Joint Budget Committee

Staff Figure Setting
FY 2026-27

Department of Health Care Policy and Financing
All divisions except Behavioral Health and Office of Community Living

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How to Use this Document

The Department Overview contains a table summarizing the staff recommended incremental changes followed by brief explanations of each incremental change. A similar overview table is provided for each division, but the description of incremental changes is not repeated, since it is available under the Department Overview. More details about the incremental changes are provided in the sections following the Department Overview and the division summary tables.

Decision items, both department-requested items and staff-initiated items, are discussed either in the Decision Items Affecting Multiple Divisions or at the beginning of the most relevant division. Within a section, decision items are listed in the requested priority order, if applicable.

Department Overview

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

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

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

→ Summary of Staff Recommendations

Department of Health Care Policy and Financing

Item	Total Funds	General Funds	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$19,044,163,448	$5,684,210,687	$2,216,304,635	$160,576,367	$10,983,071,759	847.8
Long Bill Supplemental	165,364,306	41,724,274	22,751,021	-6,969	100,895,980	0.0
Total	$19,209,527,754	$5,725,934,961	$2,239,055,656	$160,569,398	$11,083,967,739	847.8
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$19,209,527,754	$5,725,934,961	$2,239,055,656	$160,569,398	$11,083,967,739	847.8
Medical forecast	1,861,796,677	468,259,025	266,403,679	0	1,127,133,973	0.0
Eligibility & benefit changes	-26,280,434	-9,931,128	-1,841,108	0	-14,508,198	0.0
Provider rates	-154,850,263	-51,353,904	-13,911,938	0	-89,584,421	1.0
Administration	36,286,714	-6,460,407	10,366,162	0	32,380,959	22.6
Continuation of supplemental actions	-428,493,161	-177,726,173	-17,344,835	-484,951	-232,937,202	11.9
Employee compensation common policies	9,791,585	2,966,778	1,529,542	0	5,295,265	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0
Impacts driven by other agencies	2,640,053	1,226,935	93,091	0	1,320,027	1.8
Prior year actions	37,382,050	15,219,353	-4,075,326	-1,652,006	27,890,029	-2.6
Total	$20,552,078,273	$5,969,416,269	$2,480,748,345	$158,419,014	$11,943,494,645	882.5

Item	Total Funds	General Funds	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Changes from FY 2025-26	$1,342,550,519	$243,481,308	$241,692,689	-$2,150,384	$859,526,906	34.7
Percentage Change	7.0%	4.3%	10.8%	-1.3%	7.8%	0.0
FY 2026-27 Executive Request	$20,335,552,332	$5,863,896,245	$2,474,525,564	$173,201,256	$11,823,929,267	895.2
Staff Rec. Above/-Below Request	$216,525,941	$105,520,024	$6,222,781	-$14,782,242	$119,565,378	-12.7

Medical forecast

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R1 Medical Services Premiums	$1,491,009,550	$350,954,466	$236,462,836	$903,592,248	0.0	EK
R2 Behavioral health	232,326,516	45,066,026	24,526,594	162,733,896	0.0	EP
R5 Office of Community Living	60,986,773	32,321,158	-1,602,749	30,268,364	0.0	TD
R3 Child Health Plan Plus	46,983,793	9,427,330	7,016,998	30,539,465	0.0	EK
R4 Other programs & services	30,490,045	30,490,045	0	0	0.0	EK
Total	$1,861,796,677	$468,259,025	$266,403,679	$1,127,133,973	0.0	

Requests R1 through R5 propose changes to both FY 2025-26 and FY 2026-27 based on a new forecast of caseload and expenditures under current law and policy. They are described as requests by the Department, but they are not really discretionary, because they represent what the Department expects to spend absent a change in current law or policy. Most of Medicaid operates as an entitlement program, meaning that the people determined eligible have a legal right to the plan benefits. The Department has specific statutory authority, in Section 24-75-109 (1)(a), C.R.S., to overexpend the Medicaid appropriations, if necessary to pay the plan benefits. If the Department's forecast is correct, then these expenditures will happen and the only way to prevent them from happening, or to change the level of expenditures, would be to change current law or policy, such as adjusting the eligibility criteria, plan benefits, or provider rates.

In February 2026, the Department submitted an update to the forecast requests. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The November 2025 forecast used for the Governor's request incorporated data through June 2025. The February 2026 forecast incorporates data through December 2025.

The table below shows the incremental difference between the February 2026 forecast and the November 2025 forecast for the forecast requests. This comparison can be useful in understanding how much more or less there is to work with in the overall budget compared to the Governor's request, based on the new information in the February forecast. For this purpose, it is most useful to focus on the cumulative change over both years.

February 2026 Forecast Higher/-Lower than November 2025 Forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 2025-26					
Medical Services Premiums	$187,777,168	$48,868,898	$28,390,538	$0	$110,517,732
Behavioral Health	-8,202,963	-365,947	-3,966,821	0	-3,870,195
Children's Basic Health Plan	-24,109,691	-7,829,043	-609,349	0	-15,671,299
Other Programs and Services	15,595,829	15,595,829	0	0	0
Office of Community Living	26,380,976	13,691,689	-501,203	0	13,190,490
Total - Difference	$197,441,319	$69,961,426	$23,313,165	$0	$104,166,728
% Change from Nov Forecast	*1.1%*	*1.3%*	*1.2%*	*0.0%*	*1.0%*
FY 2026-27					

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Medical Services Premiums	$299,987,301	$138,232,249	$11,553,360	$0	$150,201,692
Behavioral Health	10,101,495	-4,961,921	-3,657,241	0	18,720,657
Children's Basic Health Plan	-21,111,280	-7,688,827	299,879	0	-13,722,332
Other Programs and Services	6,613,232	6,613,232	0	0	0
Office of Community Living	9,813,742	5,413,039	-506,168	0	4,906,871
Total - Difference	$305,404,490	$137,607,772	$7,689,830	$0	$160,106,888
% Change from Nov Forecast	*1.5%*	*2.3%*	*0.4%*	*0.0%*	*1.4%*
Cumulative over both years					
Medical Services Premiums	487,764,469	187,101,147	39,943,898	0	260,719,424
Behavioral Health	1,898,532	-5,327,868	-7,624,062	0	14,850,462
Children's Basic Health Plan	-45,220,971	-15,517,870	-309,470	0	-29,393,631
Other Programs and Services	22,209,061	22,209,061	0	0	0
Office of Community Living	36,194,718	19,104,728	-1,007,371	0	18,097,361
Total - Difference	$502,845,809	$207,569,198	$31,002,995	$0	$264,273,616
% Change from Nov Forecast	*1.3%*	*1.8%*	*0.8%*	*0.0%*	*1.2%*

→ R1 Medical Services Premiums

Request

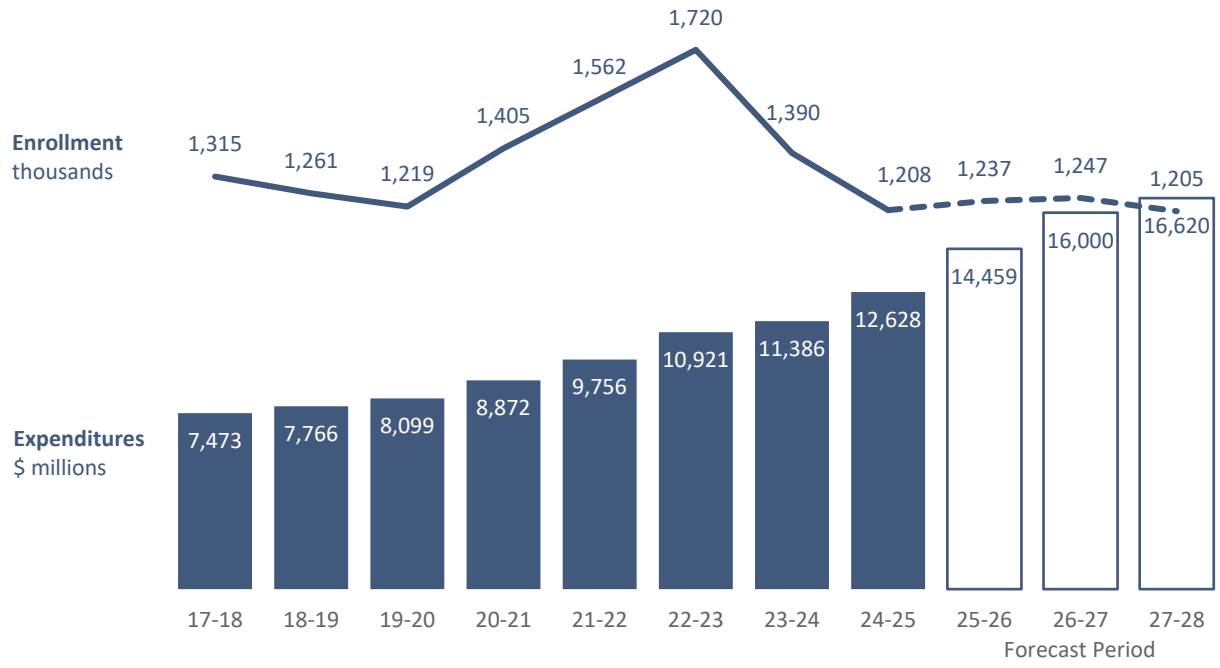
The Department requests a change to the Medical Services Premiums appropriation for both FY 2025-26 and FY 2026-27 based on a new forecast of caseload and expenditures under current law and policy. Medical Services Premiums pays for physical health and most long-term services and supports for people eligible for Medicaid.

In February 2026, the Department submitted an update to the R1 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2026 forecast differs from the Governor's request by $187.8 million total funds, including $48.9 million General Fund, in FY 2025-26 and $300.0 million total funds, including $138.2 million General Fund, in FY 2026-27. The cumulative General Fund difference over the two years is $187.1 million higher than the Governor's November request.

Recommendation

Staff recommends using the Department's February 2026 forecast of enrollment and expenditures to modify both the FY 2025-26 and FY 2026-27 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



https://www.kff.org/medicaid/what-are-the-implications-of-the-recent-elimination-of-the-medicaid-prescription-drug-rebate-cap/

→ R3 Child Health Plan Plus

Request

The Department requests a change to the Child Health Plan Plus (CHP+) for both FY 2025-26 and FY 2026-27 based on a new forecast of caseload and expenditures under current law and policy. CHP+ pays for physical health services for eligible children and pregnant women and for dental services for children. The Department markets the program as CHP+. In state statute it is the Children's Basic Health Plan. In federal statute it is the Children's Health Insurance Program.

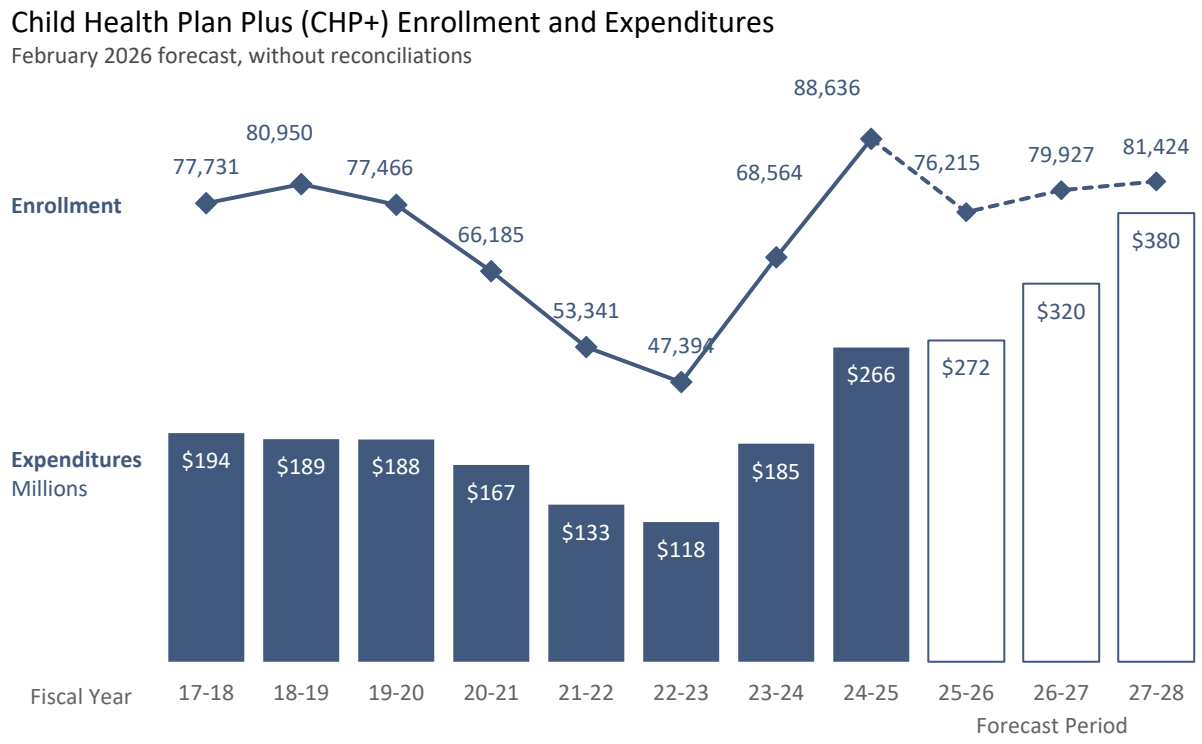
In February 2026, the Department submitted an update to the R3 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2026 forecast differs from the forecast used for the Governor's request by -$24.1 million

total funds, including -$7.8 million General Fund, in FY 2025-26 and -$21.1 million total funds, including -$7.7 million General Fund, in FY 2026-27. The cumulative General Fund difference over the two years is -$15.5 million.

Recommendation

Staff recommends using the Department's February 2026 forecast of enrollment and expenditures to modify both the FY 2025-26 and FY 2026-27 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

The chart below summarizes the Department's forecast.



→ R4 Other programs & services

Request

The Department requests a change for both FY 2025-26 and FY 2026-27 based on a new forecast of caseload and expenditures under current law and policy for other programs that are not part of the categories above but operate like an entitlement program.

The two largest programs are the Medicare Modernization Act and the health services for children lacking access due to their immigration status. The Department has long prepared a forecast for the Medicare Modernization Act. The health services for children lacking access due to their immigration status is a new program where the Department needs to project the costs.

In addition, there are some smaller programs the Department has not historically projected that the Department wants to start forecasting. These programs appear in the Department's February forecast, but to say that the Department prepared a forecast for them is a stretch. The numbers did not change from November. It is probably more accurate to say that the Department aspires to forecast these smaller programs but has not yet built the tools.

In February 2026, the Department submitted an update to the R4 forecast. This update is not an "official" request and it is not accounted for in the Governor's budget balancing. It was submitted after the General Assembly's budget request deadlines. However, it represents the most current forecast of expenditures available. The February 2026 forecast differs from the Governor's request by $15.6 million General Fund in FY 2025-26 and $6.6 million General Fund in FY 2026-27. The cumulative General Fund difference over the two years is $22.2 million.

Recommendation

Staff recommends using the Department's February 2026 forecast of enrollment and expenditures to modify both the FY 2025-26 and FY 2026-27 appropriations. This is the best estimate available of what the actual costs will be for the program based on current law and policy.

FY 2025-26

The projection for FY 2025-26 is up $15.6 million General Fund or 4.6 percent. The table below shows the major contributors to the change from the FY 2025-26 appropriation to the Department's February 2026 forecast for FY 2025-26. It does not show differences from FY 2024-25 expenditures.

FY 2025-26

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 25-26 Appropriation					
Medicare Modernization Act	$268,225,649	$268,225,649	$0	$0	$0
Children Lacking Access Due to Immigration	53,360,259	53,360,259	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - Appropriation	$346,547,333	$338,502,873	$0	$0	$8,044,460
FY 25-26 Feb Projection					
Medicare Modernization Act	$257,599,472	$257,599,472	$0	$0	$0
Children Lacking Access Due to Immigration	79,582,265	79,582,265	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - FY 25-26 Projection	$362,143,162	$354,098,702	$0	$0	$8,044,460
Projection Higher/-Lower than Appropriation					

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Medicare Modernization Act	-$10,626,177	-$10,626,177	$0	$0	$0
Children Lacking Access Due to Immigration	26,222,006	26,222,006	0	0	0
Reproductive Health	0	0	0	0	0
Abortion Care	0	0	0	0	0
Health-Related Social Needs (HRSN)	0	0	0	0	0
Reentry Services	0	0	0	0	0
Total - Difference	$15,595,829	$15,595,829	$0	$0	$0
Percent Change					
Medicare Modernization Act	-4.0%	-4.0%	n/a	n/a	n/a
Children Lacking Access Due to Immigration	49.1%	49.1%	n/a	n/a	n/a
Reproductive Health	0.0%	0.0%	n/a	n/a	n/a
Abortion Care	0.0%	0.0%	n/a	n/a	n/a
Health-Related Social Needs (HRSN)	0.0%	0.0%	n/a	n/a	0.0%
Reentry Services	0.0%	0.0%	n/a	n/a	0.0%
Total - Percent change	4.5%	4.6%	n/a	n/a	0.0%

FY 2026-27

The Department projects expenditures will increase $33.4 million General Fund from FY 2025-26 to FY 2026-27. The table below shows the major contributors to the General Fund change.

FY 2026-27

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
FY 25-26 Feb Projection					
Medicare Modernization Act	$257,599,472	$257,599,472	$0	$0	$0
Children Lacking Access Due to Immigration	79,582,265	79,582,265	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - FY 25-26 Projection	$362,143,162	$354,098,702	$0	$0	$8,044,460
FY 26-27 Feb Projection					
Medicare Modernization Act	$271,406,559	$271,406,559	$0	$0	$0
Children Lacking Access Due to Immigration	96,265,223	96,265,223	0	0	0
Reproductive Health	2,614,490	2,614,490	0	0	0
Abortion Care	5,857,600	5,857,600	0	0	0
Health-Related Social Needs (HRSN)	12,900,408	7,622,681	0	0	5,277,727
Reentry Services	6,517,727	3,750,994	0	0	2,766,733
Total - FY 26-27 Projection	$395,562,007	$387,517,547	$0	$0	$8,044,460
FY 26-27 Higher/-Lower than FY 25-26					
Medicare Modernization Act	$13,807,087	$13,807,087	$0	$0	$0
Children Lacking Access Due to Immigration	16,682,958	16,682,958	0	0	0
Reproductive Health	0	0	0	0	0
Abortion Care	2,928,800	2,928,800	0	0	0

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds
Health-Related Social Needs (HRSN)	0	0	0	0	0
Reentry Services	0	0	0	0	0
Total - Difference	$33,418,845	$33,418,845	$0	$0	$0
Percent Change					
Medicare Modernization Act	5.4%	5.4%	n/a	n/a	n/a
Children Lacking Access Due to Immigration	21.0%	21.0%	n/a	n/a	n/a
Reproductive Health	0.0%	0.0%	n/a	n/a	n/a
Abortion Care	100.0%	100.0%	n/a	n/a	n/a
Health-Related Social Needs (HRSN)	0.0%	0.0%	n/a	n/a	0.0%
Reentry Services	0.0%	0.0%	n/a	n/a	0.0%
Total - Percent change	9.2%	9.4%	n/a	n/a	0.0%

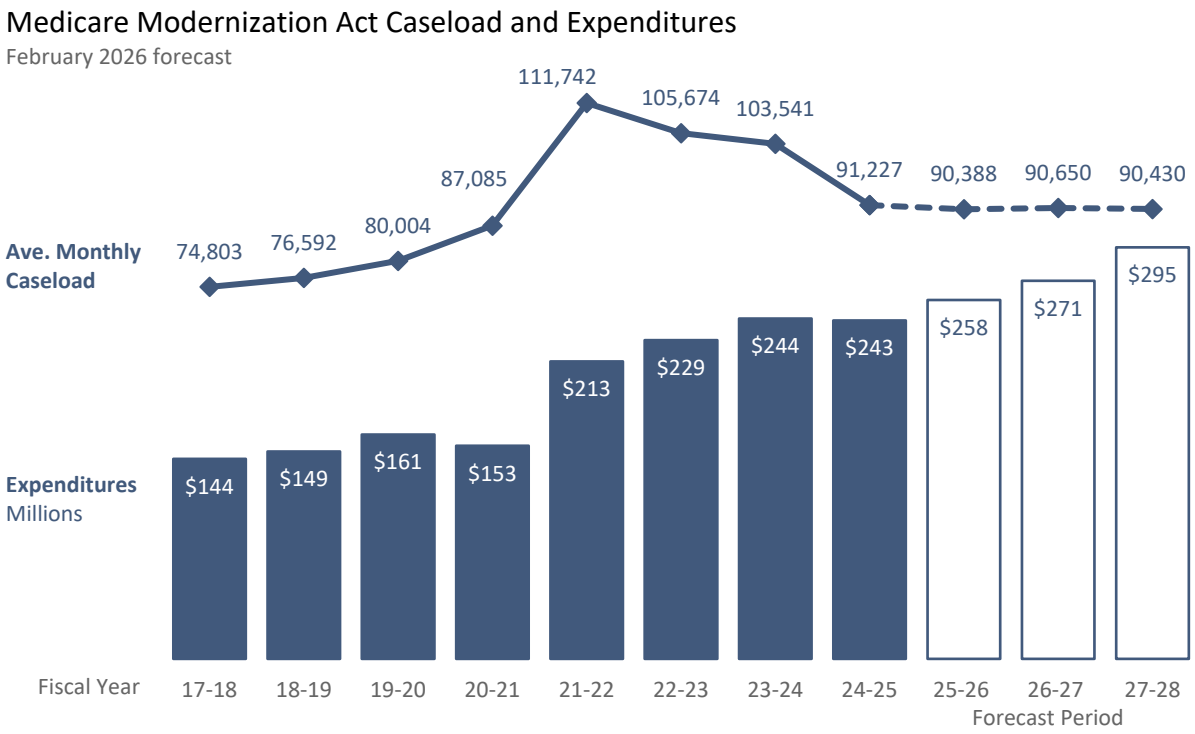
Medicare Modernization Act

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

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

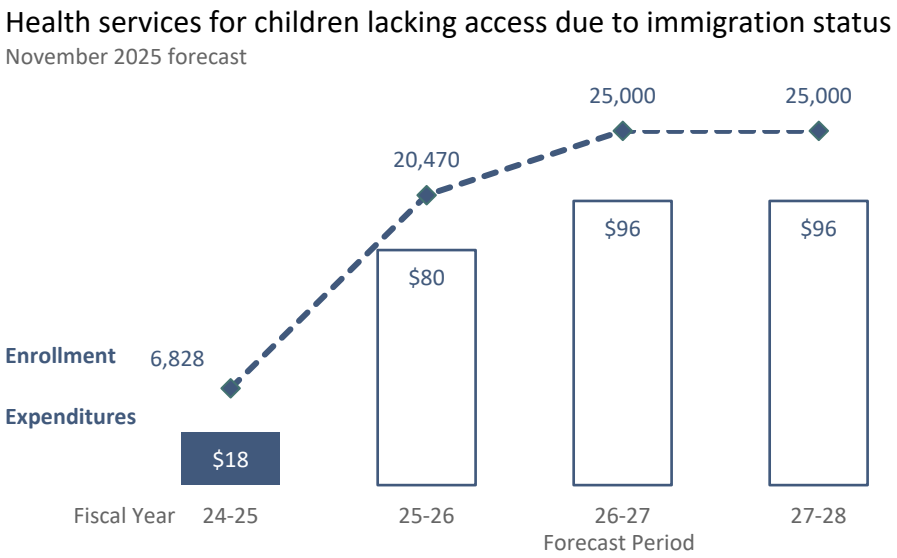
This is a state obligation with no federal match, but the federal match rate for Medicaid does impact the calculation of how much the state owes.

The graph below summarizes the Department's projection.



Health Services for Children Lacking Access Due to Immigration Status

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



Eligibility & benefit changes

Eligibility & benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R6.36 IDD cost share	-12,641,818	-6,320,909	0	-6,320,909	0.0	TD
R17 Community connector age limit	-7,441,256	-3,738,675	17,147	-3,719,728	0.0	TD
R18 3D mammograms	635,758	128,456	37,885	469,417	0.0	EK
BA7k Cover All Coloradans limits	0	0	0	0	0.0	EK
BA7l Adult dental annual cap	-6,833,118	0	-1,896,140	-4,936,978	0.0	EK
BA7q Equine therapy	0	0	0	0	0.0	EK
Total	-$26,280,434	-$9,931,128	-$1,841,108	-$14,508,198	0.0	

→ R18 3D Mammograms

Request

The Department seeks to expand Medicaid benefits to cover three-dimensional (3D) mammography for earlier and more accurate detection of breast cancer.

The Department projects that the new benefit will change expenditures by:

- Year 1: $635,758 total funds, including $128,456 General Fund

The Centers for Disease Control and Prevention, US Preventive Services Task Force, and American College of Radiology identify 3D mammography as an effective screening tool.

Recommendation

Staff recommends approval of the request. According to the Department, 3D mammogram technology is widely available and preferred by providers. The Department says 3D mammography is the standard of care adopted by commercial insurers. The Department is so confident in this perspective that the cost projection assumes 100 percent of the utilization of 2D mammograms will convert to claims for 3D mammograms.

Evidence Designation

The Department describes the request as evidence-informed. Studies show 3D mammograms improve cancer detection and reduce false-positive rates compared to 2D mammograms, especially in women with dense breast tissue. According to the Department, dense breast tissue is more prevalent in some ethnic groups, making 3D mammography an important tool for equitable care.

Staff describes the request as promising with at least one quality randomized control trial.[1] However, it is important to note that the research findings are limited to improvements in detection. There is not research to determine if the earlier detection actually improves health outcomes. It might be that the 2D mammography is good enough and more cost-effective and that the 3D mammography doesn't actually improve the prognosis.

