission member submission*<br>Work with JBC staff and HCPF to further disaggregate the Medical Services Premiums line in the Long Bill so the JBC receives regularly updated trends by program and service line, including the LTSS waivers now inside it. | JBC; JBC staff; HCPF | Medical Services Premiums totaled $14,042,894,588 in FY 2025-26 across five service categories (HCPF, August 5). | **Commission member** |
| **113** | ◆ **Prevent improper payments before they are made**<br>*How it is run · Dept · Department figure · New (Oct 22) · Added from Commission member submissions*<br>Shift program integrity from “pay and recover” to “identify, prevent and act”: move fraud, waste and abuse analytics closer to claims adjudication, with prepayment analytics, duplicate-billing detection and provider screening; expand | HCPF; vendors; State Auditor | HCPF projected $36.2M TF / $18.1M GF from prepayment review in FY26-27 under existing authority (line 10). | **Commission member** |

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| | contingency or performance-based contracts with vendors that prevent improper payments, paid on independently validated savings rather than claims denied, with safeguards for providers and members and net savings reported after vendor fees; and create an inter-agency and vendor payment integrity task force. Relates to lines 9 and 10. | | | |
| **114** | **◆ Find other insurance before Medicaid pays**<br>*How it is run · Dept · Department figure · New (Oct 22) · Added from a Commission member submission*<br>Improve how Medicaid identifies other responsible payers before claims are paid – insurance verification, real-time data matching and coordination-of-benefits technology – and report what is recovered through third-party liability against what is avoided up front, testing whether more technology or performance-based contracting yields net savings. Relates to lines 9, 10 and 69. | HCPF; vendors | FY25-26: $152M third-party liability recoveries and $93M third-party liability cost avoidance (HCPF, Oct 2). | **Commission member, Organization** |
| **8** | **Streamline contracts, policy memos and rulemaking**<br>*How it is run · Dept, MSB · Cost neutral · Original (Sept 24)*<br>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 Legislative Legal Services for review under the Administrative Procedure Act. | 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. | **Public, Organization**<br>Fact Sheet: Policy Suggestions for Medicaid Commission<br>HCPF/RAEs Slash Couple Therapy from Medicaid, Losing $9 Federal Dollars for Every $1 of Ca<br>CBHC Medicaid Commission Recommendations |
| **17** | **Target reductions by acuity, not across the board**<br>*What providers and plans are paid · Dept, Bill, Budget · Cost neutral · Original (Sept 24) · Updated Oct 22*<br>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. Also proposed (October 20): exclude primary care from provider rate cuts (a community health center association). HCPF reports it will implement benefit limits, not yet specified (HCPF, October 20). | 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). | **Government agency, Public, Organization**<br>CCHN Recommendation to Medicaid Commission<br>Current Fiscal Year Action Plans |
| **69** | **Member explanation of benefits; real-time insurance checks**<br>*How it is run · Dept · Cost neutral · Original (Sept 24)*<br>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 | Cost neutral | **Public, Organization**<br>Public input; CMA; parents |
| **70** | **Pilot policy changes before statewide rollout**<br>*How it is run · Dept, MSB · Not yet costed · Original (Sept 24) · Updated Oct 22*<br>Pilot policy changes before statewide rollout; publish a rule-change calendar; finish absorbing one change before starting the next. See line 80 for notice. Also proposed (October 20): a two- to three-year pediatric high-acuity care pilot – extended care centers, enhanced PDN rates, equipment refurbishment, expedited hospital-to-home authorization and targeted agency audits – with measurable goals and public reporting (a pediatric nurse). | HCPF; Medical Services Board | Not costed two- to three-year – pilot duration (a pediatric nurse, October 20) | **Public**<br>Survey (several independent respondents) |
| **80** | **Notice and justification before benefit or eligibility changes**<br>*How it is run · Dept, MSB, Bill · Not yet costed · Added after Sept 24 · Updated Oct 22* | General Assembly; HCPF; Medical Services Board | Not costed; cites the nurse assessor, caregiver cap and discharge-summary changes as savings that did not materialize | **Public, Organization**<br>Fact Sheet: Policy Suggestions for Medicaid Commission |

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| | 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. Also proposed (October 20): hold benefit and program design discussions with patient, disability, consumer and provider organizations so affected communities are represented (a hospital association), and publish payment methodologies in advance with notice before changes (a behavioral health provider association). | | | Recommendations to the 2026 Colorado Medicaid Commission<br>CBHC Medicaid Commission Recommendations |
| **100** | **National CMS quality measures in place of state-specific ones**<br>*How it is run · Dept · Not yet costed · New (Oct 22) · Split from line 15*<br>Replace state-specific hospital and provider quality measures with national CMS measures providers already report. Split from line 15. Also proposed (October 20): in moving to national measures, keep the full CMS Maternity Core Set, give critical access hospitals a way to report, and stratify by race, ethnicity and payer (a perinatal quality collaborative). | HCPF | Not costed. Office hours (October 5) cautioned that practice-level outcome measures, including the child core set, absorb practice-support time in reporting rather than care, and that some adolescent services are billed outside Medicaid for confidentiality, so they never appear in the measure. | **Public, Organization** |
| **103** | **Dynamic budgeting: track how cuts shift costs elsewhere**<br>*How it is run · Dept · Cost neutral · New (Oct 22) · Split from line 16*<br>Show how proposed lines compound or offset one another and who carries each; track how a cut or limit in one benefit shifts cost to another, using 12 months of claims data. Split from line 16. Also proposed (October 20): before reducing the CES Community Connector benefit, publish the original utilization assumptions and why actual use diverged (a member of the public); before pediatric HCBS, CNA or PDN reductions, a fiscal analysis comparing home-based with hospital, emergency and institutional costs and counting parents leaving the workforce (a pediatric nurse). | HCPF; OSPB; JBC staff | Cost neutral to build. Office hours (October 5). | **Public** |
| **120** | **"Gold card" prior authorization exemptions**<br>*How it is run · Dept, Bill · Not yet costed · New (Oct 22) · Added from submissions received October 6–21*<br>Let providers with consistently high prior-authorization approval rates on specific procedures skip prior authorization on those procedures for a set period, as HB24-1149 does for commercial carriers; it could be piloted in dental first. | General Assembly (statute); HCPF | Not costed; reduces Department review workload (dental association). | **Organization**<br>Colorado Dental Association Input to Legislative Medicaid Commission |

## Where the money sits

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 carries the Department's own one-year forecast. Everything else is smaller than $25M GF or is not yet costed.

## 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).
- A request that the final report focus on findings and areas of agreement rather than specific directives (a process request).
- Requests about how panels are balanced and whether stakeholders can respond to proposals before they are advanced (process requests).