This lack of connection between the research and improved health outcomes would be the primary argument against the request. This is a difficult budget year to expand benefits, rather than contract them. The Department ranked this as one of the lowest priorities. However, it is difficult for the JBC staff to recommend against the guidelines from the Centers for Disease Control and Prevention, US Preventive Services Task Force, and American College of Radiology.

→ BA7k Cover All Coloradans limits [legislation]

Request

The Department requests legislation to limit the benefits for immigrant children and pregnant adults.

The request assumes the new benefit limits would take effect in March or April 2028 after the completion of needed system changes. The proposed limits change the Department's forecast by:

- Year 1: $127,950 General Fund
- Year 2: -$5.1 million total funds, including -$4.1 million General Fund
- Year 3: -$24.9 million total funds, including $-21.7 million General Fund

Specifically, the Department wants to stop new coverage for long-term services and supports while grandfathering in existing users, cap dental services at $750 annually, remove immigrants from behavioral health managed care while preserving access to fee-for-service managed care, and remove them from the accountable care collaborative.

BA7k Cover All Coloradans limits - request

Item	Total Funds	General Fund	Federal Funds
FY 2026-27			
Long-term services and supports	$0	$0	$0
Dental $750 annual cap	0	0	0
Behavioral health capitations	0	0	0
Accountable Care Collaborative	0	0	0
Systems costs	127,950	127,950	0
Total	$127,950	$127,950	$0
FY 2027-28			
Long-term services and supports	$0	$0	$0
Dental $750 annual cap	-1,993,715	-1,839,414	-154,301
Behavioral health capitations	-4,070,583	-3,457,310	-613,273

[1] Digital breast tomosynthesis plus synthesised mammography versus digital screening mammography for the detection of invasive breast cancer

Item	Total Funds	General Fund	Federal Funds
Accountable Care Collaborative	-1,332,917	-1,138,666	-194,251
Systems costs	2,341,295	2,341,295	0
Total	-$5,055,920	-$4,094,095	-$961,825
FY 2028-29			
Long-term services and supports	$0	$0	$0
Dental $750 annual cap	-7,974,860	-7,357,658	-617,202
Behavioral health capitations	-12,211,750	-10,371,931	-1,839,819
Accountable Care Collaborative	-5,331,668	-4,554,665	-777,003
Systems costs	585,004	585,004	0
Total	-$24,933,274	-$21,699,250	-$3,234,024

What is Cover All Coloradans?

In this request, the Department uses the term "Cover All Coloradans" to mean health insurance provided by the Department for pregnant people and children who would qualify for Medicaid or CHP+ if not for their immigration status. However, legislators and stakeholders may use the term more broadly or differently.

"Cover All Coloradans" does not appear in statute. Proponents and opponents use the phrase to describe several changes to health coverage for immigrants. Most of the changes, but not all, were authorized in H.B. 22-1289 (Health Benefits for Colorado Children and Pregnant Persons). However, the term is not synonymous with H.B. 22-1289. That bill included provisions that most people would not consider part of "Cover All Coloradans". For example, the bill eliminated CHP+ member premiums, increased Medicaid coverage for lactation support and breast pumps, and addressed health surveys of birthing parents.

The programs people lump under "Cover All Coloradans" share similar goals but differ significantly in their governing laws, funding sources, and administration. This often causes confusion. For example, during debate on the supplemental bill for Health Care Policy and Financing, some legislators used "Cover All Coloradans" to refer to OmniSalud.

Even focusing just on the request, Cover All Coloradans includes two distinct programs:

- Coverage for pregnant people is provided through Medicaid and CHP+. It receives a 65 percent federal match.[2] Funding appears in the Medical Services Premiums line item and Children's Basic Health Plan line item. The benefits must comply with federal policies and changes require approval from the federal Centers for Medicare and Medicaid Services.
- Coverage for children is a state-only program funded by the General Fund. The funding appears in the Other Medical Services division under the line item "Health Benefits For Children Lacking Access Due To Immigration Status". The state can design the benefits for the children however it wants and without federal approval.

In this analysis, the JBC staff attempts to use "Cover All Coloradans" in the same way as the Department.

[2] The program still draws a 65 percent match, even though the federal government recently lowered the match to 50 percent for other pregnant people on Medicaid.

Doesn't the Department cover all immigrants?

Some legislators mistakenly believe that the Department provides comprehensive health coverage to all immigrants. This is understandable given the marketing name "Cover All Coloradans".

The Department does provide limited, federally required coverage of emergency services for noncitizens. This coverage of emergency services existed before H.B. 22-1289. It helps protect hospitals from uncompensated care they are required to provide. Emergency services for children receive a federal match, while nonemergency services for children fall under the state-funded "Cover All Coloradans". The emergency services are limited to the emergency event. The emergency services do not provide comprehensive care. The federal regulations define emergency services but there is some discretion for the provider to determine what constitutes an emergency. Almost all the payments for emergency services go to hospitals, but the payments can cover services in other treatment locations.

Some lawfully present noncitizens with a qualifying immigration status can receive full Medicaid benefits, either immediately or after a five-year waiting period. This coverage existed prior to H.B. 22-1289 and the JBC staff has never heard anyone refer to these services as part of "Cover All Coloradans". However, that might change with more attention. Provisions in H.R. 1 limited the "qualified immigrants" so that fewer people can receive benefits.

Finally, the Department has a small program that provides reproductive health benefits to people regardless of immigration status. It mostly pays for long-acting reversible contraceptives. The eligible population and benefits are narrow.

What is OmniSalud and how does it fit with the request?

The request does not make any changes to OmniSalud.

OmniSalud connects people lacking legal status to insurance plans and provides limited state subsidies, similar to the federal tax credits available through the Affordable Care Act. Like "Cover All Coloradans", the term "OmniSalud" does not appear in statute but there is more consensus on what it means. It refers to one and only one program. OmniSalud was authorized in S.B. 20-215. There were some attempted changes to it in H.B. 22-1289, but they mostly didn't pan out due to federal regulations. OmniSalud is overseen by the Division of Insurance, not Health Care Policy and Financing, and the subsidies are funded through insurance taxes. The Insurance plans are private, rather than Medicaid. The Division of insurance estimates that in plan year 2026 OmniSalud will spend about $50 million and serve roughly 6,700 people. It uses a lottery to keep expenditures within the available funds.

How many other states cover services for immigrants?

For children with low income, 14 states plus the District of Columbia provide state-funded coverage regardless of immigration status, according to the Kaiser Family Foundation.[3]

For pregnant people, 24 states plus the District of Columbia provide Medicaid and CHP+ coverage regardless of immigration status. The federal authority is through the From-Conception-to-End-of-Pregnancy (FCEP) program in the statutes for the Children's Health Insurance Program, even though the benefits are delivered mostly

[3] State Health Coverage for Immigrants and Implications for Health Coverage and Care, May 29, 2025

through Medicaid with only a small portion through CHP+. Colorado and 12 states plus the District of Columbia extend the postpartum coverage to one year.

The Kaiser Family Foundation says 7 states plus the District of Columbia provide state-funded coverage for some adults regardless of immigration status. Kaiser includes Colorado in this count because of the OmniSalud program. Health Care Policy and Financing does not provide full coverage for adults without a qualifying immigration status. The Department does provide the limited emergency services and the small program for reproductive health described above.

Why does changing the Cover All Coloradans benefits require a bill?

Statutes define the eligibility and the benefits. The people eligible are children and pregnant people who would qualify for Medicaid or CHP+ except for their immigration status. The benefits and costs to the beneficiary must be the same as for Medicaid and CHP+, such that eligible individuals must not be able to tell the difference. Some legislators expressed a desire during debate on H.B. 22-1289 that the providers not know the difference in immigration status between the clients, but this is not explicitly part of the statute. Breaking the program links to Medicaid and CHP+ requires a change to the statutes.

If the General Assembly reduces the funding but does not change the statutes, then the Department will still need to follow the statutes and provide the same eligibility and benefits as Medicaid and CHP+. The Department has authority to spend more than the appropriation, if the actual costs are higher.

Recommendation

Staff recommends the requested legislation with modifications to:

- End the long-term services and supports coverage, rather than grandfather existing users
- End the dental benefit for Cover All Coloradans, rather than capping it
- Remove the children from the Accountable Care Collaborative but not the pregnant people
- Accelerate the implementation timeline and make several technical changes to the projected savings

The staff recommendation changes the forecast by -$17.1 million General Fund in FY 2026-27, compared to the Department's request that costs $127,950 General Fund in FY 2026-27. The ongoing change from the staff recommendation is -$29.0 million General Fund, beginning in FY 2027-28. This compares to the requested change of -$21.7 million beginning in FY 2028-29.

Why reduce the Cover All Coloradans benefits?

Arguments for reduction

- These are new programs that started in January 2025 and fit the principal of last in first out.
- There is no federal match for the services to children.
- The actual and projected expenditures far exceed the original estimate. It is unknown if legislators would have voted the same way with a more accurate Fiscal Note.
- The expenditures are growing very quickly. This might be a short-term issue during the ramp up of the program. The Department expects the enrollment and per capita expenditures will eventually stabilize. Medicaid expenditures for children do not typically grow at the rates in Cover All Coloradans. However, this

is a new program without a trend history to inform the projections or assumptions about where the costs might stabilize.

- The General Fund costs could climb even higher.
  - So far, the children have not significantly used long-term services and supports. If the children start using long-term services and supports at the same rates as children on Medicaid, the General Fund costs would skyrocket.
  - For the pregnant people, Colorado is currently receiving a 65 percent federal match, but the federal government recently reduced the match to 50 percent for other pregnant people on Medicaid. If the federal government removed all federal matching funds, state statute still requires the Department to provide coverage using General Fund.
- Some of the population served is not legally present in the US.
- The General Assembly needs to do something to change the health care expenditure trends. The alternatives to achieve similar savings are not more palatable.

Arguments against reduction

- All people should have access to affordable health care.
- The people live in Colorado.
- Their health and economic productivity impacts the community.
- Denying health care to immigrants may negatively impact population health and make everyone more vulnerable to diseases.
- Unhealthy workers impact businesses.
- Some providers can't or won't turn away immigrants, leading to an increase in uncompensated care.
- An increase in uncompensated care may destabilize providers.
- To balance an increase in uncompensated care, providers may increase charges to private insurance.
- Lower access to preventive care may increase acuity and costs when people need unavoidable care.

How much are the services costing compared to the original estimate?

The tables below compare the Fiscal Note for H.B. 22-1289 to the February forecast.

Fiscal Note H.B. 22-1289

Item	Enrol	Total Funds	General Fund	Federal Funds
FY 2024-25				
Pregnant people - Medicaid	2,165	$13,322,208	$4,662,773	$8,659,435
Pregnant people - CHP+	138	1,054,254	$368,990	$685,264
Children	1,327	2,102,665	$2,102,665	$0
Total	3,630	$16,479,126	$7,134,427	$9,344,699
FY 2025-26				
Pregnant people - Medicaid	2,193	$27,433,944	$9,601,881	$17,832,063
Pregnant people - CHP+	140	2,141,533	$749,537	$1,391,996
Children	1,344	4,360,863	$4,360,863	0
Total	3,677	$33,936,341	$14,712,282	$19,224,059
FY 2026-27				

Item	Enrol	Total Funds	General Fund	Federal Funds
Pregnant people - Medicaid	2,193	$27,433,944	$9,601,881	$17,832,063
Pregnant people - CHP+	140	2,141,533	$749,537	$1,391,996
Children	1,344	4,360,863	$4,360,863	0
Total	3,677	$33,936,341	$14,712,282	$19,224,059

February Forecast

Item	Enrol	Total Funds	General Fund	Federal Funds
FY 2024-25 Actual				
Pregnant people - Medicaid	1,841	$20,424,318	$7,148,512	$13,275,806
Pregnant people - CHP+	244	2,149,721	$752,403	$1,397,318
Children	6,828	17,780,840	$17,780,840	$0
Total	8,913	$40,354,879	$25,681,755	$14,673,124
FY 2025-26				
Pregnant people - Medicaid	6,939	$67,959,940	$23,785,979	$44,173,961
Pregnant people - CHP+	389	3,467,130	$1,213,496	$2,253,634
Children	20,470	79,582,265	$79,582,265	0
Total	27,798	$151,009,335	$104,581,740	$46,427,595
FY 2026-27				
Pregnant people - Medicaid	8,411	$84,345,375	$29,520,882	$54,824,493
Pregnant people - CHP+	495	4,693,739	$1,642,809	$3,050,930
Children	25,000	96,265,223	$96,265,223	0
Total	33,906	$185,304,337	$127,428,914	$57,875,423

Difference

Item	Enrol	Total Funds	General Fund	Federal Funds
FY 2024-25 Actual				
Pregnant people - Medicaid	-324	$7,102,110	$2,485,739	$4,616,371
Pregnant people - CHP+	106	1,095,467	$383,413	$712,054
Children	5,501	15,678,175	15,678,175	0
Total	5,283	$23,875,753	$18,547,328	$5,328,425
FY 2025-26				
Pregnant people - Medicaid	4,746	$40,525,996	$14,184,098	$26,341,898
Pregnant people - CHP+	249	1,325,597	$463,959	$861,638
Children	19,126	75,221,402	$75,221,402	0
Total	24,121	$117,072,994	$89,869,458	$27,203,536
FY 2026-27				
Pregnant people - Medicaid	6,218	$56,911,431	$19,919,001	$36,992,430
Pregnant people - CHP+	355	2,552,206	$893,272	$1,658,934
Children	23,656	91,904,360	$91,904,360	0
Total	30,229	$151,367,996	$112,716,632	$38,651,364

How long does it take to change the benefits?

The biggest dollar difference between the staff recommendation and the request is due to the implementation timeline.

The request assumes the new benefits would take effect in March or April of 2028. This is because the Department wants to design a new benefit plan within the information technology systems that is specific to the CAC populations. The original intent was for the benefits to be indistinguishable from Medicaid and CHP+ and so the Department designed the information technology systems to simply add the CAC populations to the existing benefits. This approach saved money and sped up the work compared to building a new benefit plan specific to the CAC populations. However, it is not a flexible design that allows the Department to dial up or down the benefits for the CAC populations without impacting other Medicaid and CHP+ members.

Designing a new benefit plan within the information technology systems is a significant project that takes time. In addition, the Department must make urgent changes to comply with H.R. 1. Sequencing the changes becomes challenging so that different teams are not impacting the same code at the same time before changes are tested and validated.

The Department's timeline requires legislators to make difficult votes with no significant relief to the General Fund budget until FY 2028-29. The long-term expenditure trends are important, but the General Assembly is trying to close a budget shortfall now.

The JBC staff's priority is to achieve the savings quickly. When pressed on the timeline, the Department determined that there are ways to implement the changes sooner, but these solutions are not optimal. The Department sounds like a car mechanic saying that if you really want the lawnmower engine and you don't care about the noise, increased pollution, and lack of power, then yes, they can get you the car tomorrow and it will run, barely. If the JBC's priority is sound information technology design and infrastructure, then it should stick with the originally requested timeline. If the JBC wants to change the cost trend as soon as possible, the staff recommendation achieves that goal.

The staff recommendation assumes the following implementation timeline:

- Long-term services and supports: January 2027 to stop adding new beneficiaries; June 2027 to end benefits for current utilizers
- Dental services: July 2026
- Behavioral health capitation payments: January 2027
- Accountable Care Collaborative: January 2027

Summary Table

The table below summarizes the staff recommendation. Each component of the staff recommendation is discussed in the subsections following the table.

BA7k Cover All Coloradans limits - recommendation

Item	Total Funds	General Fund	Adult Dental Fund	Federal Funds
FY 2026-27				
Long-term services and supports	-$54,602	-$54,602	$0	$0

Item	Total Funds	General Fund	Adult Dental Fund	Federal Funds
End dental benefit	-15,243,726	-13,017,388	-779,218	-1,447,120
Behavioral health capitations	-6,105,875	-4,909,993	0	-1,195,882
Accountable Care Collaborative	-2,161,257	-2,161,257	0	0
Systems costs	3,054,249	3,054,249	0	0
Total	-$20,511,211	-$17,088,991	-$779,218	-$2,643,002
FY 2027-28				
Long-term services and supports	-$655,219	-$655,219	$0	$0
End dental benefit	-16,629,519	-14,200,787	-850,056	-1,578,676
Behavioral health capitations	-12,211,750	-9,819,986	0	-2,391,764
Accountable Care Collaborative	-4,322,514	-4,322,514	0	0
Systems costs	0	0	0	0
Total	-$32,968,946	-$28,998,506		-$3,970,440
FY 2028-29				
Long-term services and supports	-$655,219	-$655,219	$0	$0
End dental benefit	-16,629,519	-14,200,787	-850,056	-1,578,676
Behavioral health capitations	-12,211,750	-9,819,986	0	-2,391,764
Accountable Care Collaborative	-4,322,514	-4,322,514	0	0
Systems costs	0	0	0	0
Total	-$32,968,946	-$28,998,506		-$3,970,440

Long-term services and supports

Request

The Department proposes eliminating new coverage for long-term services and supports and grandfathering existing users. Specifically, the Department proposes limiting access to:

- home- and community-based services
  - including personal care and homemaker services through Community First Choice
- long-term home health
- private duty nursing
- hospice
- nursing home care

The CAC populations do not currently use much long-term services and supports. Only 49 of the CAC enrollees, all children, accessed long-term services and supports from January 1, 2025 through November 30, 2025. The expenditure per utilizer for home- and community-based services was only $10,921 for the CAC children, compared to $56,521 for Medicaid children.

Even a trickle of utilizers of long-term services and supports could grow the budget exponentially. The cost per utilizer is high. People receiving long-term services and supports tend to continue receiving services until they age out. Each new utilizer could easily drive expenditures for another 15 plus years.

The Department did not estimate any savings associated with ending long-term services and support. The Department says the number of utilizers is so small and the time series is so short that the Department lacks confidence in forecasting the potential savings. Furthermore, the request assumes the limit would not occur

until sometime in FY 2027-28 (the request is not specific on a date) and the Department's February forecast does not show any enrollment growth in FY 2027-28 that would be avoided. The Department says this part of the request is about insulating the program from potential large expenditure increases in the future, rather than savings relative to the projected expenditures.

Recommendation

Staff recommends eliminating the long-term services and supports benefits for CAC with no grandfather provisions. If the CAC children used home- and community-based services at the same rates as Medicaid children, the costs would grow by $20.3 million General Fund. The costs could go even higher if the CAC children started using nursing, long-term home health, private duty nursing, and hospice services at the same rates as Medicaid children.

The JBC could grandfather existing users, but this would drop the projected savings to about $120,000 per year, because it only prevents new growth. The grandfathered users could still increase the services consumed and drive costs up. This is a relatively new benefit, so the people receiving care have not been dependent on it for years, nor built their lives around it.

The staff recommendation assumes the Department could make eligibility system changes to stop adding new beneficiaries effective January 2027. However, staff assumes it would take until June 2027 to make the billing system changes needed to remove the benefits for members currently receiving long-term services and supports.

While there are immediate savings associated with the staff recommendation, the primary goal is to prevent potential future explosive growth, if CAC members begin using long-term services and supports at the same rates as Medicaid children.

Dental Services

Request

The Department proposes a $750 annual cap on dental services for Cover All Coloradans. In a different request (BA7l), the Department proposes a similar annual cap on dental services for other Medicaid clients, but that cap would be $3,000.

From July through December 2025 there were 7,546 distinct utilizers of CAC dental services, including 1,026 pregnant people and 6,520 children.

The Department did not submit a new estimate of the savings, but the Department revised some of the assumptions and acknowledged some technical errors[4] in the original request. The Department's original estimate assumed implementation in April 2028, with partial savings in FY 2027-28 and full savings in FY 2028-29. After consideration, the Department believes it can build off the system work for the $3,000 annual cap for non-CAC populations without needing to build a separate benefit plan for the CAC populations. With this change to the technology approach, the Department believes it can implement a dental cap for FY 2026-27.

[4] The original estimate showed General Fund savings for the pregnant people, but the source of funds is the Adult Dental Fund. The original estimate assumed a 50 percent federal match for the services to pregnant people but the federal match is 65 percent. Finally, the original estimate did not account for the delay between when services are provided and paid. Although the dental cap applies to the plan year, some of the savings will occur in the next fiscal year because of the delay.

With the updates, the JBC staff estimates that the Department's request would change the forecast for FY 2026-27 by -$7.3 million total funds, including -$6.2 million General Fund. However, this still includes an assumption that the JBC staff believes overestimates the savings. As described below, the JBC staff believes the Department lacks sufficient data to reliably project the savings from an adult dental cap for CAC.

Recommendation

Staff recommends eliminating the dental benefit for Cover All Coloradans, rather than capping it. The staff recommendation changes the forecast by -$15.2 million total funds, including -13.8 million General Fund.

Since the Department submitted the budget amendment, the Department significantly increased the forecast for the Cover All Coloradans children. Eliminating the dental benefit, rather than capping it, is a logical next step for further reducing the CAC benefits to fit the budget. Compared to the November forecast, the February forecast for the children was higher by $26.2 million General Fund in FY 2025-26 and $35.9 million General Fund in FY 2026-27.

Many private insurance programs and Medicare do not cover dental services.

A lack of adequate dental insurance is not typically as financially catastrophic as a lack of adequate health insurance. Paying for dental services out of pocket can be expensive, but the scale is not normally the same as for other health services. Also, some of the most expensive and urgent services would continue to get covered through the emergency services for noncitizens, somewhat mitigating the impact on clients.

The Department does not have enough data to reliably project the fiscal impact of a $750 annual cap. The JBC staff believes the Department's assumptions result in a projection that is too high. The Department used the number of utilizers and the dental expenditures from July through December 2025. The Department assumed the expenditures would double to get to a total for the fiscal year, but the Department assumed the utilizers would remain constant. This resulted in high per capita expenditures relative to a $750 annual cap. Instead, we could assume that the utilizers in the first six months got their root canals and cavities filled and they are done for the year. In this scenario, additional expenditures in the second half of the year would be driven by new utilizers. If we assume the utilizers double, we get much lower per capita expenditures. In the alternate scenario, the estimated General Fund savings from a $750 annual cap would be only $2.0 million compared to the Department's estimate of $7.2 million. Both the Department's estimate and the alternate scenario use extreme assumptions and the truth is probably somewhere in between. The JBC staff is not arguing for a different estimate. Rather, staff is highlighting the significant uncertainty about the savings.

There is significant uncertainty when projecting the savings from the staff recommendation to end the dental benefit, too. However, the leaps in logic are shorter. The JBC staff believes the estimated savings from ending the dental benefit are significantly more reliable than the estimated savings from a dental cap.

The staff calculation starts with the expenditures from July through December 2025 and doubles them to get an estimate for FY 2025-26. Then, the JBC staff inflates the expenditures by the forecasted enrollment growth to get an estimate for FY 2026-27. Finally, the JBC staff adjusts for the delay between when services are delivered and paid, assuming one month of the savings will impact FY 2027-28 expenditures.

End CAC dental benefits

Item	Total Funds	General Fund	Adult Dental Fund	Federal Funds
FY 2026-27				
Pregnant	-2,226,338	$0	-$779,218	-$1,447,120
Children	-13,017,388	-13,017,388	0	0
Total	-$15,243,726	-$13,017,388	-$779,218	-$1,447,120
FY 2027-28				
Pregnant	-2,428,732	$0	-$850,056	-$1,578,676
Children	-14,200,787	-14,200,787	0	0
Total	-$16,629,519	-$14,200,787	-$850,056	-$1,578,676

The recommendation assumes the Department could end the dental benefits effective July 2027. The Department said it could implement an annual cap by that date. In the worst-case scenario, the Department could just set the cap at $0 to get the savings starting in FY 2026-27.

Behavioral health capitation payments

Request

The Department proposes paying for behavioral health services to the CAC populations through fee-for-service, rather than managed care. The Department currently makes capitated payments per member per month to the Regional Accountable Entities (RAEs). The rates take into account targeted expenditures for all members. However, the CAC populations currently use less services and less expensive services than the overall population. The Department projects it will save money by paying on a fee-for-service basis for only the services the CAC populations use, rather than on a per member per month basis for managed care.

There are services that members can get through managed care that fee-for-service would not reimburse. The bullets below highlight the services that would no longer be available, except when categorized as an emergency. Of note, the residential services are very high cost, if the CAC members started using them.

- Assertive Community Treatment
- Case management services
- Clubhouse/drop-in centers
- Drug screening and monitoring
- Individual and group therapy
- Inpatient hospital psychiatric care
- Medication management
- Outpatient hospital psychiatric services
- Prevention/early intervention activities
- Psychiatrist services
- Recovery services
- Residential and inpatient substance use disorder services
- Residential mental health services
- Respite services
- School-based and day treatment services for children/youth

- Social detoxification services
- Vocational services

This is a reduction in benefits for CAC members relative to the other beneficiaries. Therefore, it requires legislation. However, these are services that the Department says the CAC populations are not regularly using.

In addition, the Department received new federal guidance that any state-funded services to immigrants who do not qualify for Medicaid or CHP+ cannot be comingled with a Medicaid or CHP+ managed care contract. This means the Department must pull the money for the CAC children out of the contracts with the Regional Accountable Entities for behavioral health and care management. The Department could make new, separate contracts for managed care for the CAC populations. However, the rate structure would be challenging due to the smaller population and volatile risk. The request is to avoid separate behavioral health managed care contracts for the CAC populations and instead provide care through fee-for-service.

Recommendation

Staff recommends the requested legislative change. The current process pays for behavioral health services that CAC members are not using. The recommendation reduces payments to providers, but it reduces the workload and risk for the providers proportionally.

The members will still be able to access standard behavioral health services through fee-for-service. If the members start using more behavioral health services, then that will reduce the savings, but the costs should still be less than under managed care. This is because the members will not be able to access high-cost residential services outside of managed care.

The recommendation assumes implementation in January 2027, rather than the requested April 2028.

If the General Assembly does nothing and the current utilization patterns continue, then the rates will eventually come down on their own. The new federal guidance will require the Department to set up new and separate managed care contracts for the CAC populations. The rate setting process will look at targeted expenditures specifically for the CAC populations, rather than the overall population. However, the timing for a rate change is uncertain. The Department needs a sufficiently sustained utilization pattern to inform the targeted rates and make a case that they are actuarially sound. The best proxy currently is the overall population. With a narrowly targeted managed care contract the provider risk goes up and the rates will need to take that into account. Also, keeping the CAC populations in managed care allows them to access high-cost residential services. Expenditure patterns could increase more than if the members are limited to fee-for-service. Removing the CAC populations from managed care is a safer and more predictable way to achieve savings than waiting and hoping that the rates come down on their own.

Accountable Care Collaborative

Request

The Department wants to remove the CAC populations from the Accountable Care Collaborative (ACC). The Department's rationale walks a fine line. For the non-CAC populations, the Department argues that the ACC saves money by providing care coordination, monitoring clients, and developing innovative programs and interventions that improve health outcomes. The RAEs and the providers they contract with can earn incentives when they improve health outcomes. However, for the CAC the Department says we are paying for highly

administrative services that are not applicable to the populations. The CAC populations have simple needs, the Department argues, rather than the complex needs and costs that the Department believes the ACC excels at containing. Also, the Department argues that the pregnant members could still access services such as prenatal plus, nurse home visiting, and doula and lactation support.

This is a way to reduce expenditures for the CAC without cutting people off from direct services. The impact of the ACC on members is indirect and often not perceived by the members, or at least not attributed by the members to the ACC.

Recommendation

Staff recommends removing the children from the ACC but not the pregnant people. The JBC staff has a hard time with the Department's logic. If we think the ACC doesn't save money, then let's cut it for all populations, not just the CAC. If we think that the ACC saves money, then why would we want to cut it for the CAC? We want to contain CAC costs, not let them grow due to a lack of coordinated care.

The Department says the ACC excels at containing costs for complex situations that require significant care coordination. That sounds like pregnancy. The State wants lots of prenatal visits, diagnostic tests, and coaching on nutrition, supplements, and behavioral choices in order to increase the odds of healthy births. Then the State wants lots of postnatal follow up to avoid preventable complications and to catch and intervene early with development issues.

For the children, the JBC staff is more amenable to the Department's argument that the care is primarily simple and routine and not heavily influenced by the ACC care coordination, but only if removing the children from the ACC is part of a bigger change that removes the long-term care and behavioral health managed care. Children using long-term care or behavioral health managed care likely fall in the category of complex. If the JBC wants the Department to continue covering long-term services and supports and behavioral health managed care for the CAC, then staff believes the Department should keep paying for the ACC to coordinate care and contain these complex costs.

Most of the General Fund savings comes from removing the CAC children from the ACC, rather than from removing the pregnant adults. Therefore, the staff recommendation does not dramatically reduce the projected savings compared to the original request. The additional savings from including the pregnant people would be in the range of $600,000 General Fund annually, but the JBC staff would need additional time to calculate it. The original request is not a great barometer, because it missed some savings from ending behavioral health incentives and assumed the wrong federal match rate. Also, the Department did not provide the level of detail the JBC staff would need to update the projection for the pregnant people to align with the February forecast.

System costs

For the system costs, the JBC staff recommendation assumes the same total cost over all years as the original request. However, due to the recommendation to accelerate the implementation schedule, the JBC staff moved all the system costs to FY 2026-27. The timing and total for the system costs might need some refinement through the fiscal note process.

→ BA7l Adult dental annual cap

Request

The Department proposes a $3,000 annual cap on adult dental services.

The request changes projected expenditures by:

- -$6.4 million total funds, including -$1.3 million from the Adult Dental Fund

Decreasing expenditures from the Adult Dental Fund saves General Fund by reducing the General Fund obligation for a TABOR refund in any year when a TABOR refund is due. The source of revenue to the Adult Dental Fund is transfers from the Unclaimed Property Trust Fund (UPTF). The UPTF is exempt from TABOR, but transfers to support the adult dental benefit cross the TABOR boundary.

Comprehensive dental services for children to age 21 and emergency dental services for adults would still be covered, because these are required benefits.

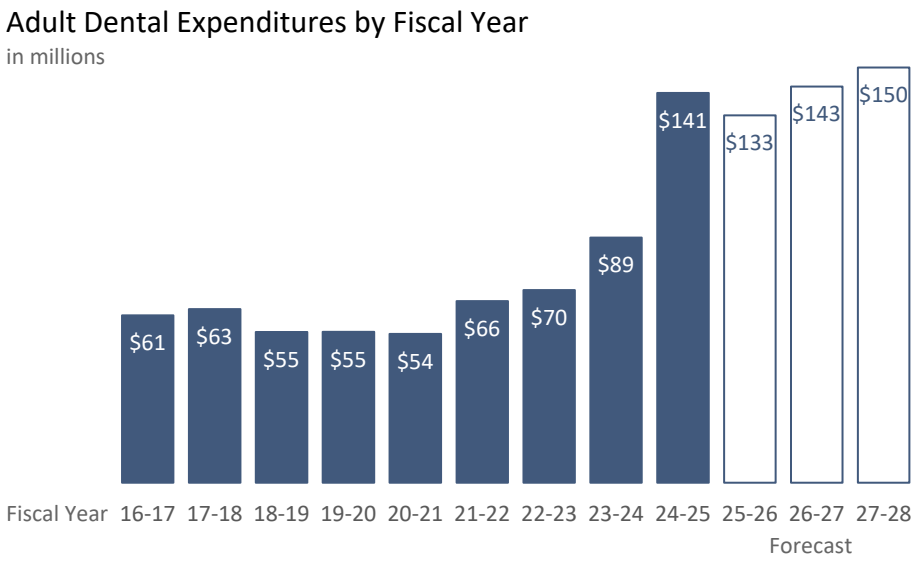
The Department estimates about 4,000 adults spend more than $3,000 each year and would need to reduce expenditures to comply with a $3,000 annual cap.

Recommendation

Staff recommends approval of the request but with technical corrections. The JBC staff estimates that when fully implemented the cap will change the forecast by -$1.5 million General Fund annually, compared to the Department's estimate of -$1.3 million General Fund.

The Department has used dental caps in prior years to contain expenditures. The most recent annual cap was $1,500 prior to FY 2023-24. Other state Medicaid programs and private insurance use annual caps as a strategy to contain costs.

Costs for the adult dental benefit are increasing. This request addresses a driver of trend. The chart below shows adult dental expenditures over time.



An annual cap does not necessarily mean people will go without care. Sometimes clients and providers work together to spread costs over multiple plan years. Deferred dental care reduces overall health and may cause clients to live with pain, infection, and inflammation for longer periods. This may lead to higher costs for other medical services and emergency dental services. Over time, the deferral of care could erode some of the savings achieved through this strategy.

The General Assembly could achieve more savings with a lower annual cap. For example, last year the JBC staff estimated that a $1,500 annual cap would save $4.4 million General Fund. Federal regulations do not require dental coverage, but any dental coverage offered must meet sufficiency standards. Indiana recently lost a court case with an annual dental cap of $1,000. A $3,000 annual cap saves less money than a $1,500 annual cap, but it has less impact on the clients and providers and a lower risk of a legal challenge.

The staff recommendation makes several technical modifications to the Department's calculations. The Department's original calculation captured some General Fund expenditures that are not impacted by the adult dental cap. Also, the Department discounted the projected savings by 15 percent to account for the supplemental reduction in dental provider rates. However, the supplemental reduction to dental provider rates primarily impacted preventive services and the adult dental cap will primarily impact higher cost remediating procedures. The two policy changes can be implemented independent of each other without changing the savings estimate for either one. The Department's original calculation did not account for the supplemental 1.6 percent decrease in provider rates. Finally, the Department's original calculation did not account for the delay between when services are provided and billed. Some of the savings will not occur until FY 2027-28.

Adult Dental Cap

Item	Total Funds	General Fund	Adult Dental	Hospital Provider Fee	Federal Funds
Department estimate FY 2026-27 and ongoing	-$6,480,905	-$41,715	-$1,310,599	-$476,228	-$4,652,363
General Fund obligation for TABOR refund	-1,310,599	-1,310,599	0	0	0
Net savings	-$7,791,504	-$1,352,314	-$1,310,599	-$476,228	-$4,652,363
JBC Staff estimate FY 2026-27	-$6,833,118	$0	-$1,390,778	-$505,362	-$4,936,978
General Fund obligation for TABOR refund	-1,390,778	-1,390,778	0	0	0

Item	Total Funds	General Fund	Adult Dental	Hospital Provider Fee	Federal Funds
Net savings	-$8,223,896	-$1,390,778	-$1,390,778	-$505,362	-$4,936,978
JBC Staff estimate FY 2027-28	-$7,454,310	$0	-$1,517,212	-$551,304	-$5,385,794
General Fund obligation for TABOR refund	-1,517,212	-1,517,212	0	0	0
Net savings	-$8,971,522	-$1,517,212	-$1,517,212	-$551,304	-$5,385,794

→ BA7q Equine therapy [legislation]

Request

The Department proposes ending coverage of two equine services, effective July 1, 2026.

Ending the benefits changes the Department's forecast by:

- Year 1: -$525,840 total funds, including -$262,920 General Fund
- Year 2: -$573,644 total funds, including -$286,822 General Fund

The Department covers hippotherapy under the state plan, pursuant to H.B. 22-1068 (Rep.s McCormick & Lynch/Sen. Juaquez Lewis), and adaptive therapeutic equine activities under the Adult Supported Living Services and the Children's Extensive Support Services waivers. There are technical differences between the benefits, but both aim to use a horse's movement to help develop and enhance motor skills, self-regulation, communication opportunities, and social and emotional well-being. The services are designed for children with intellectual and developmental disabilities but adults can use them, too. Eliminating the state plan services requires a change to Section 25.5-5-332, C.R.S.

House Bill 22-1068 assumed 168 users of equine services.

Recommendation

Staff recommends the requested legislation but staff assumes a fiscal impact of -$363,028 total funds, including -$181,514 General Fund.

This is not a standard benefit under private insurance or Medicare. The benefit impacts a small number of clients and providers. It is not a core Medicaid service. While there is evidence supporting that equine services are beneficial, there is also evidence that other therapies covered under Medicaid improve motor skills, self-regulation, communication opportunities, and social and emotional well-being. These alternatives include physical therapy, occupational therapy, speech therapy, and movement therapy.

The Department is not projecting a significant substitution of services. Most of the clients already use other therapies and enhance them with equine services. The Department views this as an add-on service. However, if clients increase their utilization of therapies because they cannot access equine services, then that will decrease the savings.

The Department's estimate included savings from the waivers, but there has been no utilization through the waivers since the state plan benefit was introduced. Therefore, the lower staff estimate of the savings is based on the estimated state plan expenditures.

Provider rates

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R13 Denver Health fed funds	0	0	0	0	0.0	EK
R14.2 IV nutrition rates	$615,320	$203,628	$24,453	$387,239	0.0	EP
R15 Home health/nurse rates	-26,582,980	-13,670,319	160,503	-13,073,164	1.0	TD
BA7f Nonwheelchair transport	-52,128,472	-15,674,567	-10,389,669	-26,064,236	0.0	EK
BA7h School health withhold	0	0	0	0	0.0	EK
BA7i Hospital medical education	-76,754,131	-22,212,646	-3,707,225	-50,834,260	0.0	EK
BA7m Sleep study rates	0	0	0	0	0.0	EK
BA7s Provider rates -0.75%	0	0	0	0	0.0	EK
Total	-$154,850,263	-$51,353,904	-$13,911,938	-$89,584,421	1.0	

→ R13 Denver health fed funds [legislation]

Request

The Department requests legislation to use public funds that Denver Health transfers to the state to draw additional federal funds for Denver Health. The supplemental payments would support physician services provided by Denver Health.

Year 1: The Department seeks an increase of $3.5 million cash funds and $7.8 million federal funds. The cash funds would come from Denver Health.

House Bill 25-1213 authorized similar financing for hospitals, but an additional statutory change is needed to authorize payments specifically for physician services. The proposed legislation would use the same legal arguments as H.B. 25-1213 to classify Denver Health's transfers as exempt from TABOR. As a result, Denver Health would receive $7.8 million in new federal funds at no cost to the General Fund.

To receive the federal funds, Denver Health must:

- expand the number of physicians and eligible practitioners
- support graduate medical education
- increase screenings for breast cancer, for colorectal cancer, and for depression and follow up plans

Recommendation

Staff recommends the proposed legislation. It would increase the federal funds available to support Denver Health with no cost to the General Fund. House Bill 25-1213 established the precedent for Denver Health's transfers to be exempt from TABOR.

Evidence designation

The Department indicates that the evidence designation is Evidence-Informed. The Department says ample evidence exists to support the importance of screenings for breast cancer, for colorectal cancer, and for depression and follow up plans to promote early detection and improve health outcomes for patients. All three screenings are identified as critical health areas by the National Committee for Quality Assurance (NCQA) in their State of Health Care Quality Report. The report provides links in the "Why it Matters" section for each screening to studies showing the efficacy.

Staff agrees with the Department's designation that the screenings are evidence-informed, but the evidence is not critical to the staff recommendation. The staff recommendation is based on more federal funds for Denver Health at no cost to the General Fund.

→ BA7f Nonwheelchair transport

Request

The Department proposes reducing rates for non-emergency medical transportation (NEMT) when the client does not need a wheelchair.

The rate reduction would take effect July 1, 2026, and change the Department's forecast by:

- Year 1: -$10.3 million total funds, including -$3.1 million General Fund
- Year 2: -$12.0 million total funds, including -$3.6 million General Fund

The Department would reduce the pickup fee for ambulatory clients from $36.40 to $30.00, or 17.6 percent. In addition to the pickup fee, the Department pays a fee per mile that would not change. When looking at the total compensation for a typical metro trip, the rate reduction is closer to 11.0 percent.

In addition, the Department argues that the rate for a nonwheelchair vehicle should be lower than the rate for a wheelchair vehicle to account for the differences in equipment needs. The Department currently pays the same pickup fee for services to ambulatory clients and clients needing a vehicle with accommodations for a wheelchair.

Recommendation

Staff recommends a significantly larger reduction in the nonwheelchair pickup rate from $36.40 to $4.00. The recommendation changes the forecast by -$60.8 total funds, including -$18.4 General Fund. The table below compares the staff recommendation to the request.

NEMT nonwheelchair rates

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds
Request				
FY 2026-27	-$10,296,982	-$3,096,211	-$2,052,280	-$5,148,491
FY 2027-28	-$12,009,847	-$3,639,555	-$2,365,369	-$6,004,924

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds
Staff recommendation				
FY 2026-27	-$52,128,472	-$15,674,567	-$10,389,669	-$26,064,236
FY 2027-28	-$60,799,852	-$18,425,247	-$11,974,679	-$30,399,926
Staff rec higher/-lower				
FY 2026-27	-$41,831,490	-$12,578,356	-$8,337,389	-$20,915,745
FY 2027-28	-$48,790,005	-$14,785,692	-$9,609,310	-$24,395,002

The staff recommendation would:

- align rates with an objective external analysis
- provide similar access to services as the non-Medicaid population
- reign in expenditures for a service where costs more than quadrupled in two years
- reduce incentives for fraud
- target a rate that is too high, rather than make an across-the-board reduction

Aligning rates with the Public Utilities Commission

A third party has already done market analysis to determine a "fair" rate for very similar transportation services. Normally, the JBC staff would hesitate to recommend such a large percentage rate reduction without the typical access analysis, benchmark comparison, and stakeholder engagement that happens through the Medicaid Provider Rate Review Advisory Committee (MPRRAC). In this case, the Public Utilities Commission (PUC) establishes maximum rates for large market taxi carriers. A large market taxi carrier provides indiscriminate passenger transportation for compensation in a taxicab on a call-and-demand basis within and between points in the 10 most populous counties. The staff recommendation is to piggyback on the work of the PUC, rather than waiting for the next MPRRAC review. If stakeholders believe the staff recommendation is too low, then that implies the PUC rates are too low. Those stakeholders should focus their efforts on convincing the PUC to raise rates.

The JBC staff questions whether an MPRRAC review would add value over the work already done by the Public Utilities Commission. This is not the type of medical service the MPRRAC normally reviews. The MPRRAC membership does not include anyone with special knowledge of vehicle operating costs or transportation business models. Also, the JBC staff questions the value of an MPRRAC benchmark comparison to other state Medicaid programs when many state Medicaid programs are experiencing similar fraud to Colorado. In the most recent MPRRAC analysis of NEMT rates, the Department said, "As a result of the fraud investigation, the utilization data for NEMT in SFY 2022-23 is unusable. Consequently, estimating Colorado Medicaid payments is not feasible, and the average benchmark ratio cannot be calculated." The JBC staff does not know when the Department will have useable data for a valid benchmark comparison with other states.

The current nonwheelchair rates are high relative to private transportation services. Most NEMT services are paid through a flat pickup rate for each leg of a trip plus mileage, though different methods for determining the reimbursement might apply for different types of trips. The average NEMT urban round trip is 19.5 miles, or slightly longer than the distance from Union Station to Anschutz Medical Center and back. The average rural round trip is 77.5 miles. The table below compares the maximum rate set by the Public Utilities Commission for

large market taxi carriers with what the Department would pay for nonwheelchair transportation for a similar trip.

Round Trip Union Station to Anschutz

Item	Pickup Fee	Units	Per Mile	Miles	Total	$ vs PUC	% vs PUC
PUC Large Market Taxi Carrier	$3.50	2	$2.80	18.8	$59.64	$0.00	0.0%
Current Medicaid rates	$36.40	2	$3.00	18.8	$129.20	$69.56	116.6%
Requested rates in BA7f	$30.00	2	$3.00	18.8	$116.40	$56.76	95.2%
Staff recommendation	$4.00	2	$3.00	18.8	$64.40	$4.76	8.0%

The JBC staff recommendation is a significant reduction from both current rates and the request, but for a typical metro trip the reimbursement would still be 8.0 percent higher than the maximum rates allowed by the PUC for taxis.

There are differences in business costs between Medicaid providers and taxis, from the complexity of regulations and billing to driver idle time and client no-shows. The Department says there are additional regulatory, accessibility, and administrative requirements operating as a Medicaid provider. These include federal compliance obligations, driver screening and specialized training, ADA accessible vehicles, higher insurance coverage, trip documentation and audit readiness, call center and scheduling coordination, and quality monitoring. The JBC staff does not have data to quantify these differences. Some premium for NEMT services might be appropriate and that is the reason the JBC staff recommendation is 8.0 percent higher than the PUC rates.

Also, the PUC rates apply to trips in the 10 most populous counties. The Medicaid rates apply statewide, including in rural communities with different costs and costs of living.

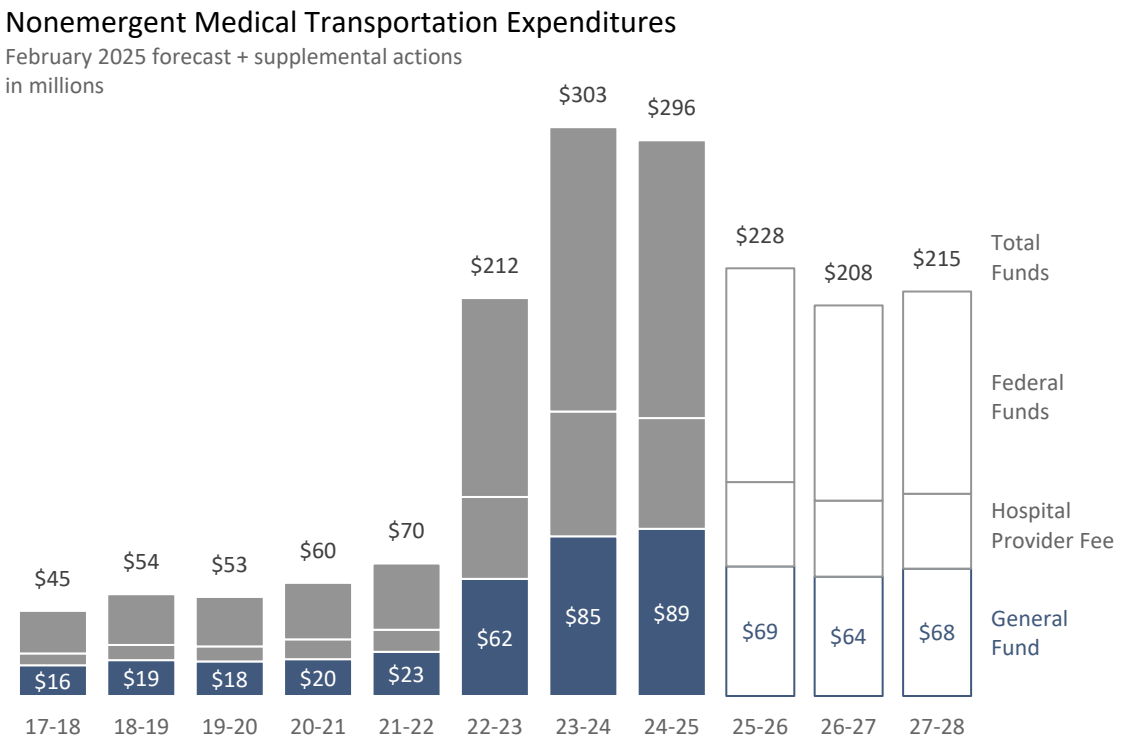
Impact on access to services

Relative to the general population, the JBC staff expects Medicaid clients will see no lower access to services, wait times, or service safety. This assumption is based on the general population already receiving taxi services at the rates approved by the PUC. If there is a difference in access to services, the JBC staff assumes it would occur in rural areas. The PUC rates do not apply to rural areas, so there is not the same evidence that the rates are sufficient to maintain access in rural communities.

Expenditure trends

This recommendation addresses a driver of trend. Medicaid expenditures for NEMT increased from $70 million in FY 2021-22 to $303 million in FY 2023-24. The graph below summarizes recent and projected expenditures for NEMT. It includes the impact of three recent measures approved by the JBC to contain costs:

- A reduction last year in the mileage rate from $6.10 to $3.00, expected to change the forecast by -$45.7 million total funds, including -$13.7 million General Fund
- A supplemental corrective action plan with one large NEMT provider expected to change the forecast by -$17.6 million total funds, including -$5.3 million General Fund
- A supplemental correction to the billing code used for XL wheelchair transportation expected to change the forecast by -$32.9 million total funds, including -$9.9 million General Fund



With the recommendation, plus the actions the JBC has already approved, the projected expenditures for FY 2026-27 would still be more than twice the actual expenditures in FY 2021-22.

The current rates might be creating an attractive environment for fraud. The fraud problems emerged shortly after the General Assembly approved a significant increase in the mileage reimbursement rate for NEMT in FY 2022-23 from $2.12 per mile to $6.10 per mile. The increase was based on the 2021 MPRRAC review that estimated Medicaid rates were only 37.5 percent of the benchmark. JBC members heard complaints about excessive wait times and unreliable services. The Department requested an increase to 60.8 percent of the benchmark with a long-term goal of 80 percent of the benchmark. The General Assembly approved an increase to 70 percent of the benchmark. The benchmark included Medicare rates, but Medicare mostly pays for ambulance trips. Medicare's coverage of transportation services is very limited. The rate increase occurred in July 2022. The Department saw an increase in providers and utilization. It appeared that the rate increase was achieving the intended impact. However, by August 2023 the Department had evidence suggesting parts of the increases in utilization and providers were attributable to fraud. For FY 2025-26, the General Assembly reduced the mileage reimburse to $3.00 per mile.

Background

What is the benefit?

Medicaid covers non-emergency transportation to medically necessary services from a Medicaid provider for all full beneficiaries. The benefit is federally mandated.

What is the federal match?

The service is defined in state law as an administrative service that draws a 50 percent federal match regardless of the eligibility category. At the time, defining NEMT as an administrative service provided more flexibility for managing the costs and delivery methods and an enhanced match for expansion populations was not available. The Department is exploring a statutory change that would allow an enhanced match for expansion populations. Such a change would reduce expenditures from the Hospital Provider Fee and increase federal funds. The state match comes from the General Fund or the Hospital Provider Fee, depending on the eligibility category.

Who provides the services?

Medicaid will pay for public transportation when it meets the member's needs. Some taxis with special licensing provide NEMT services. The Department can reimburse family members and friends that provide services. Ride share companies, like Uber and Lyft, do not drug test and certify drivers to the standards specified in statute for the NEMT benefit. Some providers are dedicated NEMT providers. The Department says it is exploring policy changes that would allow Uber and Lyft through the statewide broker. Both companies have dedicated divisions tailored to healthcare.

Who uses the services and for what?

The primary users of the benefit include people with disabilities, the elderly, and people with certain conditions, including behavioral health needs and renal disease. Statewide utilization data is skewed by the fraud issues. There is a nine-county metro area that the fraud schemes avoided due to additional scrutiny by a contracted broker that arranges for services. In the nine-county region with brokered services, the top five purposes for trip in December 2024 were:

- 51.35% Methadone clinic
- 10.41% Dialysis
- 8.58% Specialist
- 6.99% Behavioral/mental health
- 4.09% Physical/occupational therapy

How is the program performing?

In the brokered region, for December 2024, the average call wait time to schedule services was 15 minutes. The Department is trying to get it down to 5 minutes in the next contract. Members can self-schedule through an internet portal with no wait. The broker asks members to schedule 3 days ahead, but urgent trips with less than 48 hours of advance notice are covered. Ninety-three percent of trips were completed "on-time", but that means the driver was more than 15 minutes late for 7 percent of the trips (for a ride usually scheduled 3 days in advance). The driver didn't show for 0.02 percent of trips (46). The client didn't show for 9.9% of trips (17,822). The broker recorded service complaints on 0.09% (158) of trips. The Department lacks similar performance metrics outside the nine-county broker region.

The broker is paid on a fixed rate contract and the mileage reimbursement rates will have no impact on call wait times. The Department sees big differences in on time trips and driver no shows by provider and believes performance can be improved by steering services to the better providers. In other words, the Department sees

the timeliness and consistency of drivers as primarily a management issue, rather than a function of insufficient rates and a dearth of providers.

→ BA7h School health withhold [legislation]

Request

The Department wants to increase the federal funds withheld from school health services and use the money to offset state General Fund expenses. The money would otherwise get distributed to schools.

The request changes the Department's forecast for Medical Services Premiums by:

- Year 1: -$6,593,204 General Fund and $6,593,204 reappropriated funds transferred from school health services.

When school districts and Boards of Cooperative Education Services (BOCES) spend local tax dollars to provide health services to children eligible for Medicaid, they can go through an administratively intensive process to certify the public expenditures. Certified public expenditures can match federal funds. The Department withholds a small percentage of the federal funds for the Department's actual administrative costs to certify the public expenditures. The Department then distributes the rest of the federal funds to the schools that earned them.

The Department proposes changing the statute to allow up to 10 percent of the federal funds to offset General Fund in Medical Services Premiums. Current law[5] allows the Department to withhold up to 10 percent of the federal funds for administrative purposes. The Department does not have administrative expenses to justify withholding 10 percent. Currently, the withhold for administration is approximately 2.5 percent. This proposal would take another 7.5 percent of the federal funds away from schools and use it to save General fund.

The Department already does something similar with other supplemental payments, where the Department takes a portion off the top to offset General Fund.

Recommendation

Staff recommends denying the request. If the JBC wants to cut schools to fund Medicaid, then just cut the school finance budget. The schools have to do an enormous amount of administrative work to document these expenditures. We want the schools to put in the administrative effort, in order to maximize the federal funds to support the schools. This proposal reduces the financial incentive for schools to go through the trouble.

[5] Section 25.5-5-318 (8)(b), C.R.S.

→ BA7i Hospital medical education

Request

The Department proposes reducing payments for medical education to hospitals that are part of a system.

After the budget amendment, the Department submitted a correction to the estimated impact. Based on the revised calculation, the proposal changes the forecast by:

- Year 1: -$50.6 million total funds, including -$14.6 million General Fund
- Year 2: -$55.1 million total funds, including -$16.0 million General Fund

The payments are for indirect medical education (IME) costs associated with training residents. The IME adjustment is intended to cover inefficient care associated with teaching, such as increased testing, longer patient stays, and lower physician productivity. This is in contrast to the direct graduate medical education (DGME) adjustment that pays for resident stipends, faculty salaries, and administrative overhead.

Of the 85 hospitals in the state, 20 receive the IME adjustment. Of the 20 hospitals receiving the IME adjustment, 18 are part of a system and 2 are independent.

The Department argues that system hospitals are better able to absorb reductions than independent hospitals, because they can balance the negative impacts across a broader range of services, locations, and payers. By limiting the reduction to system hospitals, the Department is protecting two hospitals that receive IME and are independent. These hospitals are Denver Health and Wray Community Hospital. None of the other independent hospitals are currently receiving an IME adjustment.

Recommendation

Staff recommends eliminating the IME adjustment and adding a request for information asking the Department to examine graduate medical education over the interim and make recommendations for changes.

In a difficult budget year, the General Assembly is forced to make choices between reductions to services and medical education. This recommendation prioritizes direct services over the adjustment for *indirect* medical education. It preserves the adjustment for direct graduate medical education, so hospitals would continue to get compensation for resident stipends, faculty salaries, and administrative overhead. Direct graduate medical education might be a logical next place to reduce funding, if the General Assembly needs additional savings to balance the budget, but the current staff recommendation focuses on the indirect medical education adjustment.

One way to look at this request is that it is just a provider rate reduction. It doesn't matter if you pay the hospitals for indirect medical education or for delivering babies, because it all goes into the same pot. It is a targeted rate reduction that does not impact all providers, or even all hospitals, proportionally. The JBC has expressed a preference for targeted provider rate reductions over across-the-board reductions. So, the question is whether this proposal is targeted in a way that makes sense.

Many studies over multiple decades suggest that the Medicare formula for IME results in payments several times more than the amounts empirically justified by the independent effect of teaching on hospital costs (e.g.

Medicare Payment Advisory Commission March 2007, March 2017, and June 2021). Colorado's Medicaid reimbursement for medical education builds off the Medicare formula. So, Colorado's Medicaid IME payments reward hospitals that teach disproportionately to the actual additional costs in the same way as the Medicare payments. In addition, the IME payments trigger based on inpatient and not outpatient services, potentially creating perverse incentives. Differences in patient acuity are often cited as a justification for IME payments, but the hospital base rates and supplemental payments already factor in differences in acuity. The staff recommendation reduces hospitals in proportion to how much they benefit from this IME adjustment that MedPAC reports describe as bloated, inequitable, potentially creating perverse incentives, and partially redundant.

Some of the negative impact of the reduction will get mitigated by an increase in supplemental payments from the Hospital Provider Fee. Reducing hospital payments creates room under the hospital Upper Payment Limit, allowing an increase in supplemental payments. The state match for the supplemental payments comes from the hospitals through the Hospital Provider Fee, but there is still a net benefit to the hospitals. In a January 16, 2026 fact sheet, the Department estimated that the net benefit from higher supplemental payments would offset $17.2 million of the Department's requested reduction to IME. The staff recommended reduction is larger than the request and would result in a proportionally larger increase in supplemental payments. There is no similar offsetting increase in compensation that occurs with rate reductions for any other provider. This makes reductions to hospital rates particularly cost effective. The same General Fund reduction results in a smaller net negative impact on hospitals than for any other provider with a similar caseload mix.

Not every state makes Medicaid payments for medical education. Seven state Medicaid programs do not pay for medical education at all, including Massachusetts that has some of the most robust medical education programs in the country. Another 11 state Medicaid programs do not pay for IME, bringing the total that do not pay for IME to 18 state Medicaid programs. There are other ways to ensure a pipeline of providers than IME payments.

Toward the end of ensuring a pipeline of providers, staff recommends a request for information. The JBC staff is concerned that reimbursements for medical education are not entirely equitable and in proportion to the teaching provided. For example, previous rounds of budget reductions reduced medical education funding for Denver Health and University Hospital, but not for other hospitals. Also, a National Conference of State Legislatures brief suggests there might be better ways to target the funding to where it is needed. For example, some states target medical education funding to specialties and regions where there are provider shortages. Some states provide funding for health professions beyond physicians, such as nursing, behavioral health, or dental. Some states leverage local and private insurance funds to help support medical education. Rather than building on the Medicare formula for medical education, Colorado could move to something more flexible and targeted, like grant funding. Here is the proposed request for information:

N Department of Health Care Policy and Financing, Executive Director's Office – The Joint Budget Committee requests that the Department submit a report by November 1, 2026, on medical education. The report should summarize all the ways the Department supports medical education and trends in the medical education expenditures. The report should include recommendations on how to target the limited resources more efficiently and equitably to the areas of greatest need. The report should include analysis of promising models from other states and ideas for alternate fund sources to support medical education.

The table below summarizes the impact of the staff recommendation by hospital and compares it to the Department's request. The estimated savings in the first year is 11/12ths of the total, due to assuming an average one-month lag between when services are provided and paid.

Indirect Medical Education

Hospital	System	Request	Staff Rec	Difference
University of Colorado Hospital	UCHealth	-$22,269,752	-$27,837,191	-$5,567,438
Children's Hospital Colorado	Childrens	-14,451,398	-18,064,248	-3,612,850
Denver Health Medical Center		0	-14,781,217	-14,781,217
Parkview Medical Center	UCHealth	-3,581,211	-4,476,513	-895,303
St. Joseph Hospital	Intermountain (nee SCL Health)	-2,797,360	-3,496,700	-699,340
Sky Ridge Medical Center	HealthONE	-1,836,921	-2,296,152	-459,230
Swedish Medical Center	HealthONE	-1,671,814	-2,089,768	-417,954
North Colorado Medical Center	Banner Health	-1,580,305	-1,975,381	-395,076
Centura St. Anthony North Hospital	Commonspirit Health	-1,508,950	-1,886,187	-377,237
The Medical Center of Aurora	HealthONE	-1,507,640	-1,884,550	-376,910
Centura St. Mary-Corwin Hospital	Commonspirit Health	-795,435	-994,294	-198,859
Poudre Valley Hospital	UCHealth	-639,741	-799,676	-159,935
Centura St. Anthony Hospital	Commonspirit Health	-575,061	-718,826	-143,765
Presbyterian/St. Luke's Medical Center	HealthONE	-565,757	-707,196	-141,439
St. Mary's Hospital & Medical Center, Inc.	Intermountain (nee SCL Health)	-480,840	-601,050	-120,210
Rose Medical Center	HealthONE	-333,241	-416,551	-83,310
Centura Penrose-St. Francis Hospital	Commonspirit Health	-221,662	-277,078	-55,416
Memorial Hospital Central	UCHealth	-179,663	-224,578	-44,916
HCA HealthONE Mountain Ridge (nee North Suburban Medical Center)	HealthONE	-149,836	-187,295	-37,459
Wray Community District Hospital		0	-17,328	-17,328
Full year savings		-$55,146,587	-$83,731,779	-$28,585,192
General Fund		-15,959,423	-24,231,977	-8,272,555
Hospital Provider Fee		-2,663,580	-4,044,245	-1,380,665
Federal Funds		-36,523,584	-55,455,557	-18,931,972
FY 2026-27 Savings		-$50,551,038	-$76,754,131	-$26,203,092
General Fund		-14,629,471	-22,212,646	-7,583,176
Hospital Provider Fee		-2,441,615	-3,707,225	-1,265,609
Federal Funds		-33,479,952	-50,834,260	-17,354,307

→ BA7m Sleep study rates

Request

The Department proposes rebalancing provider rates for sleep studies. Rates below 80 percent of the benchmark would be brought up and rates above 100 percent would be brought down.

The request changes the Department's forecast by:

- Year 1: -$237,797 total funds, including -$71,339 General Fund
- Year 2: -$259,414 total funds, including -$77,824 General Fund

Recommendation

Staff recommends denying the request. Based on further conversations with the Department, the savings (and more) were already captured in the supplemental action to reduce rates to 85 percent of Medicare. The Department agrees that the request was an error and should not be approved.

→ BA7s Provider rates -0.75%

Request

The Department requests a -0.75 percent provider rate reduction.

The request changes the forecast by

- Year 1: -$72.9 million total funds, including -$26.5 million General Fund
- Year 2: -$79.5 million total funds, including -$29.9 million General Fund

Recommendation

Staff recommends recommends delaying action on an across-the-board provider rate adjustment until later in the balancing process.

Administration

Administration

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R6.21 Children in Rocky PRIME	-3,476,470	-1,738,235	0	-1,738,235	0.0	EK
R8 Single assessment	-11,668,682	-6,192,265	60,986	-5,537,403	2.7	TD
R9 Provider directory	5,955,875	451,455	248,360	5,256,060	0.0	EK
R10.2 3rd party insurance	3,089,490	242,166	132,707	2,714,617	0.9	EK
R11 Salesforce support	0	0	0	0	0.0	EK
R14.1 Chronic pain management	290,738	94,867	50,502	145,369	1.0	EP
R16 Unspent grant admin	0	-800,000	800,000	0	0.0	EP
R19 Consolidate line items	0	0	0	0	0.0	TD
R20 CHP+ Trust consolidation	0	0	0	0	0.0	EK
BA7r All Payer Claims Database	-559,662	-405,415	-15,731	-138,516	0.0	EK
BA8 Federal HR1 compliance	$40,423,139	$827,873	$9,032,339	$30,562,927	11.0	EK
BA9 Federal rules compliance	558,388	222,196	56,999	279,193	3.3	EK
BA11 CCBHC implementation	1,673,898	836,951	0	836,947	3.7	EP
Total	$36,286,714	-$6,460,407	$10,366,162	$32,380,959	22.6	

→ R6.21 Children in Rocky PRIME

Request

The Department no longer plans to expand the managed care contract with Rocky Mountain Health PRIME to include children. Instead, the children will continue to receive Medicaid coverage on a fee-for-service basis.

Year 1: This reduces the Department's forecast by $3.5 million total funds, including $1.7 million General Fund.

The Department previously planned to include children in Rocky Mountain Health PRIME beginning in FY 2026-27 as part of Phase III of the Accountable Care Collaborative. The current administrative structure sometimes causes confusion for families and providers when the payment procedures are different for children and parents in the same family. The Department estimated that the managed care rates would be $3.5 million higher due to expectations for greater care coordination and actuarial services needed to set the rates.

In addition, the Department identified $6.2 million in one-time costs from paying prospectively through managed care rather than after service delivery. However, the Department expected the one-time costs could get absorbed through the structure of the contract with Rocky PRIME and so the Department did not request or receive the one-time funding. The Department now says that absorbing the one-time costs proved infeasible under federal regulations. The Department would need system changes, since this would be the only payment on this nonstandard timetable. The Department says the system changes would be challenging but not insurmountable. Of more concern, the Department says the change would create a misalignment between the enrollment data and capitation payments that would look like an error to federal auditors, triggering payback requirements and potentially penalties.

The Department now estimates that moving the children to Rocky Prime would require:

- $6.2 million total funds, including $3.1 million General Fund, for the one-time shift in the timing of payments
- $3.5 million total funds, including $1.7 million General Fund, already budgeted for the difference between the projected fee-for-service and managed care rates
- Some amount for system changes that the Department did not estimate

Reversing the policy direction and keeping the children in fee-for-services avoids all of these costs with no decrease in benefits for the children.

Recommendation

Staff recommends approval of the request. Including the children and parents in the same plan is the better policy outcome to minimize confusion and administrative hassle for both the members and providers. However, the cost to move the children to managed care would be higher than originally estimated by the Department and probably not worth the marginal benefit.

It is possible that including the children in managed care would result in better health outcomes and that savings would offset the increased costs. However, projecting savings from managed care is highly speculative, especially since the children already receive care coordination through the Accountable Care Collaborative. Also, the per capita expenditures for children are already low and the potential savings from whatever benefits managed care provides are correspondingly limited.

The JBC could consider going the other direction and moving the adults out of Rocky PRIME and into fee-for-service. The JBC staff did not attempt to price out the difference in cost under that scenario.

→ R9 Provider directory

Request

The Department wants money to improve the provider directory to meet federal standards. In addition, the Department requests a net neutral transfer of funds from OIT to where contract services will actually be purchased for usability testing, interface updates, feedback loops, and directory performance evaluation.

The Department requests:

- Year 1: $6.0 million total funds, including $451,455 General Fund
- Year 2: $1.9 million total funds, including $311,355 General Fund

The provider directory helps members, providers, care coordinators, and call center staff locate participating providers for referrals. Recent federal guidance increased minimum requirements around mobile useability, quarterly updates, cultural and linguistic detail, interoperability with other software, user-friendly search features, and accessibility. The directory must now include fee-for-service providers and not just managed care providers.

Historically, the provider directory has been problematic. Providers don't consistently update their information, so the directory includes providers who have moved or closed. The directory doesn't say how many Medicaid

patients a provider sees or if they have openings. The Department says the changes will make limited improvements to these fundamental challenges. The improved system will incorporate data from the Regional Accountable Entities for primary care and behavioral health providers and flag duplicate, conflicting, or incomplete records to improve the accuracy of the directory. It will allow members to flag inaccurate information and that will trigger a follow up. The improved system will prioritize search results to show providers who recently billed Medicaid at the top, making it more likely that an inquiry will identify a provider who actually sees Medicaid patients. The system will comply with federal regulations, reduce the administrative burden on providers for updates, and include some performance enhancements, but the provider directory will likely remain a blunt and limited tool.

Recommendation

Reluctantly, staff recommends approval of the request in order to comply with the new federal regulations. This is a lot of money to spend relative to the marginal improvements that the JBC staff expects in the user's experience. The only saving grace is the favorable federal match rate. The idea of an up-to-the-minute provider directory is enticing, but:

- updating the directory is not part of the regular administrative activities of the providers
- there are no incentives for the providers to keep the directory up to date
- the directory is missing whether the provider is actually seeing new Medicaid patients

The new directory uses workarounds to slightly mitigate these challenges, but it does not fix the fundamental problems. An earnest and well-intended federal regulation is requiring the state to do something that the JBC staff believes will add very little value. The new directory will be more mobile friendly, culturally competent, and accessible, so that more people can experience how mediocre it actually is in helping them find a provider who will see them.

→ R10.2 3rd party insurance

Request

In cases where a third-party insurer should pay, rather than Medicaid, the Department wants to shift money from a vendor that checks claims after they are paid to information technology systems that stop improper payments in advance.

The request does not change total funds, but it results in the following adjustments:

- Year 1: -$781,599 General Fund, -$418,965 cash funds, $1,200,564 federal funds and an increase of two positions (1.8 FTE in FY 2026-27)

The Department argues prepayment claims reviews are more efficient and might lead to lower costs, but that is not the source of the savings in the request. Rather, the state gets a better federal match for information technology systems than for post-payment claims reviews.

Recommendation

Staff recommends:

- only one position, rather than the requested two positions
- application of the JBC's common policies for new FTE
- taking savings from the FY 2025-26 appropriation for contract services that the Department says it will not use

Moving money from post-payment claims reviews to prepayment claims edits is total funds neutral but results in a better federal match. Also, it results in a better outcome by preventing improper payments, rather than needing to recover the payments.

With limited resources in the current budget, staff recommends combining the responsibilities for the two positions into one. The staff recommendation is based on the statistical analyst salary, which is the higher of the two requested positions.

The Department argues that they need two FTE to make the change. In the Department's request, one position would be a statistical analyst that would:

- Design, implement, and maintain provider-specific TPL business rules within the MMIS, including rules targeting cost avoidance and pre-claim edits;
- Perform data analysis across Medicaid claims, eligibility, and third-party carrier files to identify patterns in coverage and flag irrelevant or missing TPL indicators;
- Collaborate with IT system vendors to scope and test MMIS system enhancements to the TPL subsystem, ensuring alignment with Department priorities and federal regulations;
- Act as the operational lead for establishing and executing data sharing agreements with commercial carriers, including coordination with legal, privacy, and compliance teams;
- Conduct ongoing evaluation of data feeds received from commercial carriers to assess match rates, data quality, and integration opportunities into MMIS and the TPL vendor subsystem;
- Track and document cost avoidance outcomes related to business rules and pre-claim editing activities, reporting findings to CMS as required;
- Support cross-functional collaboration with the Department and TPL vendors to assess performance and identify new system enhancement opportunities.

The other position would be an administrator that would:

- Maintain internal records and tracking logs for all executed and pending data sharing agreements, including version control and submission deadlines;
- Manage schedules, prepare meeting materials, and coordinate stakeholder engagement meetings with internal teams, external vendors, and commercial carriers;
- Assist in organizing, tracking, and filing MMIS enhancement requests and supporting documentation for system change boards and vendor coordination;
- Provide support in documenting business processes related to TPL enhancement activities, including drafting standard operating procedures and meeting summaries;
- Monitor and triage communications across shared inboxes related to TPL operations, data sharing agreements, and MMIS enhancements, escalating items to appropriate staff;

- Assist with formatting and submitting CMS documentation, such as Advance Planning Documents or federal match justifications, when requested;
- Provide logistical support for onsite and virtual meetings, vendor demos, provider briefings, and workgroups, including notetaking and follow-up tracking;
- Perform other administrative and office coordinator duties as needed to support timely execution of project deliverables.

The staff recommendation would require one person to perform both of these functions and/or for existing staff to help with some of these duties.

The Department received 2.0 FTE in FY 2023-24 for a very similar request (see R11). The Department says those FTE addressed different staffing shortfalls. Those FTE were to manage vendor, provider, and member data loads, oversee post-payment recovery processes, and strengthen internal analysis and oversight. In particular, those staff work on "data ingestion" or getting the information into the Department's data systems to determine when a third party is liable. Although the tasks are somewhat different, the JBC staff sees significant overlap in the Department's description of the functions, especially for the administrator position.

The components of the staff recommendation are summarized in the table below.

R10.2 3rd party liability

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds	FTE
FY 2025-26					
Third Party Liability Contract	-$3,212,252	-$1,043,983	-$562,144	-$1,606,125	0.0
FY 2026-27					
Third Party Liability Contract	-$3,212,252	-$1,043,983	-$562,144	-$1,606,125	0.0
Medicaid Management Information System	3,000,000	227,400	125,100	2,647,500	0.0
Personal Services	81,338	13,421	6,914	61,003	0.9
Operating Expenses	8,152	1,345	693	6,114	0.0
Centrally appropriated costs	0	0	0	0	0.0
Total - FY 2026-27	-$122,762	-$801,817	-$429,437	$1,108,492	0.9
FY 2027-28					
Third Party Liability Contract	-3,212,252	-1,043,983	-562,144	-1,606,125	0.0
Medicaid Management Information System	3,000,000	227,400	125,100	2,647,500	0.0
Personal Services	90,376	14,912	7,682	67,782	0.9
Operating Expenses	1,280	211	109	960	0.0
Centrally appropriated costs	22,906	3,780	1,947	17,179	0.0
Total - FY 2027-28	-$97,690	-$797,680	-$427,306	$1,127,296	0.9

As an alternative, the JBC could make the reduction to the third party liability contract and not reinvest any of the savings in the Medicaid Management Information System or new staff. This would slightly increase the General Fund savings to $242,166, but it would decrease the Department's ability to stop improper payments before they happen. Also, it would reduce the federal funds earned by $2.7 million. Given the favorable federal match for this activity and the better policy outcome, the staff recommendation is to reinvest a small portion of the General Fund savings.

→ R11 Salesforce support

Request

The Department requests funds for licenses, data storage, staff, and contract services to maintain and support Salesforce systems.

Year 1: The request costs $700,172 total funds, including $223,727 General Fund, and 1.8 FTE.

More of the Department's programs are using Salesforce. The cumulative effect of many programs adopting the same platform led the Department to conclude that more support is needed. The Department points to:

- Growing expectations for digital services and automation
- More complex integrations with other systems
- A larger and more diverse user base across programs
- More sophisticated business needs

The software is versatile and users can configure it for many different purposes, but the Department primarily uses it for customer relations management. For example, when a member reaches out to the call center, Salesforce can interact with other systems and help track statistics related to the contact; pull up relevant resources for the person assisting the member, such as eligibility files, case notes, and service records; or engage other people who need to know about the call.

Recommendation

Staff recommends denial of the request.

The request assumes a massive increase in workload, yet the explanation for that increase is insufficient. In response to JBC staff questions, the Department provided some key workload metrics to support the request.

Salesforce actual and projected users and heat tickets

Category	FY 23-24	FY 24-25	FY 25-26	FY 26-27
Number of Salesforce Users	240	250	250	450
Heat Tickets				
Closed	185	189	265	653
Backlog	294	363	414	465
Subtotal Heat Tickets	479	552	679	1,118

When asked why the users will increase from 250 in FY 2025-26 to 450 in FY 2026-27, the Department said:

> Various teams within HCPF turn to Salesforce to streamline workflows, improve visibility into the member's journey when contacting anyone in the Department, and gain access to data needed to do their jobs more effectively that they cannot get elsewhere. As those teams continue to learn about Salesforce and join the Organization, the license count will go up. Outside of "general" HCPF Users, contact center users are expected to increase due to the proposed shared services (between agencies HCPF, CDHS, CDPHE for case management) and HR1 program requirements.

The requests for shared services and H.R. 1 program requirements (R7 and BA8 respectively) already include funding for Salesforce licenses, data storage, and support. Prior year funding in FY 2025-26, approved through *R7a County escalation resolution unit*, provided for the purchase of 105 licenses for new users. Based on the Department's metrics, the Department has not yet used those additional licenses. The Department did not present any new evidence supporting a further increase in county users beyond those 105 licenses.

Heat tickets, which represent Salesforce support workload, are another metric to consider. The heat tickets increased 15.2 percent from FY 2023-24 to FY 2024-25. The number of heat tickets the Department was able to close remained about the same, so the backlog increased from 294 to 363. These tickets vary from simple password resets to more complex proposals for enhancements. Some of the enhancements are mission critical and some are nice improvements. It is unclear to staff the mix of tickets in the backlog. The unknown nature of the complexity, necessity, and workload requirements associated with the backlog makes it difficult for staff to assess the need for additional staff and contract resources to bring down the backlog.

The request assumes a massive increase in heat tickets, yet the explanation for that increase is insufficient. The Department projects a 23 percent increase in heat tickets in FY 2025-26 and a 65 percent increase in FY 2026-27. Presumably, this is tied to the increase in Salesforce users that the Department has not explained.

The JBC staff is in favor of adequate technical support for highly used and beneficial technology. However, after two rounds of back-and-forth questions and a virtual meeting, the Department is still unable to explain what is driving the need, why the JBC should trust the workload projections, and how the workload figures support the request.

→ R20 CHP+ Trust consolidation

Request

The Department proposes a net zero change to consolidate appropriations from the Children's Basic Health Plan (CHP+) Trust in the line item that pays for services.

The CHP+ Trust receives 18 percent of the revenue from the tobacco master settlement. In some prior years, the revenue was more than enough for services and it paid for administration directly related to CHP+. For the foreseeable future, the Department projects service costs will exceed tobacco revenue. The General Fund will need to pay the difference. Putting all the appropriations from the CHP+ Trust in one line item simplifies the accounting. Under the proposal, administrative costs for CHP+ will appear as a General Fund expense, which more accurately reflects the source of funds for any incremental increase in administrative costs for CHP+. The

General Assembly already approved a similar consolidation of appropriations from the Health Care Expansion Fund. Once the annual service costs exceeded the revenue, the cash funds became merely an offset to the General Fund, rather than the sole source of funds.

Recommendation

Staff recommends approval of this budget neutral request. It simplifies the appropriations. It will save time for the JBC staff and the Department in allocating and tracking appropriations. Also, it changes the way the Department presents administrative costs for CHP+ to more accurately and transparently reflect that changes in administrative costs impact the General Fund.

→ BA7r All Payer Claims Database

Request

The Department wants to reduce the All Payer Claims Database (APCD) to reflect lower than expected system maintenance costs. The request changes the appropriation by:

- Year 1: -$559,662 total funds, including -$405,415 General Fund

The APCD collects information from insurers and makes it available to researchers and public agencies to improve health care, improve health, and reduce costs. Each claim contains information on what services were provided and why, who received and who provided services, when and where services were provided, and how much was charged and paid. Examples of data from the APCD informing policy making can be found in the annual APCD reports.

In FY 2025-26, the General Assembly provided funding for urgent security upgrades identified by an OIT audit to protect the sensitive health data in the APCD. The request estimated ongoing expenditures for system maintenance and operations of $1.0 million total funds, including $749,107 General Fund. Now that the system changes are mostly complete, the Department has better information on the ongoing maintenance and operation costs. The Department lowered the estimated costs to $474,456 total funds, including $343,692 General Fund. The General Assembly can reduce the appropriation by the difference of $559,662 total funds, including $405,415 General Fund, with no negative impact on operations.

Recommendation

Staff recommends approval of the request. The reduction trues up the appropriation to the expected need. There will be no negative impact on operations.

→ BA8 Federal HR 1 compliance

Request

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

The request increases the Department's expected expenditures by:

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

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

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

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

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

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

Supplemental Action

The JBC approved the request for FY 2025-26 with modification to the fund sources, but indicated that it wanted to revisit the amounts for FY 2026-27 and beyond during figure setting. The fund source modification reflected that most of the work relates to the expansion populations. The expansion populations must show community engagement and renew eligibility every six months.

Recommendation

Staff recommends approval of the request with modification to the fund sources.

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

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

The tables below summarize the JBC's supplemental action and the staff recommendation for FY 2026-27.

FY 2025-26 Federal HR 1 compliance

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds	FTE
Compliance Administration					
Compliance Program Manager	$0	$0	$0	$0	0.0
Stakeholder Engagement Contractor	130,800	41,795	22,428	66,577	0.0
Work Requirements & Eligibility Redeterminations					
System Changes Contractors - MMIS	3,810,600	0	438,219	3,372,381	0.0
MMIS Rollforward Funding	-438,219	0	-438,219	0	0.0
System Changes Contractors - CBMS	834,334	0	93,058	741,276	0.0
CBMS Rollforward Funding	-93,058	0	-93,058	0	0.0
System Changes Staff	203,369	0	23,388	179,981	1.5
Community Engagement					
Operations, Compliance, & Escalations Staff	68,101	0	33,438	34,663	1.0
Operations, Compliance, & Escalations Contractors	96,169	0	47,219	48,950	0.0
Customer Call Center Increased Staffing	0	0	0	0	0.0
Customer Call Center Operations Staff	0	0	0	0	0.0
Customer Call Center Technology Contracts	0	0	0	0	0.0
Eligibility Auditing & Review Staff	102,153	0	26,151	76,002	1.5
County Administration	0	0	0	0	0.0
CBMS Interface Maintenance	500,000	0	245,500	254,500	0.0
Communications Staff	0	0	0	0	0.0
Social Media & Texting Campaign Contractor	96,831	0	47,544	49,287	0.0
Customer Outreach Process	0	0	0	0	0.0
Outreach Campaign	0	0	0	0	0.0
Informational Inserts	0	0	0	0	0.0
Additional Mailing	0	0	0	0	0.0
Texting Campaign	0	0	0	0	0.0
Appeals Staff	0	0	0	0	0.0
Appeals Contractor	0	0	0	0	0.0
Appeals Printing Supplies	0	0	0	0	0.0
Appeals Increased Licenses	0	0	0	0	0.0
OCL Grievances & Appeals	52,152	16,663	8,943	26,546	0.0
Disability Assessment Increases	0	0	0	0	0.0
Equifax Costs	0	0	0	0	0.0
Fraud, Waste, and Abuse Provisions					
Post-Payment Review and Complex Audits Staff	0	0	0	0	0.0
Fraud Referrals Contractor	0	0	0	0	0.0
Accounting Specialist Contractor	0	0	0	0	0.0
Targeted Case Management Review Contractor	0	0	0	0	0.0
Marketplace TPL Contractor	0	0	0	0	0.0
Total Request	$5,363,232	$58,458	$454,611	$4,850,163	4.0

FY 2026-27 Federal HR 1 compliance

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds	FTE
Compliance Administration					

Item	Total Funds	General Fund	Hospital Provider Fee	Federal Funds	FTE
Compliance Program Manager	$138,410	$44,226	$23,733	$70,451	1.0
Stakeholder Engagement Contractor	261,600	83,589	44,857	133,154	0.0
Work Requirements & Eligibility Redeterminations					
System Changes Contractors - MMIS	13,090,560	0	1,505,414	11,585,146	0.0
MMIS Rollforward Funding	-1,505,414	0	-1,505,414	0	0.0
System Changes Contractors - CBMS	3,784,980	0	420,511	3,364,469	0.0
CBMS Rollforward Funding	-420,511	0	-420,511	0	0.0
System Changes Staff	378,289	0	43,503	334,786	3.0
Community Engagement					
Operations, Compliance, & Escalations Staff	223,485	0	109,731	113,754	2.0
Operations, Compliance, & Escalations Contractors	396,216	0	194,542	201,674	0.0
Customer Call Center Increased Staffing	3,102,048	0	1,523,105	1,578,943	0.0
Customer Call Center Operations Staff	1,199,990	0	307,198	892,792	0.0
Customer Call Center Technology Contracts	288,609	0	73,884	214,725	0.0
Eligibility Auditing & Review Staff	335,228	0	85,818	249,410	3.0
County Administration	17,413,807	0	4,353,451	13,060,356	0.0
CBMS Interface Maintenance	1,000,000	0	491,000	509,000	0.0
Communications Staff	110,175	0	54,096	56,079	1.0
Social Media & Texting Campaign Contractor	199,472	0	97,941	101,531	0.0
Customer Outreach Process	100,000	0	49,100	50,900	0.0
Outreach Campaign	700,000	0	343,700	356,300	0.0
Informational Inserts	200,000	0	98,200	101,800	0.0
Additional Mailing	655,500	0	321,851	333,649	0.0
Texting Campaign	100,000	0	49,100	50,900	0.0
Appeals Staff	276,820	0	135,918	140,902	2.0
Appeals Contractor	110,500	0	54,256	56,244	0.0
Appeals Printing Supplies	33,000	0	16,203	16,797	0.0
Appeals Increased Licenses	45,576	0	22,378	23,198	0.0
OCL Grievances & Appeals	107,433	34,327	18,422	54,684	0.0
Disability Assessment Increases	555,750	177,579	95,294	282,877	0.0
Equifax Costs	1,194,175	0	586,340	607,835	0.0
Fraud, Waste, and Abuse Provisions					
Post-Payment Review and Complex Audits Staff	301,079	96,203	51,626	153,250	3.0
Fraud Referrals Contractor	193,662	61,881	33,207	98,574	0.0
Accounting Specialist Contractor	198,432	63,405	34,025	101,002	0.0
Targeted Case Management Review Contractor	832,500	266,008	142,749	423,743	0.0
Marketplace TPL Contractor	185,000	59,113	31,722	94,165	0.0
Total Request	$45,786,371	$886,331	$9,486,950	$35,413,090	15.0

Compliance administration

To implement the changes the Department will need to update state regulations and federal authorizations. The Department requests 1.0 FTE and contract services for regulatory research, rule drafting, and preparing state plan amendments, and negotiating the amendments with the federal Centers for Medicare and Medicaid Services. The contract services started January 1, 2026 and the FTE would start July 1, 2026. Both would run through December 2028.

Work Requirements & Eligibility Redeterminations

To enforce the work requirements and eligibility redeterminations, the Department needs to change both the Colorado Benefits Management System (CBMS) that handles eligibility determinations and the Medicaid Management Information System (MMIS) that handles claims and payments. In addition, the Department requests three new positions, two analysts and one manager, to oversee and maintain the new code related to the work requirements and eligibility redeterminations. The Department gets a 90 percent federal match for development and 75 percent federal match for maintenance. The Department anticipates that most, but not all, of the work will qualify for the 90 percent federal match. The Department proposes that the contract work will run through June 2029 and the FTE will be ongoing. For FY 2026-27, the Department thinks it will have funds that were rolled forward from prior years for other projects that it can redirect to absorb the state share of the contract work.

Community Engagement

Operations, Compliance & Escalation

The Department requests 2.0 FTE and contract resources, starting in April 2026, to update the Department's operations and guidance to the counties, ensure that procedures comply with the federal regulations, and respond to a projected increase in escalations and eligibility complaints.

Customer Call Center

The Department projects an increase in call center volume with roughly 155,000 members needing to complete compliance forms and provide documentation for the work requirements. The Department requests additional contract resources for:

- Customer call center increased staffing to support 36 new agents
- Customer call center operations staff for
  - 3 quality assurance analysts
  - 2 training support analysts
  - 3 managers
  - 3 IT system administrators
- Customer call center technology for system licenses

Eligibility Auditing & Review Staff

The Department requests 3.0 FTE to conduct internal eligibility audits, in parallel with county audits, to catch and solve problems before they become federal audit findings.

County administration & CBMS interfaces

The Department requests $17.4 million total funds for county administration so that the counties can hire an estimated 178 additional eligibility staff to handle the twice yearly renewals for expansion members. The Department requests the additional funds for FY 2026-27 and FY 2027-28. By FY 2028-29 the Department expects the shared services requested in *R7 Eligibility admin* will relieve county workload and eliminate the need for the additional resources. If the *R7 Eligibility admin* request is not approved, the temporary nature of the county administration funding might need revisiting.

In addition, the Department requests $1.0 million total funds additional interfaces with CBMS associated with the additional county eligibility workers. The Department requested the money as ongoing, but the staff recommendation assumes the costs will phase out in FY 2028-29 with the funding for the additional county eligibility workers.

Communications

The Department requests funding for

- 1.0 FTE communications staff through December 2028 to work on FAQs, website content, fact sheets, newsletters, and stakeholder engagement
- Social media & texting campaign contractor for the work requirements and twice a year renewals
- Customer outreach process to send automated electronic notices to members who disenrolled for procedural reasons
- Outreach campaign as required by federal law from June 30, 2026 through August 31, 2026
- Informational inserts and mailing
- Texting campaign

This is an area where elements overlap and the JBC might be able to shave some dollars off the total. For example, perhaps the Department could make the texting campaign part of the outreach campaign and does not need funding for both. However, the totals dollars are relatively small, the savings would be to the Hospital Provider Fee, rather than the General Fund, and this funding may address some of the concerns expressed by JBC members about people failing to renew due to lack of information or administrative hurdles.

Appeals

The Department requests funds for

- 2.0 FTE and contract resources to manage a projected increase in appeals
- Appeals printing supplies
- Appeals increased licenses for Salesforce
- OCL grievances and appeals where the state match comes from the General Fund
- Disability assessment increases for a projected increase in people applying for disability in response to the work requirements

Equifax costs

The Department requests resources for additional income verifications to meet the work requirements.

Fraud, Waste, and Abuse Provisions

- 3.0 FTE for post-payment review and complex audits staff
- Fraud referrals contractor to respond to an expected increase in referrals with more pre- and post-payment reviews
- Accounting specialist contractor to ensure accurate and timely accounting of cost savings, recoveries, federal shares, and reimbursements to providers
- Targeted case management review contractor to perform claim and record reviews of case case management agencies

- Marketplace third party liability contractor to load data from the federal government to help comply with out-of-state member regulations

Summary by Fiscal Year

The next table is a variation on the previous tables that shows the total funds by fiscal year and the expected end date for the time-limited funding. The table reflects the request, but there is significant uncertainty about how some of the provisions of H.R. 1 will work, including the procedures for verifying community engagement, and the federal guidance is evolving. The JBC staff expects multiple iterations on this funding plan over the next few years.

Federal HR 1 compliance total funds by fiscal year

Item	FTE	FY 25-26	FY 26-27	FY 27-28	FY 28-29	Through
Compliance Administration						
Compliance Program Manager	1.0	$0	$138,410	$144,047	$72,614	Dec-28
Stakeholder Engagement Contractor	0.0	130,800	261,600	261,600	130,800	Dec-28
Work Requirements & Eligibility Redeterminations						
System Changes Contractors - MMIS	0.0	3,810,600	13,090,560	12,491,560	9,590,080	Jun-29
MMIS Rollforward Funding						
System Changes Contractors - CBMS	0.0	837,600	3,784,980	3,810,450	3,842,700	Jun-29
CBMS Rollforward Funding						
System Changes Staff	3.0	203,369	378,289	383,134	383,134	Ongoing
Community Engagement						
Operations, Compliance, & Escalations Staff	2.0	68,101	223,485	226,715	226,715	Ongoing
Operations, Compliance, & Escalations Contractors	0.0	96,169	396,216	408,102	420,345	Ongoing
Customer Call Center Increased Staffing	0.0	0	3,102,048	3,102,048	3,102,048	Ongoing
Customer Call Center Operations Staff	0.0	0	1,199,990	1,199,990	1,199,990	Ongoing
Customer Call Center Technology Contracts	0.0	0	288,609	288,609	288,609	Ongoing
Eligibility Auditing & Review Staff	3.0	102,153	335,228	340,073	340,073	Ongoing
County Administration	0.0	0	17,413,807	17,413,807	0	Jun-28
CBMS Interface Maintenance	0.0	500,000	1,000,000	1,000,000	1,000,000	Jun-28
Communications Staff	1.0	0	110,175	113,357	57,143	Dec-28
Social Media & Texting Campaign Contractor	0.0	96,831	199,472	205,456	211,620	Ongoing
Customer Outreach Process	0.0	0	100,000	200,000	0	Jun-28
Outreach Campaign	0.0	0	700,000	700,000	0	Jun-28
Informational Inserts	0.0	0	200,000	400,000	400,000	Ongoing
Additional Mailing	0.0	0	655,500	1,311,000	1,311,000	Ongoing
Texting Campaign	0.0	0	100,000	0	0	Dec-26
Appeals Staff	2.0	0	276,820	288,095	288,095	Ongoing
Appeals Contractor	0.0	0	110,500	113,815	58,615	Dec-28
Appeals Printing Supplies	0.0	0	33,000	66,000	66,000	Ongoing
Appeals Increased Licenses	0.0	0	45,576	91,152	91,152	Ongoing
OCL Grievances & Appeals	0.0	52,152	107,433	110,656	113,976	Ongoing
Disability Assessment Increases	0.0	0	555,750	1,111,500	1,111,500	Ongoing
Equifax Costs	0.0	0	1,194,175	2,388,350	2,388,350	Ongoing
Fraud, Waste, and Abuse Provisions						
Post-Payment Review and Complex Audits Staff	3.0	0	301,079	308,065	308,065	Ongoing
Fraud Referrals Contractor	0.0	0	193,662	199,472	205,456	Ongoing
Accounting Specialist Contractor	0.0	0	198,432	204,385	210,517	Ongoing
Targeted Case Management Review Contractor	0.0	0	832,500	857,475	883,199	Ongoing
Marketplace TPL Contractor	0.0	0	185,000	190,550	196,267	Ongoing

Item	FTE	FY 25-26	FY 26-27	FY 27-28	FY 28-29	Through
Total	15.0	$5,897,775	$47,712,296	$49,929,463	$28,498,063	

→ BA9 Federal rules compliance

Request

The Department requests funding for seven new positions plus contract resources to comply with several new federal rules.

The request increases the Department's funding by:

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

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

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

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

Supplemental Action

The JBC denied the request for FY 2025-26, based on the staff recommendation that it did not meet the JBC's supplemental criteria and the Department could absorb $73,531 in General Fund costs. However, the JBC indicated that it would revisit the amounts for FY 2026-27 and beyond during figure setting.

Recommendation

Staff recommends $558,388 total funds, including $222,196 General Fund, and 3.3 FTE. The recommendation includes funding for

- 1.0 rate analyst for more frequent benchmarks, comparisons, and reviews of select provider rates
- 2.0 administrators for expanded incident management requirements and responding to grievances
- Contract actuary services for additional requirements in setting managed care rates
- 1.0 statistical analyst (0.3 FTE in FY 2026-27) for new communication and reporting requirements for prior authorization requests

The table below summarizes the staff recommendation. Each component of the recommendation is discussed in more detail in the subsections following the table.

BA9 Federal rules compliance

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Beneficiary Advisory Council (BAC)	$0	$0	$0	$0	0.0
Comparative Rate Analysis & Disclosure and Interested Parties Advisory Group					
Rate analyst	$101,968	$35,690	$15,295	$50,983	1.0
Program administrator	0	0	0	0	0.0
Contractor Funding	0	0	0	0	0.0
Subtotal	$101,968	$35,690	$15,295	$50,983	1.0
Ensuring Access to HCBS Medicaid Services					
Administrators	$178,393	$89,197	$0	$89,196	2.0
Contract services	0	0	0	0	0.0
Subtotal	$178,393	$89,197	$0	$89,196	2.0
Managed Care Rates	$240,750	$84,263	$36,112	$120,375	0.0
Managed Care Access and Quality					
Access & quality oversight	$0	$0	$0	$0	0.0
Quality rating system and secret shoppers	0	0	0	0	0.0
Subtotal	$0	$0	$0	$0	0.0
Interoperability & Prior Authorization Requests (PARs)					
PAR reporting	$37,278	$13,047	$5,592	$18,639	0.3
Licensing	0	0	0	0	0.0
Training	0	0	0	0	0.0
Subtotal	$37,278	$13,047	$5,592	$18,639	0.3
Total	$558,388	$222,196	$56,999	$279,193	3.3

Beneficiary Advisory Council

Request

The Department requests 1.0 FTE and funds for meeting expenses and member reimbursements for expanded duties of the Medical Advisory Committee (MAC) and a new Beneficiary Advisory Council (BAC) composed of Medicaid members and their families or caregivers.

The request costs

- Current year: $43,254 total funds, including $15,134 General Fund
- Year 1: $161,966 total funds, including $56,689 General Fund
- Year 2: $163,230 total funds, including $57,131 General Fund

The new regulations require opening at least two MAC meetings per year to the public, including a public comment period. They require at least 25 percent of the MAC membership come from the BAC. They require the Department to publish an annual report summarizing MAC and BAC activities.

The FTE would primarily support BAC member preparation and education to participate in the MAC and sit equally at the table. The federal regulation specifically requires states to provide support to the BAC. The

Department notes that member committees often have personal and traumatic experiences to share and argues that supporting an all-member committee requires

- trauma-informed facilitation
- sustained relational engagement
- structured preparation of each agenda item
- plain-language materials
- reimbursement administration
- technical assistance

Recommendation

Staff recommends denying this portion of the request. To meet the new federal requirements, the Department is building on existing member committees. The Department has a Member Experience Advisory Committee (MEAC) and a MEAC Alumni committee. These committees were designed as engagement forums focused on experience-sharing and feedback gathering. They were not structured as formal recommendation bodies working in coordination with a broader stakeholder council. However, the Department already has 1.0 FTE dedicated to supporting the MEAC and MEAC Alumni. The leap to support their expanded duties as the BAC does not sound so dramatic that the work cannot be absorbed within existing resources.

Comparative Rate Analysis & Disclosure and Interested Parties Advisory Group

Request

The Department requests 2.0 FTE and contract services for a comparative payment rate analysis, a disclosure report, and to support the Interested Parties Advisory Group. The FTE include a rate analyst and program administrator.

The request costs

- Year 1: $357,318 total funds, including $125,060 General Fund
- Year 2: $361,856 total funds, including $126,650 General Fund

The required comparative payment rate analysis is a benchmark comparison to Medicare for primary care, obstetrical and gynecological services, and outpatient mental health and substance use disorder services. This is very similar to the benchmarking work of the Medicaid Provider Rate Review Advisory Committee (MPRRAC), but the new regulation requires annual analysis, rather than every three years.

The disclosure report and Interested Parties Advisory Group will look at rates for personal care, home health aide, homemaker, and habilitation services. The Interested Parties Advisory Group consists of direct care workers, members, authorized representatives, and other members of the community. Again, this is similar to the work of the MPRRAC, but these specific services must get reviewed annually and by people with specific relevant credentials.

Recommendation

Staff recommends the rate analyst and application of the JBC's common policies regarding new FTE. The recommendation does not include funding for the program administrator or contract services. The new federal requirements overlap with the existing work of the MPRRAC and the JBC staff believes the Department can and

should leverage the existing infrastructure of the MPRRAC to meet the requirements. However, the federal regulations create a new Interested Parties Advisory Group that needs staff support, and they require annual benchmarks, comparisons, and reviews for select rates. That drives enough additional work to justify a new FTE. The staff recommendation is to keep the rate comparison work in house, and so it does not include funding for the requested contract services.

Ensuring Access to HCBS Medicaid Services

Request

The Department requests 2.0 FTE and contract funding for expanded requirements for home- and community-based services (HCBS).

The request costs

- Year 1: $476,741 total funds, including $200,820 General Fund
- Year 2: $476,656 total funds, including $238,328 General Fund

The new federal rules require a new definition for HCBS critical incidents and increase requirements for reporting, investigating, and sharing information. The Department currently does similar work for the approximately 19,000 members receiving services for people with intellectual and developmental disabilities. The new incident management requirements apply to all HCBS services, expanding the population served to roughly 90,000 members.

In addition, the new federal rules require the Department to establish a process for members to submit grievances directly to the Department related to compliance with person-centered planning rules and for timely resolution of those grievances.

Recommendation

Staff recommends the requested 2.0 FTE for the new incident management requirements and expected increase in FTE, with application of the JBC's common policies for new FTE. The JBC staff does not recommend the requested $250,000 in contract services. The Department says the contract services are to "create an implementation strategy" but requests ongoing funding. The Department can create an implementation strategy in house with existing resources.

Managed Care Rates

Request

The Department requests $240,750 for actuary services for increased requirements in setting managed care rates. The contractor will help with calculations of the average commercial rate, state directed payments, medical loss ratios, and in-lieu of services (substitutes for a covered service or setting under the state plan).

Recommendation

Staff recommends approval of the request. Without additional resources the Department will not comply with the increased requirements when setting managed care rates.

Managed Care Access and Quality

Request

The Department requests 1.0 FTE and contract resources for new requirements to demonstrate access in managed care plans and compare plans.

The request costs

- Year 1: $2,113,320 total funds, including $539,662 General Fund
- Year 2: $2,113,328 total funds, including $539,665 General Fund

The Department must conduct annual enrollee experience surveys, set appointment time standards for certain services, and use "secret shoppers" to validate compliance. The appointment time standards apply to primary care, obstetrics and gynecology, and outpatient mental health and substance use disorder services.

The Department must develop a quality rating system for managed care plans and publish the data for members to compare plans. Also, the Department must compare managed care rates with fee-for-service rates for homemaker services, home health aide services, personal care services, and habilitation services.

The FTE will oversee the quality rating system, manage the "secret shopper" contract, and monitor new activities and processes related to appointment wait time standards. The contract services will design the quality rating system and collect and validate the data and provide the "secret shoppers".

Recommendation

Staff recommends denying the request. With Colorado's low use of managed care, members are not comparing Medicaid managed care plans. The only part of the new rule that the JBC staff sees as benefiting members is the wait time standards and specifically for mental health and substance use disorder (SUD) services. The JBC staff is in favor of funding just that piece of the request, but the Department did not break it out. The rest of the rule would provide value in a state that uses a lot of managed care, but it sounds like busy work for Colorado.

The Department still needs to comply with the rule. The request says that without funding, "Managed Care Entities (MCEs) could be forced to direct funding away from member services to ensure they have the administrative resources to comply with federal requirements". The JBC staff supports an option that requires the managed care entities to absorb the compliance costs, rather than the General Fund. The JBC staff sees low value for Medicaid members in the new rule.

The request says there are new requirements for annual enrollee experience surveys. The Department already does enrollee experience surveys. The Department did not explain how the new requirements differ from the work the Department is already doing and how much they drive a workload increase.

Interoperability & Prior Authorization Requests (PARs)

Request

The Department requests 1.0 FTE beginning March 2027 (0.3 FTE in FY 2026-27) for new requirements regarding access to health records for patients, providers, and payers, especially related to prior authorization requests. In addition, the Department requests funding in FY 2027-28 for licenses and staff training.

The Department is required to develop and maintain application program interfaces (APIs) that include information about prior authorizations (except for drugs). The APIs will facilitate electronic sharing of the information with patients, providers, and other payers.

In addition to the interoperability requirements, there are new requirements related to prior authorization requests. The Department must send decisions on urgent prior authorizations within 72 hours and standard requests must be completed within seven calendar days (instead of ten business days). Denials must include specific reasons. The Department must publicly report metrics on prior authorization requests, such as approval rates, denials, and timeframes.

The FTE will process the metrics to meet the reporting requirements and ensure compliance with the rule. The Department is absorbing the system work to develop the APIs within existing resources. After development of the APIs, the Department says it will need money in FY 2027-28 for licenses and staff training.

Recommendation

Staff recommends approval of the request with application of the JBC's common policies regarding new FTE. Prior authorization requests are a hot topic at the state level as well as the federal level. The new rule will improve the Department's communications with members and providers on prior authorization requests. In addition, it will improve the data available to policy makers evaluating the Department's use of prior authorization requests and procedures.

Continuation of supplemental actions

Continuation of supplemental actions

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R6.01 Accountable care incentives	-8,204	0	-4,102	0	-4,102	0.0	EK
R6.02 Behavioral health incentives	-7,974,052	-1,891,927	-2,095,099	0	-3,987,026	0.0	EP
R6.03 Primary care stabilization	0	0	0	0	0	0.0	EK
R6.04 Continuous coverage	-13,604,507	-5,613,172	-358,439	0	-7,632,896	0.0	EK
R6.05 Immigrant family planning	0	0	0	0	0	0.0	EK
R6.06 SBIRT training grants	-500,000	-500,000	0	0	0	0.0	EP
R6.07 Immigrant services outreach	0	0	0	0	0	0.0	EK
R6.08 Tests for specific drugs	-1,175,519	-156,344	-86,283	0	-932,892	0.0	EK
R6.09 Outpatient psychotherapy prior authorization	-31,330,942	-12,241,619	-959,135	0	-18,130,188	0.0	EP
R6.10 Pediatric behavioral therapy reviews	-20,000,000	-10,000,000	0	0	-10,000,000	0.0	EP
R6.11 Provider rates -1.6%	-52,805,563	-18,715,027	-2,872,498	0	-31,218,038	0.0	EK
R6.12 Community connector -15%	-13,639,676	-6,819,838	0	0	-6,819,838	0.0	TD
R6.13 Nursing minimum wage	0	0	0	0	0	0.0	EK
R6.14 Individual residential srvcs & supports	-5,801,116	-2,284,479	-616,079	0	-2,900,558	0.0	TD
R6.15 Pediatric behavioral therapy rates	-13,057,068	-6,528,534	0	0	-6,528,534	0.0	EP
R6.16 Dental rates	-6,889,650	-1,258,050	-1,040,337	0	-4,591,263	0.0	EK
R6.17 IDD youth transitions	-15,261,376	-7,630,688	0	0	-7,630,688	1.0	TD
R6.18 IDD waitlist	-6,497,170	-3,248,585	0	0	-3,248,585	1.0	TD
R6.19 Senior dental grants	-1,500,000	-1,500,000	0	0	0	0.0	EK
R6.20 Community health workers	-5,713,346	-1,364,558	-342,750	0	-4,006,038	0.0	EK
R6.22 Provider credentialing ACC	0	0	0	0	0	0.0	EK
R6.23 Rates above 85% Medicare	-40,934,516	-11,568,094	-2,906,351	0	-26,460,071	0.0	EK
R6.24 Drug rates	-13,171,612	-3,143,566	-982,094	0	-9,045,952	0.0	EK
R6.25 Biosimilars	-7,184,522	-1,375,261	-723,606	0	-5,085,655	0.0	EK
R6.26 3rd party pay for drugs	-5,699,660	-1,717,435	-376,497	0	-3,605,728	0.0	EK
R6.27 Specialty drug rates	-2,192,854	-820,552	-105,242	0	-1,267,060	0.0	EK
R6.28 Drug dispensing fees	-1,409,088	-424,591	-93,078	0	-891,419	0.0	EK
R6.29 LTSS presumptive eligibility	-1,472,778	-780,756	0	0	-692,022	0.0	TD
R6.30 HCBS hours soft cap	-22,796,801	-11,398,400	0	0	-11,398,401	1.0	TD
R6.31 Caregiving hours soft cap	-2,125,091	-1,062,544	0	0	-1,062,547	1.0	TD
R6.32 Homemaker hours soft cap	-563,486	-281,743	0	0	-281,743	0.0	TD
R6.33 Community connector -23%	-20,745,204	-10,372,602	0	0	-10,372,602	0.0	TD
R6.34 Community connector units	-25,307,549	-12,653,774	0	0	-12,653,775	1.0	TD
R6.35 Movement therapy rates	-716,467	-358,234	0	0	-358,233	0.0	EP
R7 Eligibility administration	-2,459,590	-2,000,000	-120,895	0	-338,695	0.0	TD
R10.1 Disability determinations	106,020	34,456	18,553	0	53,011	0.0	TD
R12 Home health administration	45,155	21,769	808	0	22,578	0.7	EK

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
BA7a Prepayment claims review	-24,712,500	-12,356,250	0	0	-12,356,250	0.0	EK
BA7b Claims rules enforcement	-9,187,501	-2,872,809	-479,402	0	-5,835,290	0.0	EK
BA7c Recovery audits	0	0	0	0	0	0.0	EK
BA7d NEMT corrective action	-3,104,169	-1,020,412	-531,672	0	-1,552,085	0.0	EK
BA7e XL Wheelchair transport	-27,563,167	-8,289,887	-5,491,780	0	-13,781,500	0.0	EK
BA7g Federal match supplemental payments	0	-5,552,072	0	-35,232	5,587,304	0.0	EK
BA7j 85% of Medicare adjustments	-13,077,988	-3,695,839	-928,537	0	-8,453,612	0.0	EK
BA7n Ambulatory surgery center services	0	0	0	0	0	0.0	EK
BA7o Member surveys	-425,294	-212,647	0	0	-212,647	0.0	EK
BA7p Movement therapy rates	716,467	358,234	$0	$0	358,233	0.0	EP
BA10 DOJ housing vouchers	-14,346,170	-6,140,284	0	0	-8,205,886	6.2	TD
BA15 Public School Health Services	$7,902,943	$0	$3,951,472	$0	$3,951,471	0.0	EK
BA16 Technical adjustments	-2,309,550	-290,059	-201,792	-449,719	-1,367,980	0.0	EK
Provider stabilization gifts	0	0	0	0	0	0.0	EK
Total	-$428,493,161	-$177,726,173	-$17,344,835	-$484,951	-$232,937,202	11.9	

→ R6.01 Accountable care incentives

Request

The Department proposes continuing an FY 2025-26 reduction to incentive payments offered through the Accountable Care Collaborative (ACC). Reducing the incentive payments changed the forecast by:

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

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

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

Supplemental Action

The JBC approved the Department's request.

Recommendation

Consistent with the supplemental action, staff recommends the Department's request.

→ R6.03 Primary care stabilization

Request

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

The request delayed the start from July 1, 2025 to January 1, 2026 and changed the projected FY 2025-26 expenditures by:

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

Supplemental Action

The JBC approved never starting the new stabilization payments. This doubled the impact to -$9.2 million total funds, including -$3.0 million General Fund, and made the savings on-going

Recommendation

Consistent with the JBC's supplemental action, the JBC staff recommends never starting the new stabilization payments. The FY 2025-26 reduction to the base will continue in FY 2026-27, rather than the Department's request to add back the funding.

→ R6.04 Continuous coverage

Request

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

The federal action changes the Department's forecast by:

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

Supplemental Action

The JBC approved the Department's request.

Recommendation

Consistent with the supplemental action, staff recommends the Department's request. The incremental change from FY 2025-26 to FY 2026-27 is -$13.6 million, including -$5.6 million General Fund.

→ R6.05 Immigrant family planning

Request

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

The request changes the Department's forecast by:

- Current year: -$500,000 General Fund

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

Supplemental Action

The JBC denied the Department's request and kept the funding at $2.6 million General Fund.

Recommendation

Consistent with the supplemental action, staff recommends denying the request. The Department's February forecast shows the Department spending all of the appropriation. If the Department is going to argue that it doesn't need all the money, then the Department should provide a forecast that shows what the Department thinks it is actually going to spend.

→ R6.07 Immigrant services outreach [legislation]

Request

The Department wants to stop three grants to nonprofits that pay for outreach related to health services for undocumented children and pregnant people. Using the authority of the executive orders, the Department ended the outreach contracts effective January 1, 2026.

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

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

Supplemental Action

The JBC approved reducing the outreach funding through legislation that would remove a statutory requirement for the Department to develop and implement an outreach strategy. However, the JBC decided to introduce the

bill with the Long Bill package, rather than with the supplemental package. This timing was intended to allow the JBC to consider other proposed changes to the Cover All Coloradans program and potentially combine multiple changes in one bill.

Recommendation

Consistent with the supplemental action, staff recommends legislation to remove the funding and the statutory requirement for an outreach strategy. There will be no change in the Long Bill, but the proposed legislation will change appropriations by:

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

If the JBC decides to make any other changes to the eligibility or benefits for immigrants, such as those requested in BA7k Cover All Coloradans, then this change can be part of the same legislation.

→ R6.08 Tests for specific drugs

Request

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

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

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

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

Supplemental Action

The JBC approved the Department's request.

Recommendation

Consistent with the supplemental action, staff recommends approval of the request. The incremental change from the FY 2025-26 appropriation is -$1,175,519 total funds, including -$156,344 General Fund.

→ R6.11 Provider rates -1.6%

Request

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

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

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$52.8 million total funds, including -$18.7 million General Fund.

→ R6.13 Nursing minimum wage [legislation]

Request

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

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

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

The statewide minimum wage will exceed $15 per hour in 2026.

Supplemental Action

The JBC approved the request and sponsored the required legislation.

Recommendation

Staff recommends continuation of the supplemental reduction. There is no incremental change from FY 2025-26. The supplemental reduction is already reflected in the lower FY 2025-26 base.

→ R6.16 Dental rates

Request

The Department is reducing select dental rates that received a large targeted rate increase in FY 2024-25.

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

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

The affected codes are the most common and represent a little over half the utilization.

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$6.9 million total funds, including -$1.3 million General Fund.

→ R6.19 Senior dental

Request

The Department proposed reducing senior dental grants by approximately half beginning in the fourth quarter of FY 2025-26.

The reduction changes the request by:

- Current year: -$500,000 General Fund
- Year1: -$2,000,000 General Fund

The senior dental grants currently provide approximately $4.0 million annually to community health centers, nonprofit dental clinics, and public health agencies. The grant recipients use the money for dental care to low-income elderly people. To receive services, a client must be 60 or over, must have income under 250 percent of the federal poverty guidelines, and generally must not have other insurance. However, if the client has a

Medicare Advantage Plan that includes dental coverage, then the Department will pay the difference in coverage. Some Medicare Advantage Plans provide minimal dental coverage. The Dental Health Care Program for Low Income Seniors Annual Report indicates 25 grantees served 4,657 seniors in FY 2024-25.

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$1.5 million General Fund.

The supplemental staff recommendation was to eliminate the program. Eliminating the grant program requires legislation. Eliminating the grant program would increase the fiscal impact by -$2.0 million General Fund.

→ R6.20 Community health workers [legislation]

Request

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

The request temporarily reduces the Department's forecast by:

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

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

Supplemental Action

The JBC approved delaying the implementation until the General Assembly can come up with the money. The expectation is that the Department would submit a budget request to begin funding community health workers at some future unspecified date.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$7.7 million total funds, including -$1.8 million General Fund.

→ R6.22 Provider credentialling ACC

Request

The Department proposed stopping a centralized, statewide program for credentialing behavioral health providers for participation with all Regional Accountable Entities (RAEs).

The original request made a one-time change for avoided system costs:

- Current year: -$650,000 total funds, including -$40,950 General Fund

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

Supplemental Action

The JBC did not approve the request.

Recommendation

The staff recommendation is consistent with the request. The annualization for FY 25-26 R6 Accountable Care Collaborative includes a change of -$650,000 total funds, including -$40,950 General Fund to remove the one-time programming costs, along with other incremental changes that were associated with that request.

→ R6.23 and BA7j Rates above 85% Medicare

Request

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

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

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$54.0 million total funds, including -$15.3 million General Fund.

→ R6.24 Drug rates

Request

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

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

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

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

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$13.2 million total funds, including -$3.1 million General Fund.

→ R6.25 Biosimilars

Request

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

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

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

Like generic drugs, biosimilars have no clinically meaningful differences in safety, purity, or effectiveness. Unlike generics, biosimilars are not chemically identical to the original. The biosimilars are made from living cells and there are non-clinically meaningful variations. This is not the same as requiring the client to fail on a different type of lower cost treatment. The biosimilars are the same treatment to address the same ailment in the same way using the same type of microorganisms, just produced by a different manufacturer.

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$7.2 million total funds, including -$1.4 million General Fund.

→ R6.26 3rd Party pay for drugs

Request

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

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

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

If a Medicaid member has 3rd party insurance and that 3rd party insurer has a closed pharmacy network, such as Kaiser, then the member will no longer be able to get full coverage for prescriptions at any pharmacy that might be convenient to them, such as Walgreens or King Soopers. Instead, they will need to go to an in-network pharmacy that might be less convenient to them. The 3rd party insurer will pay as the primary insurer and then Medicaid, as the secondary insurer, will cover any additional costs that are part of the Medicaid benefit but not part of the 3rd party insurer's benefit. The client will know the price after insurance before purchasing the drugs. However, if a client is not aware of their coverage restrictions, they could show up at an out-of-network pharmacy. The Department says that the pharmacy would redirect them to a provider that accepts their coverage.

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$5.7 million total funds, including -$1.7 million General Fund.

→ R6.27 Specialty drug rates

Request

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

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

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

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

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

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

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

Supplemental Action

The JBC denied the request and did not make the reduction.

Recommendation

Staff continues to recommend reducing the rates and by a slightly larger amount than the Department requested. In the hearing responses, the Department noted that the average Medicaid reimbursement to hospitals, including the net benefit from the supplemental payments financed with the hospital provider fee, is 80 percent of cost. Why should a few hospitals get reimbursed at 97-100 percent of costs for this particular service when the average reimbursement for all other hospitals and for all other services is 80 percent of costs? For this particular service the few hospitals that benefit are currently getting a favorable deal compared to the average reimbursement for other hospital and other services.

The Department proposes reducing the rate to 92 percent of cost with no explanation of why 92 percent is the right share. The staff recommendation is to reduce the reimbursement to 80 percent of costs in line with the average reimbursement for hospital services.

The Department's hearing response indicates that from August 2018 to February 2022 the reimbursement was 72 percent of costs with no difference in access to care. Therefore, the JBC staff assumes there will be no change in access to care with a rate at 80 percent of costs, which is higher than the 72 percent of costs reimbursed as recently as 2022.

The change in total dollars is small compared to the total budget and Medicaid reimbursement for Children's Hospital.

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

The staff recommendation changes the FY 2026-27 budget by -$2.2 million total funds, including -$820,552 General Fund.

→ R6.28 Drug dispensing fees

Request

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

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

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

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

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$1.4 million total funds, including -$424,591 General Fund.

→ R12 Home health admin

Request

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

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

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

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

The Department's November forecast assumes savings from the nursing assessments. In FY 2025-26 the Department projects savings of $14.3 million total funds, including $7.1 million General Fund. In FY 2026-27, the Department projects savings of $48.1 million total funds, including $24.1 million General Fund. If the Department is unable to resolve appeals in a timely manner, some of the projected savings could be in jeopardy. For example, private duty nursing for one member for 16 hours per day for six months while an appeal is pending would cost $154,000. Through long-term home health a certified nurse assistant for 8 hours per day for six months while an appeal is pending would cost $59,000.

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

Supplemental Action

The JBC approved the term-limited position to manage appeals but not the ongoing position to improve management of the benefit.

Recommendation

Consistent with the supplemental action, staff recommends funding for the term-limited position for appeals. In addition, staff recommends correcting a technical error in the FY 2025-26 appropriation. For FY 2025-26, the JBC approved $7,384 total funds, including $3,692 General Fund, for operating expenses related to the appeals position, but this amount did not get included in the supplemental bill due to a drafting error.

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

S14 Home health admin

Item	Total Funds	General Fund	Federal Funds	FTE
FY 2025-26 approved supplemental				
Personal services	$19,975	$9,988	$9,987	0.3
Operating	7,384	3,692	3,692	0.0
Total	$27,359	$13,680	$13,679	0.3
FY 2026-27				
Personal services	$66,584	$33,292	$33,292	1.0
Operating	1,280	640	640	0.0
Total	$67,864	$33,932	$33,932	1.0

Item	Total Funds	General Fund	Federal Funds	FTE
FY 2027-28				
Personal services	$46,609	$23,305	$23,304	0.5
Operating	896	448	448	0.0
Total	$47,505	$23,753	$23,752	0.5

Evidence designation

The Department indicates that the evidence designation is Evidence-Informed. It supports the long-term home health program. Evidence-based research supports the utilization of home health services for patients requiring oxygen for chronic obstructive pulmonary disease (COPD), managing angina, implementing protocols for alarm fatigue, and understanding the influence of family members on patient presentation. Evidence-based practices also support improved outcomes for patients by focusing on interventions that can improve, maintain, or slow the decline in the functioning of individuals receiving home health care. Research suggests that receiving care from the same home care worker over time can improve client outcomes.

The JBC staff agrees with the Department's designation that the long-term home health program is evidence-informed. The medical necessity requirements are intended to ensure that provided services fit the conditions when long-term home health improves outcomes. The recommended FTE relates to appeals of the medical necessity findings and is necessary to implement the program to fidelity.

→ BA7a Prepayment claims reviews

Request

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

The request changes the forecast by:

- Current year: -$4.5 million total funds, including -$2.2 million General Fund
- Year 1: -$29.2 million total funds, including -$14.6 million General Fund
- Year 2: -$14.0 million total funds, including -$7.0 million General Fund

These reviews involve people evaluating claims, as opposed to automated reviews. The savings estimates are based on targeting prepayment claims reviews for pediatric behavioral therapy, home- and community-based services, and durable medical equipment. These services involve complex billing requirements, rapidly growing utilization, and a demonstrated vulnerability to improper payments.

Most of the projected savings are related to pediatric behavioral therapy services. The Department is waiting for the final report from a federal audit of payments for pediatric behavioral therapy by the Office of the Inspector General. The audit found potentially improper payments related to missing documentation, inadequate credentialing and oversight, and billing practices that do not meet requirements. The draft finding is that Colorado owes in the range of $60 million to the federal government for improper payments. Similar audits in other states are getting similar results for these services. Indiana is conducting post-payment claims reviews for pediatric behavioral therapy services and finding error rates of 90-95 percent.

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$24.7 million total funds, including -$12.4 million General Fund.

The claims reviews will stop improper payments, but not all improper payments are illegitimate. Some of the payments stopped will be legitimate claims where the provider made a technical error or omission. Correcting these errors and omissions increases the administrative burden on the provider and the time from when services are rendered to when they get paid. The Department anticipates a spike in savings in FY 2026-27, but the ongoing savings will be lower as providers adapt and improve submissions for proper claims. The Department expects the ongoing savings will stabilize at $14.0 million total funds, including $7.0 million General Fund, beginning in FY 2027-28. The JBC staff is persuaded by the Department's arguments that these controls are worthwhile, but this is not a pain-free reduction. Providers will need to do more work to get paid for legitimate claims.

BA7a Prepayment claims reviews

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

→ BA7b Claims rules enforcement

Request

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

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

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

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

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

The specific proposed claims rules and the projected savings are based on annual optimization studies by the Department's vendors and analysis of current claims that don't meet the criteria. Similar to the request for *S7a Claims reviews*, the Department assumes that the savings will spike in the first year. As providers learn, correct their billing errors, and resubmit proper claims, the Department expects that the ongoing savings will stabilize at a lower rate.

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$9.2 million total funds, including -$2.9 million General Fund.

BA7b Claims rules enforcement

Item	Total Funds	General Fund	Cash Funds	Federal Funds
FY 2025-26				
System costs	$187,501	$14,213	$7,819	$165,469
Avoided payments	-3,250,000	-971,814	-167,617	-2,110,569
Total	-$3,062,499	-$957,601	-$159,798	-$1,945,100
FY 2026-27				

Item	Total Funds	General Fund	Cash Funds	Federal Funds
System costs	$750,000	$56,850	$31,275	$661,875
Avoided payments	-13,000,000	-3,887,260	-670,475	-8,442,265
Total	-$12,250,000	-$3,830,410	-$639,200	-$7,780,390
FY 2027-28				
System costs	$750,000	$56,850	$31,275	$661,875
Avoided payments	-6,500,000	-1,943,629	-335,237	-4,221,134
Total	-$5,750,000	-$1,886,779	-$303,962	-$3,559,259

→ BA7c Recovery audits

Request

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

The request changes the Department's forecast by:

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

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

Supplemental Action

The JBC approved the staff recommendation to account for the savings as part of the February forecast. The Department included the savings in the February forecast.

There is no discretionary decision for the General Assembly to make. When the Department sees areas that need auditing, it just conducts the audits. The Department has both state and federal obligations to ensure proper payments. There is no General Fund cost that the General Assembly needs to approve when the Department uses RAC services, because the contractor is paid a contingency fee from a share of the recoveries. Historically, the Department has not asked for a budget action to authorize audits.

Recommendation

Consistent with the supplemental action, staff recommends no change. The adjustment was already included in the February forecast.

→ BA7d NEMT corrective action plan

Request

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

The request changes the Department's forecast by:

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

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

Key provisions of the settlement agreement with MedRide include:

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$3.1 million total funds, including -$1.0 million General Fund.

S7d NEMT corrective action plan

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

[1] Breast and Cervical Cancer Prevention and Treatment Fund

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

→ BA7e XL wheelchair transport

Request

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

The request changes the Department's forecasted expenditures by:

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is -$27.6 million total funds, including -$8.3 million General Fund.

S7e XL Wheelchair transport

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

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

→ BA7g Federal match supplemental payments

Request

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

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

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

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

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

The Department can go back two years and retroactively claim the enhanced federal match for these supplemental payments. The request assumes the additional federal funds from retroactive claims will arrive in

FY 2026-27, resulting in an additional one-time General Fund savings in that fiscal year. The projected General Fund savings varies slightly by fiscal year based on the projected caseload mix and the proportion of total clients served that qualify for the enhanced federal match. The small change in reappropriated funds is related to money transferred from the University of Colorado's School of Medicine for the Commission on Family Medicine.

Supplemental Action

The JBC approved the request.

Recommendation

Staff recommends a slight modification to the expected timeline for when the Department will receive the retroactive federal funds. Since the original request, the Department refined the estimate of the timeline. The total General Fund savings over both fiscal years remains roughly the same.

Revised - BA7g Federal match supplemental payments

Item	Total Funds	General Fund	Reapprop. Funds	Federal Funds
FY 2025-26				
Pediatric Specialty Hospital	0	-1,862,171	0	1,862,171
Colorado Commission on Family Medicine	0	-1,420,735	-35,232	1,455,967
Total	$0	-$3,282,906	-$35,232	$3,318,138
FY 2026-27				
Pediatric Specialty Hospital	0	-5,222,224	0	5,222,224
Colorado Commission on Family Medicine	0	-3,612,754	-70,464	3,683,218
Total	$0	-$8,834,978	-$70,464	$8,905,442
FY 2027-28				
Pediatric Specialty Hospital	0	-2,107,054	0	2,107,054
Colorado Commission on Family Medicine	0	-1,415,575	-70,464	1,486,039
Total	$0	-$3,522,629	-$70,464	$3,593,093

→ BA7n Ambulatory surgery center services

Request

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

The expansion changed the Department's forecasted expenditures by:

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

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

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

Supplemental Action

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

Recommendation

Consistent with the supplemental action, staff recommends assuming no savings.

→ BA7o Member surveys

Request

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

The request reduces the Department's expected expenditures by:

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

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

The Money Follows the Person demonstration grant provides time-limited federal funds to help move people from nursing homes to community settings. There are no matching state funds and the federal funds do not

appear in the Long Bill. The Department expects federal approval to use a portion of the grant funds for the survey costs in FY 2026-27.

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

Supplemental Action

The JBC approved the request based on the Department's plan through FY 2027-28. However, the expectation is that the Department will submit a new request if it wants the increased field interviewers in FY 2028-29. The reduction in FY 2025-26 is because the appropriation overestimated the actual cost. The reduction in FY 2026-27 is due to a combination of the federal Money Follows the Person grant paying for a portion of the survey costs and the Department using state FTE instead of contract services. Most of the savings in FY 2026-27 are one-time and the Department will need General Fund in FY 2027-28, but the Department expects modest on-going savings in FY 2027-28 from the conversion of contract services to state FTE.

Recommendation

Consistent with the supplemental action, staff recommends the request through FY 2027-28. The incremental change from FY 2025-26 to FY 2026-27 is -$425,294 total funds, including -$212,647 General Fund.

BA7o Member services

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

→ BA15 Public school health services

Request

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

The request changes the Department's forecast by:

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

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

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

Supplemental Action

The JBC approved the request.

Recommendation

Consistent with the supplemental action, staff recommends the request. The incremental change from FY 2025-26 to FY 2026-27 is $7.9 million total funds, including $4.0 million cash funds from certified public expenditures.

→ BA16 Technical adjustments

Request

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

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

In addition, the Department proposed renaming a division and line item.

Supplemental Action

The JBC approved the request with modifications to the reappropriated funds for CBMS by agency. The JBC did not address the request to rename the division and line item.

Recommendation

1. Consistent with the supplemental action, staff recommends the request with the modifications to the reappropriated funds for CBMS by agency. The incremental change from FY 2025-26 to FY 2026-27 is -$2.2 million total funds, including -$290,059 General Fund.
2. In addition, staff recommends fixing a drafting error. The JBC approved the rollforward authority for one-time funds for CBMS to expand integrated character recognition (ICR), Interactive Voice Recognition (IVR) for members, and a policy bot. The Department had to delay the work due to urgent changes needed to comply with H.R. 1. The supplemental bill did not include the approved rollforward authority, so staff recommends fixing that in the Long Bill add-on.
3. Finally, the JBC staff recommends the requested rename of the line item, but not the rename of the division. The JBC has not yet addressed the Department's renaming request.

Rename the Indigent Care Program division to Safety Net Provider Support

The Indigent Care Program division got its name from the Colorado Indigent Care Program that provided discounted care on a sliding scale to people with income to 250 percent of the federal poverty guidelines who are not eligible for Medicaid or CHP+. The Colorado Indigent Care Program has been absorbed into the hospital supplemental payments financed with the Hospital Provider Fee.

Staff does not recommend changing the division name. Although the Colorado Indigent Care Program has been absorbed, the name "Indigent Care Program" still describes the purpose of the funding in the division. The name is broad and vague, but not any more so than the proposed alternative "Safety Net Provider Support". The JBC staff is open to a better name, but "Safety Net Provider Support" is not an improvement.

The JBC staff has lots of ideas for improving the layout of the Long Bill for the Department, but these changes are a low priority. There is not much value in focusing on net zero movements of appropriations or renaming divisions when the General Assembly is debating eligibility and benefit changes.

Rename the Safety Net Provider Payments line to Disproportionate Share Hospital Payments

Staff recommends this name change. The new name references a specific federal program. The money in the line item only goes to hospitals and does not benefit any other types of safety net providers. The new name makes it clear why the money is not comingled with other hospital supplemental payments.

→ Provider Stabilization gifts

Request

This was a staff-initiated supplemental. The Department did not submit a formal request.

Supplemental Action

The JBC approved the staff recommendation to provide an additional $20.0 million spending authority from the Provider Stabilization Fund in FY 2025-26 and then again in FY 2026-27.

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

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

Recommendation

Consistent with the supplemental action, staff recommends $20.0 million spending authority from the Provider Stabilization Fund in FY 2026-27 for the gifts, grants, and donations. There is no incremental change from FY 2025-26.

(1) Executive Director's Office

The Executive Director's Office division contains the administrative funding for the Department. Specifically, this funding supports the Department's personnel and operating expenses. In addition, this division contains contract funding for provider audits, eligibility determinations, client and provider services, utilization and quality reviews, and information technology contracts. The sources of cash funds and reappropriated funds reflect the Department's financing as a whole and the programs supported by the FTE in the division. The largest source of cash funds for the division is the Healthcare Affordability and Sustainability Fee.

Executive Director's Office

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$654,880,029	$147,828,444	$82,483,432	$36,167,056	$388,401,097	808.3
Long Bill Supplemental	-$3,204,868	-$1,040,291	-$562,144	$0	-$1,602,433	0.0
Total FY 2025-26	$651,675,161	$146,788,153	$81,921,288	$36,167,056	$386,798,664	808.3
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$651,675,161	$146,788,153	$81,921,288	$36,167,056	$386,798,664	808.3
Employee compensation common policies	9,791,585	2,966,778	1,529,542	0	5,295,265	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0
Impacts driven by other agencies	729,473	239,645	125,091	0	364,737	1.8
Prior year actions	-23,363,780	-3,709,331	-1,542,614	-1,652,006	-16,459,829	-2.6
Eligibility & benefit changes	100,000	31,953	17,147	0	50,900	0.0
Provider rates	2,952,823	294,329	160,503	0	2,497,991	1.0
Administration	51,806,639	4,522,550	7,148,169	0	40,135,920	22.6
Continuation of supplemental actions	1,427,301	794,335	-393,350	-449,719	1,476,035	11.9
Total FY 2026-27	$699,396,500	$153,209,241	$89,439,198	$34,051,904	$422,696,157	843.0
Changes from FY 2025-26	$47,721,339	$6,421,088	$7,517,910	-$2,115,152	$35,897,493	34.7
Percentage Change	7.3%	4.4%	9.2%	-5.8%	9.3%	4.3%
FY 2026-27 Executive Request	$739,429,028	$166,449,461	$87,653,543	$42,198,741	$443,127,283	895.2
Staff Rec. Above/-Below Request	-$40,032,528	-$13,240,220	$1,785,655	-$8,146,837	-$20,431,126	-52.2

(2) Medical Services Premiums

This division provides funding for physical health and most long-term services and supports for individuals qualifying for the Medicaid program. Behavioral health services are financed in the next division. Long-term services and supports for people with intellectual and developmental disabilities are financed in the Office of Community Living. The Department contracts with health care providers through fee-for-service and managed care arrangements in order to provide these services to eligible clients. There is only one line item in the division, and so the division summary table and line item summary table are the same. Significant sources of cash funds include provider fees from hospitals and nursing facilities, tobacco tax revenues deposited in the Health Care Expansion Fund, recoveries and recoupments, Unclaimed Property Tax revenues deposited in the Adult Dental Fund, and funds certified at public hospitals as the state match for federal funds. The reappropriated funds are transferred from the Old Age Pension State Medical Program. Federal funds represent the federal funds available for the Medicaid program.

Medical Services Premiums

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$14,011,410,978	$3,969,292,427	$1,649,992,298	$124,197,922	$8,267,928,331	0.0
Long Bill Supplemental	$186,958,258	$48,459,443	$28,390,538	$0	$110,108,277	0.0
Total FY 2025-26	$14,198,369,236	$4,017,751,870	$1,678,382,836	$124,197,922	$8,378,036,608	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$14,198,369,236	$4,017,751,870	$1,678,382,836	$124,197,922	$8,378,036,608	0.0
Medical forecast	1,491,009,550	350,954,466	236,462,836	0	903,592,248	0.0
Impacts driven by other agencies	0	0	0	0	0	0.0
Prior year actions	50,569,317	10,623,623	2,304,645	0	37,641,049	0.0
Eligibility & benefit changes	-6,197,360	128,456	-1,858,255	0	-4,467,561	0.0
Provider rates	-157,803,086	-51,648,233	-14,072,441	0	-92,082,412	0.0
Administration	-3,476,470	-2,538,235	800,000	0	-1,738,235	0.0
Continuation of supplemental actions	-331,394,840	-122,468,482	-17,373,796	0	-191,552,562	0.0
Total FY 2026-27	$15,241,076,347	$4,202,803,465	$1,884,645,825	$124,197,922	$9,029,429,135	0.0
Changes from FY 2025-26	$1,042,707,111	$185,051,595	$206,262,989	$0	$651,392,527	0.0
Percentage Change	7.3%	4.6%	12.3%	0.0%	7.8%	0.0%
FY 2026-27 Executive Request	$16,383,597,851	$4,746,628,189	$1,915,269,183	$130,791,126	$9,590,909,353	0.0
Staff Rec. Above/-Below Request	-$1,142,521,504	-$543,824,724	-$30,623,358	-$6,593,204	-$561,480,218	0.0

(5) Indigent Care Program

The division contains funding for the safety net provider payments, pediatric specialty hospital payments, the Primary Care Fund Program, the Children's Basic Health Plan, and other safety net provider payments. These programs and payments are designed to serve Colorado's underinsured, uninsured, or otherwise medically indigent populations. The sources of cash funds are the Hospital Provider Fee, tobacco tax money, tobacco settlement money, enrollment fees for the Children's Basic Health Plan, and recoveries and recoupments. The tobacco tax money primarily goes through the Primary Care Fund to provide primary care grants. The tobacco settlement money primarily goes through the Children's Basic Health Plan Trust.

Indigent Care Program

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
FY 2025-26 Appropriation					
FY 2025-26 Appropriation	$573,821,159	$57,357,643	$182,944,471	$333,519,045	0.0
Long Bill Supplemental	-$24,109,691	-$7,544,132	-$609,349	-$15,956,210	0.0
Total FY 2025-26	$549,711,468	$49,813,511	$182,335,122	$317,562,835	0.0
FY 2026-27 Recommended Appropriation					
FY 2025-26 Appropriation	$549,711,468	$49,813,511	$182,335,122	$317,562,835	0.0
Medical forecast	46,983,793	9,427,330	7,016,998	30,539,465	0.0
Prior year actions	1,247,368	272,270	164,309	810,789	0.0
Administration	0	-2,322,699	2,322,699	0	0.0
Continuation of supplemental actions	-1,471,135	-3,668,991	-205,959	2,403,815	0.0
Total FY 2026-27	$596,471,494	$53,521,421	$191,633,169	$351,316,904	0.0
Changes from FY 2025-26	$46,760,026	$3,707,910	$9,298,047	$33,754,069	0.0
Percentage Change	8.5%	7.4%	5.1%	10.6%	0.0%
FY 2026-27 Executive Request	$617,582,774	$61,495,159	$191,333,290	$364,754,325	0.0
Staff Rec. Above/-Below Request	-$21,111,280	-$7,973,738	$299,879	-$13,437,421	0.0

(6) Other Medical Services

This division contains the funding for miscellaneous other expenditures, such as:

- the state's obligation under the Medicare Modernization Act for prescription drug benefits for people dually eligible for Medicare and Medicaid;
- certified public expenditure financing for public school health services; and
- funding for health training programs.

The division also includes funding for health programs that are not Medicaid or CHP+, such as:

- health benefits for children lacking access due to immigration status;
- the Old Age Pension State-Only Medical Program;
- senior dental program
- reproductive health for individuals not eligible for Medicaid; and
- various grant programs.

The sources of cash funds include certified public expenditures by school districts, the Old Age Pension Health and Medical Fund, and the Marijuana Tax Cash Fund. The source of reappropriated funds is a transfer from the Department of Higher Education for the Commission on Family Medicine.

Other Medical Services

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$585,906,577	$335,125,754	$149,599,071	$196,737	$100,985,015	0.0
Long Bill Supplemental	-$10,626,177	-$10,560,873	$0	-$6,969	-$58,335	0.0
Total FY 2025-26	$575,280,400	$324,564,881	$149,599,071	$189,768	$100,926,680	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$575,280,400	$324,564,881	$149,599,071	$189,768	$100,926,680	0.0
Medical forecast	30,490,045	30,490,045	0	0	0	0.0
Prior year actions	-2,557,860	2,428,800	-4,986,660	0	0	0.0
Administration	0	0	0	0	0	0.0
Continuation of supplemental actions	5,902,943	-3,692,019	3,451,472	-35,232	6,178,722	0.0
Total FY 2026-27	$609,115,528	$353,791,707	$148,063,883	$154,536	$107,105,402	0.0
Changes from FY 2025-26	$33,835,128	$29,226,826	-$1,535,188	-$35,232	$6,178,722	0.0
Percentage Change	5.9%	9.0%	-1.0%	-18.6%	6.1%	0.0%
FY 2026-27 Executive Request	$630,525,007	$394,717,320	$128,563,883	$196,737	$107,047,067	0.0
Staff Rec. Above/-Below Request	-$21,409,479	-$40,925,613	$19,500,000	-$42,201	$58,335	0.0

(7) Transfers to Other State Department Medicaid-Funded Programs

This section contains funding for programs administered by other departments that are funded with Medicaid dollars. General Fund is appropriated in this section, matched with anticipated federal funds, and then transferred to the other departments, where the Medicaid funds are reflected as reappropriated funds. The majority of the money goes to the Department of Human Services.

Transfers to Other State Department Medicaid-Funded Programs

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
Total FY 2025-26	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
FY 2026-27 Recommended Appropriation						
FY 2025-26 Appropriation	$175,053,052	$86,176,582	$2,395,303	$14,652	$86,466,515	0.0
Impacts driven by other agencies	1,910,580	987,290	-32,000	0	955,290	0.0
Prior year actions	3,917,550	2,000,000	-41,225	0	1,958,775	0.0
Total FY 2026-27	$180,881,182	$89,163,872	$2,322,078	$14,652	$89,380,580	0.0
Changes from FY 2025-26	$5,828,130	$2,987,290	-$73,225	$0	$2,914,065	0.0
Percentage Change	3.3%	3.5%	-3.1%	0.0%	3.4%	0.0%
FY 2026-27 Executive Request	$177,967,664	$87,707,113	$2,322,078	$14,652	$87,923,821	0.0
Staff Rec. Above/-Below Request	$2,913,518	$1,456,759	$0	$0	$1,456,759	0.0

Long Bill Footnotes and Requests for Information

Long Bill Footnotes

Staff recommends **CONTINUING** the following footnote:

18 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses; Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- In addition to the transfer authority provided in Section 24-75-108, C.R.S., the Department may transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote. The Department is also authorized to transfer up to 5.0 percent of the total appropriations within the line items designated with this footnote to line item appropriations within the Department of Human Services, Office of Information Technology Services, Colorado Benefits Management System subsection.

Comment: This footnote provides transfer authority for a limited portion of the appropriations for the Colorado Benefits Management System to address mismatches between where costs actually occur and the assumptions used for the appropriation.

19 Department of Health Care Policy and Financing, Executive Director's Office, Information Technology Contracts and Projects, Colorado Benefits Management Systems, Operating and Contract Expenses; Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center -- Of this appropriation, $2,500,000 remains available for expenditure until the close of the 2025-26 state fiscal year.

Comment: This footnote provides roll-forward authority for a limited portion of the appropriations for the Colorado Benefits Management System.

23 Department of Health Care Policy and Financing, Other Medical Services, Screening, Brief Intervention, and Referral to Treatment Training Grant Program -- It is the General Assembly's intent that this appropriation be used to sustain the grant program for screening, brief intervention, and referral to treatment for individuals at risk of substance abuse that is authorized in Section 25.5-5-208, C.R.S., in accordance with the requirements set forth in that section.

Comment: This footnote describes the purpose of the appropriation.

24 Department of Health Care Policy and Financing, Transfers to Other State Department Medicaid-Funded Programs, Human Services, Executive Director's Office -- The appropriation in this Health Care Policy and Financing line item corresponds to the Medicaid funding in the Department of Human Services, Executive Director's Office, General Administration. As such, the appropriation contains amounts that correspond to centralized appropriation amounts in the Department of Human Services. Consistent with section 24-75-105, C.R.S., the Department of Human Services may transfer the centralized appropriations to other line item appropriations in the Department of Human Services. In order to aid budget reconciliation between the Department of Health Care Policy and Financing and the Department of Human Services, the Department of Health Care Policy and Financing may make line item transfers

out of this appropriation to other Department of Human Services Medicaid-funded programs appropriations in this section (7) in amounts equal to the centralized appropriation transfers made by the Department of Human Services for Medicaid-funded programs in the Department of Human Services.

Comment: This footnote provides flexibility for the Department to move money between line items in Human Services and in Health Care Policy and Financing.

25 Department of Health Care Policy and Financing, Totals; Department of Higher Education, College Opportunity Fund Program, Fee-for-service Contracts with State Institutions, Fee-for-service Contracts with State Institutions for Specialty Education Programs; Governing Boards, Regents of the University of Colorado -- The Department of Higher Education shall transfer $900,000 to the Department of Health Care Policy and Financing for administrative costs and family medicine residency placements associated with care provided by the faculty of the health sciences center campus at the University of Colorado that are eligible for payment pursuant to Section 25.5-4-401, C.R.S. If the federal Centers for Medicare and Medicaid services continues to allow the Department of Health Care Policy and Financing to make supplemental payments to the University of Colorado School of Medicine, the Department of Higher Education shall transfer the amount approved, up to $112,280,907, to the Department of Health Care Policy and Financing pursuant to Section 23-18-304(1)(c), C.R.S. If permission is discontinued, or is granted for a lesser amount, the Department of Higher Education shall transfer any portion of the $112,280,907 that is not transferred to the Department of Health Care Policy and Financing to the Regents of the University of Colorado.

Comment: This footnote explains the General Assembly's assumptions about supplemental payments to the University of Colorado School of Medicine. Staff requests permission to update the numbers based on the JBC's decisions during figure setting for the Department of Higher Education.

Requests For Information

Staff recommends the following **NEW** request for information:

N Department of Health Care Policy and Financing, Executive Director's Office – The Joint Budget Committee requests that the Department submit a report by November 1, 2026, on medical education. The report should summarize all the ways the Department supports medical education and trends in the medical education expenditures. The report should include recommendations on how to target the limited resources more efficiently and equitably to the areas of greatest need. The report should include analysis of promising models from other states and ideas for alternate fund sources to support medical education.

Comment: See the recommendation on *BA7i Hospital medical education*.

Staff recommends continuing and **CONTINUING AND MODIFYING** the following request for information:

1 Department of Health Care Policy and Financing, Executive Director's Office – The Department is requested to submit monthly Medicaid expenditure and caseload reports on the Medical Services Premiums, behavioral health capitation, and the intellectual and developmental disabilities line items to the Joint Budget Committee, by the fifteenth or first business day following the fifteenth of each month.

The Department is requested to include in the report the managed care organization caseload by aid category. The Department is also requested to provide caseload and expenditure data for the Children's Basic Health Plan, the Medicare Modernization Act State Contribution Payment, and the Old Age Pension State Medical Program within the monthly report. The Department is also requested to include in the report the number of applications and the number of approvals for new intermediate care facilities for individuals with intellectual disabilities, including the number of beds and the cost of those beds.

Comment: The request provides useful information for tracking the expenditures and caseload by month.

3 Department of Health Care Policy and Financing, Medical Services Premiums – The Joint Budget Committee requests that the Department submit reports by November 1, 2025, and November 1, 2026, describing how the funding for prepayment claims reviews is getting used, including the services prioritized for prepayment claims reviews and why, and the savings achieved.

Comment: The Department submitted the FY 2024-25 High-Risk Provider & Services Prepayment Review Report as requested. The next report is due November 1, 2026.

4 Department of Health Care Policy and Financing, Other Medical Services, Public School Health Services – The Department is requested to submit a report by November 1 of each year to the Joint Budget Committee on the services that receive reimbursement from the federal government under the S.B. 97-101 public school health services program. The report is requested to include information on the type of services, how those services meet the definition of medical necessity, and the total amount of federal dollars that were distributed to each school under the program. The report should also include information on how many children were served by the program.

Comment: The report provides useful information that answers recurring questions from legislators.

Indirect Cost Assessments

There is no departmental indirect cost plan. All administrative costs are allocated by fund source directly. The Department does collect statewide indirects and the revenue offsets General Fund in the Executive Director's Office, General Administration, Personal Services.

Appendix A: Numbers Pages

Appendix A details the actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, the requested appropriation for next fiscal year, and the staff recommendation. Appendix A organizes this information by line item and fund source.

Appendix A: Numbers Pages

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
DEPARTMENT OF HEALTH CARE POLICY AND FINANCING **Kim Bimestefer, Executive Director**						
(1) EXECUTIVE DIRECTOR'S OFFICE						
Primary functions: Provides all of the administrative, audit and oversight functions for the Department.						
(A) General Administration						
Personal Services	80,135,753	112,250,662	76,887,573	86,877,488	82,188,814	*
FTE	805.2	840.7	805.3	892.2	840.0	
General Fund	28,314,157	40,937,179	29,499,324	33,986,114	31,468,255	
Cash Funds	7,604,505	9,317,990	6,461,326	6,792,701	6,859,734	
Reappropriated Funds	2,070,808	3,270,441	3,155,881	3,211,037	3,211,037	
Federal Funds	42,146,283	58,725,052	37,771,042	42,887,636	40,649,788	
Health, Life, and Dental	10,639,237	12,911,669	13,063,358	18,795,810	18,658,556	*
General Fund	4,148,063	5,465,466	5,500,214	7,257,282	7,155,285	
Cash Funds	849,729	854,712	745,138	1,578,417	1,619,486	
Reappropriated Funds	221,797	59,708	0	0	0	
Federal Funds	5,419,648	6,531,783	6,818,006	9,960,111	9,883,785	
Short-term Disability	100,903	65,134	51,631	68,185	66,611	*
General Fund	38,739	52,016	23,801	26,673	25,961	
Cash Funds	8,239	8,218	460	5,466	5,443	
Reappropriated Funds	1,911	568	0	0	0	
Federal Funds	52,014	4,332	27,370	36,046	35,207	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Paid Family and Medical Leave Insurance	0	363,855	378,612	435,548	428,550 *
General Fund	0	156,036	152,639	170,267	166,752
Cash Funds	0	21,973	27,311	35,143	35,308
Reappropriated Funds	0	1,705	0	0	0
Federal Funds	0	184,141	198,662	230,138	226,490
S.B. 04-257 Amortization Equalization Disbursement	3,356,675	0	0	0	0
General Fund	1,293,879	0	0	0	0
Cash Funds	269,385	0	0	0	0
Reappropriated Funds	62,817	0	0	0	0
Federal Funds	1,730,594	0	0	0	0
S.B. 06-235 Supplemental Amortization Equalization Disbursement	3,356,675	0	0	0	0
General Fund	1,293,878	0	0	0	0
Cash Funds	269,386	0	0	0	0
Reappropriated Funds	62,817	0	0	0	0
Federal Funds	1,730,594	0	0	0	0
Unfunded Liability Amortization Equalization Disbursement Payments	0	8,616,195	7,939,888	9,678,995	9,523,443 *
General Fund	0	3,467,483	3,391,947	3,776,790	3,698,662
Cash Funds	0	753,289	370,079	787,945	791,616
Reappropriated Funds	0	37,888	0	0	0
Federal Funds	0	4,357,535	4,177,862	5,114,260	5,033,165

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Salary Survey	3,665,128	2,734,825	2,299,634	3,153,644	3,153,644
General Fund	1,410,514	1,174,883	931,069	1,229,899	1,229,899
Cash Funds	269,531	162,995	166,773	260,274	260,274
Reappropriated Funds	53,934	12,853	0	0	0
Federal Funds	1,931,149	1,384,094	1,201,792	1,663,471	1,663,471
Step Pay	0	834,248	151,359	71,157	71,157
General Fund	0	358,393	58,370	26,074	26,074
Cash Funds	0	49,721	10,885	8,287	8,287
Reappropriated Funds	0	3,921	0	0	0
Federal Funds	0	422,213	82,104	36,796	36,796
PERA Direct Distribution	187,622	1,448,480	1,638,429	1,662,395	1,662,395
General Fund	77,283	622,267	663,317	651,784	651,784
Cash Funds	13,659	86,329	118,817	133,743	133,743
Reappropriated Funds	2,869	6,808	0	0	0
Federal Funds	93,811	733,076	856,295	876,868	876,868
Temporary Employees Related to Authorized Leave	5,978	5,978	0	0	0
General Fund	2,414	2,414	0	0	0
Cash Funds	400	400	0	0	0
Reappropriated Funds	112	112	0	0	0
Federal Funds	3,052	3,052	0	0	0
Worker's Compensation	184,274	254,896	230,107	366,471	366,471
General Fund	68,015	92,516	93,242	141,027	141,027
Cash Funds	16,898	27,708	18,755	42,542	42,542
Reappropriated Funds	7,224	7,224	6,781	0	0
Federal Funds	92,137	127,448	111,329	182,902	182,902

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Operating Expenses	3,167,767	3,023,583	3,472,945	4,706,103	4,212,850	*
General Fund	1,429,780	1,331,689	1,351,857	1,947,437	1,378,090	
Cash Funds	341,279	304,097	309,346	430,773	710,963	
Reappropriated Funds	13,921	61,415	50,071	30,852	30,852	
Federal Funds	1,382,787	1,326,382	1,761,671	2,297,041	2,092,945	
Legal Services	1,814,684	2,825,964	2,824,915	4,774,269	4,774,269	
General Fund	663,061	1,014,264	879,508	1,567,650	1,567,650	
Cash Funds	197,130	327,629	532,950	819,485	819,485	
Reappropriated Funds	47,151	71,089	0	0	0	
Federal Funds	907,342	1,412,982	1,412,457	2,387,134	2,387,134	
Administrative Law Judge Services	544,650	822,526	2,636,344	2,175,042	2,638,969	*
General Fund	198,961	300,504	883,077	766,899	917,675	
Cash Funds	59,203	89,409	345,254	230,781	311,968	
Reappropriated Funds	14,161	21,350	0	0	0	
Federal Funds	272,325	411,263	1,408,013	1,177,362	1,409,326	
Payment to Risk Management and Property Funds	567,472	249,606	280,008	146,590	146,590	
General Fund	233,022	87,782	91,378	48,911	48,911	
Cash Funds	40,825	27,132	18,381	24,920	24,920	
Reappropriated Funds	9,889	9,889	6,646	0	0	
Federal Funds	283,736	124,803	163,603	72,759	72,759	
Leased Space	2,677,250	1,715,440	3,712,918	3,950,540	3,860,631	*
General Fund	1,138,701	533,761	1,482,562	1,584,957	1,539,235	
Cash Funds	190,024	285,110	325,099	332,997	336,172	
Reappropriated Funds	9,900	38,849	38,849	38,849	38,849	
Federal Funds	1,338,625	857,720	1,866,408	1,993,737	1,946,375	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Payments to OIT	9,133,004	7,945,372	15,566,219	19,181,736	16,584,814	*
General Fund	3,239,622	2,496,498	6,778,666	7,625,221	7,138,981	
Cash Funds	1,190,936	1,444,834	1,202,939	1,613,888	1,351,511	
Reappropriated Funds	29,027	30,266	512,320	512,320	512,320	
Federal Funds	4,673,419	3,973,774	7,072,294	9,430,307	7,582,002	
IT Accessibility	17,682	0	0	0	20,000	*
General Fund	8,841	0	0	0	10,000	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	8,841	0	0	0	10,000	
CORE Operations	134,190	35,330	35,879	168,970	168,970	
General Fund	49,530	8,631	14,538	58,544	58,544	
Cash Funds	14,586	3,773	2,924	25,464	25,464	
Reappropriated Funds	5,261	5,261	1,058	1,058	1,058	
Federal Funds	64,813	17,665	17,359	83,904	83,904	
CORE Payroll	0	0	0	27,459	27,459	*
General Fund	0	0	0	9,061	9,061	
Cash Funds	0	0	0	4,669	4,669	
Federal Funds	0	0	0	13,729	13,729	
General Professional Services and Special Projects	46,946,295	38,155,777	48,024,810	59,177,115	57,331,510	*
General Fund	6,874,711	8,714,623	17,578,194	21,821,451	19,525,600	
Cash Funds	7,833,874	2,606,625	3,755,282	4,673,767	5,939,060	
Reappropriated Funds	15,000	81,000	81,000	81,000	81,000	
Federal Funds	32,222,710	26,753,529	26,610,334	32,600,897	31,785,850	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Merit Pay	0	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
ARPA Appropriations	14,188,392	0	0	0	0
General Fund	0	0	0	0	0
Cash Funds	14,188,392	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
SUBTOTAL - (A) General Administration	180,823,631	194,259,540	179,194,629	215,417,517	205,885,703
FTE	805.2	840.7	805.3	892.2	840
General Fund	50,483,171	66,816,405	69,373,703	82,696,041	76,757,446
Cash Funds	33,357,981	16,371,944	14,411,719	17,801,262	19,280,645
Reappropriated Funds	2,628,599	3,720,347	3,852,606	3,875,116	3,875,116
Federal Funds	94,353,880	107,350,844	91,556,601	111,045,098	105,972,496
(B) Transfers to Other Departments					
Public School Health Services Administration, Education	193,940	0	0	0	
General Fund	96,970	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	96,970	0	0	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Early Intervention, Early Childhood	4,299,441	0	0	0	
General Fund	2,102,358	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,197,083	0	0	0	
Nurse Home Visitor Program, Early Childhood	221,455	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	98,964	0	0	0	
Federal Funds	122,491	0	0	0	
Host Home Regulation, Local Affairs	122,100	0	0	0	
General Fund	61,050	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	61,050	0	0	0	
Home Modifications Benefit Administration and Housing Assistance Payments, Local Affairs	187,466	0	0	0	
General Fund	93,733	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	93,733	0	0	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Facility Survey and Certification, Public Health and Environment	7,653,916	0	0	0	
General Fund	2,895,627	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	4,758,289	0	0	0	
Prenatal Statistical Information, Public Health and Environment	5,888	0	0	0	
General Fund	2,944	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	2,944	0	0	0	
Nurse Aide Certification, Regulatory Agencies	324,042	0	0	0	
General Fund	147,370	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	14,651	0	0	0	
Federal Funds	162,021	0	0	0	
Reviews, Regulatory Agencies	0	0	0	0	
General Fund	0	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	0	0	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
SUBTOTAL - (B) Transfers to Other Departments	13,008,248	0	0	0		
FTE	0.0	0.0	0.0	0.0		
General Fund	5,400,052	0	0	0		
Cash Funds	0	0	0	0		
Reappropriated Funds	113,615	0	0	0		
Federal Funds	7,494,581	0	0	0		
(C) Information Technology Contracts and Projects						
Medicaid Management Information System Maintenance and Projects	79,066,420	80,852,539	108,417,161	127,510,082	125,510,082	*
General Fund	8,677,661	4,356,286	14,972,432	17,239,086	16,739,086	
Cash Funds	4,774,968	3,971,114	10,679,408	9,904,623	9,904,623	
Reappropriated Funds	0	0	12,204	12,204	12,204	
Federal Funds	65,613,791	72,525,139	82,753,117	100,354,169	98,854,169	
Colorado Benefits Management Systems, Operating and Contract Expenses	61,220,523	85,260,978	106,142,146	106,787,607	97,075,104	*
General Fund	11,157,074	11,159,695	12,909,380	13,798,040	12,881,973	
Cash Funds	6,542,630	5,534,149	8,407,287	7,145,533	7,344,299	
Reappropriated Funds	6,398,330	29,242,847	32,110,715	35,664,443	29,973,053	
Federal Funds	37,122,489	39,324,287	52,714,764	50,179,591	46,875,779	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Colorado Benefits Management Systems, Health Care and Economic Security Staff Development Center	1,827,327	1,985,108	2,173,592	2,173,592	2,173,592	
General Fund	559,052	651,890	693,353	714,464	714,464	
Cash Funds	353,592	341,957	379,255	358,144	358,144	
Reappropriated Funds	73	73	73	73	73	
Federal Funds	914,610	991,188	1,100,911	1,100,911	1,100,911	
Office of eHealth Innovations Operations	5,366,706	5,292,688	8,716,035	10,486,312	10,390,312	
FTE	0.0	0.0	3.0	3.0	3.0	
General Fund	2,869,668	2,564,753	2,411,251	2,868,951	2,829,820	
Cash Funds	0	0	664,397	671,985	664,397	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,497,038	2,727,935	5,640,387	6,945,376	6,896,095	
All-Payer Claims Database	8,249,242	8,552,676	9,619,029	9,293,485	9,293,485	*
General Fund	4,354,828	4,359,356	3,541,068	3,331,354	3,331,354	
Cash Funds	0	0	685,936	690,278	690,278	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,894,414	4,193,320	5,392,025	5,271,853	5,271,853	
SUBTOTAL - (C) Information Technology Contracts and Projects	155,730,218	181,943,989	235,067,963	256,251,078	244,442,575	
FTE	0.0	0.0	3.0	3.0	3.0	
General Fund	27,618,283	23,091,980	34,527,484	37,951,895	36,496,697	
Cash Funds	11,671,190	9,847,220	20,816,283	18,770,563	18,961,741	
Reappropriated Funds	6,398,403	29,242,920	32,122,992	35,676,720	29,985,330	
Federal Funds	110,042,342	119,761,869	147,601,204	163,851,900	158,998,807	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(D) Eligibility Determinations and Client Services						
Contracts for Special Eligibility Determinations	3,859,251	7,208,794	6,863,957	6,969,977	6,969,977	
General Fund	948,563	934,171	2,036,615	2,071,071	2,071,071	
Cash Funds	514,330	2,217,887	748,125	766,678	766,678	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	2,396,358	4,056,736	4,079,217	4,132,228	4,132,228	
County Administration	113,295,137	129,241,764	134,990,813	151,073,289	149,909,367	*
General Fund	20,478,568	21,004,349	21,338,324	21,151,241	19,257,016	
Cash Funds	20,118,688	32,228,364	30,475,191	33,203,435	34,715,162	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	72,697,881	76,009,051	83,177,298	96,718,613	95,937,189	
Call Center Shared Service	0	0	0	10,284,069	0	*
General Fund	0	0	0	1,380,838	0	
Cash Funds	0	0	0	686,827	0	
Reappropriated Funds	0	0	0	2,085,608	0	
Federal Funds	0	0	0	6,130,796	0	
Quality Assurance Shared Service	0	0	0	1,109,441	0	*
General Fund	0	0	0	368,655	0	
Cash Funds	0	0	0	182,554	0	
Federal Funds	0	0	0	558,232	0	
Member Case Integrity Shared Service	0	0	0	1,817,060	0	*
General Fund	0	0	0	603,788	0	
Cash Funds	0	0	0	298,991	0	
Federal Funds	0	0	0	914,281	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Document Management Shared Service	0	0	0	1,823,658	0	*
General Fund	0	0	0	267,545	0	
Cash Funds	0	0	0	132,965	0	
Reappropriated Funds	0	0	0	369,839	0	
Federal Funds	0	0	0	1,053,309	0	
Medical Assistance Sites	820,540	757,058	1,531,968	1,072,378	1,072,378	*
General Fund	0	0	0	0	0	
Cash Funds	402,983	373,323	402,984	282,089	282,089	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	417,557	383,735	1,128,984	790,289	790,289	
Administrative Case Management	599,592	685,220	869,744	869,744	869,744	
General Fund	299,796	342,610	434,872	434,872	434,872	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	299,796	342,610	434,872	434,872	434,872	
Customer Outreach	3,217,570	3,246,926	3,461,519	3,461,519	3,461,519	
General Fund	1,275,230	1,286,863	1,141,090	1,141,090	1,141,090	
Cash Funds	333,555	336,600	589,670	589,670	589,670	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,608,785	1,623,463	1,730,759	1,730,759	1,730,759	
Centralized Eligibility Vendor Contract Project	6,813,178	6,882,800	7,959,455	7,720,671	7,959,455	*
General Fund	0	0	0	0	0	
Cash Funds	2,249,919	2,321,723	2,753,409	2,670,807	2,753,409	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	4,563,259	4,561,077	5,206,046	5,049,864	5,206,046	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Connect for Health Colorado Eligibility Determination	8,242,386	7,939,905	11,174,846	11,174,846	11,174,846	
General Fund	0	0	0	0	0	
Cash Funds	4,746,203	4,680,430	4,995,156	4,995,156	4,995,156	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	3,496,183	3,259,475	6,179,690	6,179,690	6,179,690	
Eligibility Overflow Processing Center	1,540,773	1,660,262	1,904,677	1,333,274	1,904,677	*
General Fund	230,808	248,707	313,938	219,756	313,938	
Cash Funds	154,385	166,358	162,231	113,562	162,231	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,155,580	1,245,197	1,428,508	999,956	1,428,508	
Returned Mail Processing	2,567,981	2,246,974	3,298,808	3,298,808	3,298,808	
General Fund	811,112	814,688	979,135	1,017,871	1,017,871	
Cash Funds	184,978	175,226	251,592	212,856	212,856	
Reappropriated Funds	58,051	67,154	111,942	111,942	111,942	
Federal Funds	1,513,840	1,189,906	1,956,139	1,956,139	1,956,139	
Work Number Verification	1,908,503	6,003,199	11,341,713	12,535,888	12,535,888	*
General Fund	639,539	919,991	1,869,398	2,250,973	1,869,398	
Cash Funds	314,712	580,809	966,030	1,170,795	1,552,370	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	954,252	4,502,399	8,506,285	9,114,120	9,114,120	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Non-emergent Medical Transportation Broker	0	3,815,556	3,950,066	4,024,327	4,024,327	
General Fund	0	1,117,765	1,185,020	1,222,150	1,222,150	
Cash Funds	0	790,013	790,013	790,013	790,013	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	1,907,778	1,975,033	2,012,164	2,012,164	
SUBTOTAL - (D) Eligibility Determinations and Client Services	142,864,911	169,688,458	187,347,566	218,568,949	203,180,986	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	24,683,616	26,669,144	29,298,392	32,129,850	27,327,406	
Cash Funds	29,019,753	43,870,733	42,134,401	46,096,398	46,819,634	
Reappropriated Funds	58,051	67,154	111,942	2,567,389	111,942	
Federal Funds	89,103,491	99,081,427	115,802,831	137,775,312	128,922,004	
(E) Utilization and Quality Review Contracts						
Professional Service Contracts	19,494,073	21,440,984	37,774,263	33,557,135	33,557,135	*
General Fund	5,243,412	5,338,923	9,870,372	8,774,210	8,774,210	
Cash Funds	1,590,445	1,764,670	2,223,661	2,159,218	2,159,218	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	12,660,216	14,337,391	25,680,230	22,623,707	22,623,707	
SUBTOTAL - (E) Utilization and Quality Review Contracts	19,494,073	21,440,984	37,774,263	33,557,135	33,557,135	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	5,243,412	5,338,923	9,870,372	8,774,210	8,774,210	
Cash Funds	1,590,445	1,764,670	2,223,661	2,159,218	2,159,218	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	12,660,216	14,337,391	25,680,230	22,623,707	22,623,707	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(F) Provider Audits and Services						
Professional Audit Contracts	3,533,858	3,570,220	4,616,813	4,563,170	4,471,174	*
General Fund	1,446,790	1,482,816	1,845,401	1,921,568	1,921,568	
Cash Funds	320,139	302,294	533,976	430,988	384,990	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,766,929	1,785,110	2,237,436	2,210,614	2,164,616	
SUBTOTAL - (F) Provider Audits and Services	3,533,858	3,570,220	4,616,813	4,563,170	4,471,174	
FTE	0.0	0.0	0.0	0.0	0.0	
General Fund	1,446,790	1,482,816	1,845,401	1,921,568	1,921,568	
Cash Funds	320,139	302,294	533,976	430,988	384,990	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,766,929	1,785,110	2,237,436	2,210,614	2,164,616	
(G) Recoveries and Recoupment Contract Costs						
Estate Recovery	675,394	668,030	1,165,841	1,165,841	1,165,841	
General Fund	0	0	0	0	0	
Cash Funds	337,697	334,015	582,920	582,920	582,920	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	337,697	334,015	582,921	582,921	582,921	
Third-Party Liability Cost Avoidance Contract	3,064,990	2,690,376	5,626,486	9,023,738	5,811,486	*
General Fund	1,021,143	887,824	1,872,801	2,975,897	(925,757)	
Cash Funds	511,352	457,364	940,441	1,534,307	3,829,834	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	1,532,495	1,345,188	2,813,244	4,513,534	2,907,409	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
SUBTOTAL - (G) Recoveries and Recoupment					
Contract Costs	3,740,384	3,358,406	6,792,327	10,189,579	6,977,327
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	1,021,143	887,824	1,872,801	2,975,897	(925,757)
Cash Funds	849,049	791,379	1,523,361	2,117,227	4,412,754
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,870,192	1,679,203	3,396,165	5,096,455	3,490,330
(H) Indirect Cost Assessment					
Indirect Cost Assessment	1,113,873	923,528	881,600	881,600	881,600
General Fund	0	0	0	0	0
Cash Funds	196,956	276,775	277,887	277,887	277,887
Reappropriated Funds	93,623	113,548	79,516	79,516	79,516
Federal Funds	823,294	533,205	524,197	524,197	524,197
SUBTOTAL - (H) Indirect Cost Assessment	1,113,873	923,528	881,600	881,600	881,600
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	0	0	0	0
Cash Funds	196,956	276,775	277,887	277,887	277,887
Reappropriated Funds	93,623	113,548	79,516	79,516	79,516
Federal Funds	823,294	533,205	524,197	524,197	524,197
TOTAL - (1) Executive Director's Office	520,309,196	575,185,125	651,675,161	739,429,028	699,396,500
FTE	805.2	840.7	808.3	895.2	843
General Fund	115,896,467	124,287,092	146,788,153	166,449,461	150,351,570
Cash Funds	77,005,513	73,225,015	81,921,288	87,653,543	92,296,869
Reappropriated Funds	9,292,291	33,143,969	36,167,056	42,198,741	34,051,904
Federal Funds	318,114,925	344,529,049	386,798,664	443,127,283	422,696,157

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(2) MEDICAL SERVICES PREMIUMS					
Primary functions: Provides acute care medical and long-term care services to individuals eligible for Medicaid.					
Medical and Long-Term Care Services for Medicaid Eligible Individuals	11,386,151,835	12,627,795,252	14,198,369,236	16,383,597,851	15,241,076,347 *
General Fund	2,134,324,780	2,465,553,736	2,724,783,561	3,453,659,880	2,909,835,156
General Fund Exempt	1,179,901,546	1,248,839,667	1,292,968,309	1,292,968,309	1,292,968,309
Cash Funds	1,314,296,704	1,346,192,427	1,678,382,836	1,915,269,183	1,884,645,825
Reappropriated Funds	99,207,497	118,098,773	124,197,922	130,791,126	124,197,922
Federal Funds	6,658,421,308	7,449,110,649	8,378,036,608	9,590,909,353	9,029,429,135
TOTAL - (2) Medical Services Premiums	11,386,151,835	12,627,795,252	14,198,369,236	16,383,597,851	15,241,076,347
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	2,134,324,780	2,465,553,736	2,724,783,561	3,453,659,880	2,909,835,156
General Fund Exempt	1,179,901,546	1,248,839,667	1,292,968,309	1,292,968,309	1,292,968,309
Cash Funds	1,314,296,704	1,346,192,427	1,678,382,836	1,915,269,183	1,884,645,825
Reappropriated Funds	99,207,497	118,098,773	124,197,922	130,791,126	124,197,922
Federal Funds	6,658,421,308	7,449,110,649	8,378,036,608	9,590,909,353	9,029,429,135

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(4) INDIGENT CARE PROGRAM						
Safety Net Provider Payments	246,618,300	267,103,696	226,610,308	226,610,308	226,610,308	
General Fund	0	0	0	0	0	
Cash Funds	122,034,489	133,551,848	113,305,154	113,305,154	113,305,154	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	124,583,811	133,551,848	113,305,154	113,305,154	113,305,154	
Pediatric Specialty Hospital	10,764,010	13,455,012	13,455,012	13,455,012	13,455,012	*
General Fund	5,274,365	6,727,506	4,865,335	1,790,193	1,505,282	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	5,489,645	6,727,506	8,589,677	11,664,819	11,949,730	
Appropriation from Tobacco Tax Fund to the General Fund	303,203	291,034	293,077	293,077	293,077	
General Fund	0	0	0	0	0	
Cash Funds	303,203	291,034	293,077	293,077	293,077	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Primary Care Fund	53,474,732	50,008,989	34,771,339	34,771,339	34,771,339	
General Fund	7,000,000	6,500,000	0	0	0	
Cash Funds	19,608,672	18,584,947	17,516,461	17,516,461	17,516,461	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	26,866,060	24,924,042	17,254,878	17,254,878	17,254,878	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Children's Basic Health Plan Administration	1,674,518	1,652,111	3,864,405	3,864,405	3,864,405
General Fund	0	0	0	1,347,131	1,347,131
Cash Funds	577,578	578,239	1,352,542	5,411	5,411
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,096,940	1,073,872	2,511,863	2,511,863	2,511,863
Children's Basic Health Plan Medical and Dental Costs	184,933,218	266,234,655	270,717,327	338,588,633	317,477,353
General Fund	22,640,521	44,496,147	44,655,099	58,064,758	50,375,931
General Fund Exempt	303,203	0	293,077	293,077	293,077
Cash Funds	40,743,413	48,599,616	49,867,888	60,213,187	60,513,066
Reappropriated Funds	0	0	0	0	0
Federal Funds	121,246,081	173,138,892	175,901,263	220,017,611	206,295,279
TOTAL - (4) Indigent Care Program	497,767,981	598,745,497	549,711,468	617,582,774	596,471,494
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	34,914,886	57,723,653	49,520,434	61,202,082	53,228,344
General Fund Exempt	303,203	0	293,077	293,077	293,077
Cash Funds	183,267,355	201,605,684	182,335,122	191,333,290	191,633,169
Reappropriated Funds	0	0	0	0	0
Federal Funds	279,282,537	339,416,160	317,562,835	364,754,325	351,316,904

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(5) OTHER MEDICAL SERVICES						
Old Age Pension State Medical	589,696	845,722	10,000,000	10,000,000	10,000,000	
General Fund	0	0	0	0	0	
Cash Funds	589,696	845,722	10,000,000	10,000,000	10,000,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Senior Dental Program	3,930,117	3,973,964	3,490,358	1,990,358	1,990,358	
General Fund	3,930,117	3,962,510	3,462,510	1,962,510	1,962,510	
Cash Funds	0	11,454	27,848	27,848	27,848	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	
Commission on Family Medicine Residency Training Programs	9,490,170	9,490,170	9,490,170	9,490,170	9,490,170	*
General Fund	4,430,100	4,520,085	3,099,350	923,465	907,331	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	220,500	225,000	189,768	196,737	154,536	
Federal Funds	4,839,570	4,745,085	6,201,052	8,369,968	8,428,303	
Medicare Modernization Act State Contribution Payment	244,361,309	242,949,385	257,599,472	300,722,794	271,406,559	
General Fund	244,361,309	242,949,385	257,599,472	300,722,794	271,406,559	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Public School Health Services Contract Administration	1,253,344	950,336	2,000,000	2,000,000	2,000,000	
General Fund	626,672	475,168	1,000,000	1,000,000	1,000,000	
Cash Funds	0	0	0	0	0	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	626,672	475,168	1,000,000	1,000,000	1,000,000	
Public School Health Services	191,357,388	222,351,721	187,451,256	195,354,199	195,354,199	*
General Fund	0	0	0	0	0	
Cash Funds	90,710,963	110,582,434	93,725,628	97,677,100	97,677,100	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	100,646,425	111,769,287	93,725,628	97,677,099	97,677,099	
Rural Provider Access and Affordability Fund, Created in Section 25.5-1-207 (6)(a), C.R.S.	1,000,000	0	0	0	0	
General Fund	1,000,000	0	0	0	0	
Screening, Brief Intervention, and Referral to Treatment Training Grant Program	1,500,000	1,500,000	1,000,000	1,000,000	1,000,000	
General Fund	0	0	0	0	0	
Cash Funds	1,500,000	1,500,000	1,000,000	1,000,000	1,000,000	
Reappropriated Funds	0	0	0	0	0	
Federal Funds	0	0	0	0	0	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Reproductive Health Care for Individuals Not Eligible for Medicaid	1,356,927	1,893,286	2,614,490	2,114,490	2,614,490
General Fund	1,356,927	1,893,286	2,614,490	2,114,490	2,614,490
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
ARPA HCBS State-only Funds	21,418,222	0	0 0.0	0	0
Cash Funds	21,418,222	0	0	0	0
Denver Health and Hospital Authority	1,000,000	5,000,000	0	0	0
General Fund	1,000,000	5,000,000	0	0	0
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Health Benefits for Colorado Children and Pregnant Persons	0	17,780,840	53,360,259	60,335,756	96,265,223
General Fund	0	17,780,840	53,360,259	60,335,756	96,265,223
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Telehealth Remote Monitoring Grant Program	0	0	500,000	0	0
General Fund	0	0	500,000	0	0
Abortion care	0	0	2,928,800	5,857,600	5,857,600
General Fund	0	0	2,928,800	5,857,600	5,857,600

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Safety net provider stabilization payments	0	0	44,845,595	19,858,935	39,858,935
Cash Funds	0	0	44,845,595	19,858,935	39,858,935
State Only Home & Community Based Payments	0	0	0	21,800,705	0
General Fund	0	0	0	21,800,705	0
TOTAL - (5) Other Medical Services	477,257,173	506,735,424	575,280,400	630,525,007	635,837,534
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	256,705,125	276,581,274	324,564,881	394,717,320	380,013,713
Cash Funds	114,218,881	112,939,610	149,599,071	128,563,883	148,563,883
Reappropriated Funds	220,500	225,000	189,768	196,737	154,536
Federal Funds	106,112,667	116,989,540	100,926,680	107,047,067	107,105,402

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(1) TRANSFERS TO OTHER STATE DEPARTMENT MEDICAID-FUNDED PROGRAMS						
Primary functions: Provides all of the administrative, audit and oversight functions for the Department.						
(A) Corrections						
Administration	554,080	491,640	491,640			
Cash Funds	277,040	245,820	245,820			
Federal Funds	277,040	245,820	245,820			
Reentry Services	6,517,727	6,517,727	6,517,727			
General Fund	3,750,994	3,750,994	3,750,994			
Federal Funds	2,766,733	2,766,733	2,766,733			
SUBTOTAL - (A) Corrections	7,071,807	7,009,367	7,009,367			
FTE	0.0	0.0	0.0			
General Fund	3,750,994	3,750,994	3,750,994			
Cash Funds	277,040	245,820	245,820			
Federal Funds	3,043,773	3,012,553	3,012,553			
(B) Early Childhood						
Early Intervention	4,256,570	5,940,111	5,940,111	5,940,111		*
General Fund	2,128,285	2,970,056	2,970,056	2,970,056		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	2,128,285	2,970,055	2,970,055	2,970,055		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
SUBTOTAL - (B) Early Childhood	4,256,570	5,940,111	5,940,111	5,940,111		
FTE	0.0	0.0	0.0	0.0		
General Fund	2,128,285	2,970,056	2,970,056	2,970,056		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	2,128,285	2,970,055	2,970,055	2,970,055		
(C) Education						
Public School Health Services	173,412	208,269	208,269	208,269		
General Fund	86,706	104,135	104,135	104,135		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	86,706	104,134	104,134	104,134		
SUBTOTAL - (C) Education	173,412	208,269	208,269	208,269		
FTE	0.0	0.0	0.0	0.0		
General Fund	86,706	104,135	104,135	104,135		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	86,706	104,134	104,134	104,134		
(D) Human Services						
(I) Executive Director's Office						
Executive Director's Office	17,003,357	18,242,507	24,550,189	24,543,455		*
General Fund	8,501,679	9,102,264	12,256,105	12,252,738		
Cash Funds	0	18,990	18,990	18,990		
Reappropriated Funds	0	0	0	0		
Federal Funds	8,501,678	9,121,253	12,275,094	12,271,727		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
SUBTOTAL - (I) Executive Director's Office	17,003,357	18,242,507	24,550,189	24,543,455	
FTE	0.0	0.0	0.0	0.0	
General Fund	8,501,679	9,102,264	12,256,105	12,252,738	
Cash Funds	0	18,990	18,990	18,990	
Reappropriated Funds	0	0	0	0	
Federal Funds	8,501,678	9,121,253	12,275,094	12,271,727	
(II) Office of Children, Youth, and Families					
Child Welfare Administration	137,326	352,543	356,117	356,117	
General Fund	68,663	145,627	147,414	147,414	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	68,663	206,916	208,703	208,703	
Child Welfare Services	21,187,188	14,383,230	14,383,230	14,383,230	
General Fund	10,591,900	7,191,615	7,191,615	7,191,615	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	10,595,288	7,191,615	7,191,615	7,191,615	
Division of Youth Services	736,945	758,785	762,131	762,131	
General Fund	368,472	379,394	381,067	381,067	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	368,473	379,391	381,064	381,064	
Health-Related Social Needs	0	1,142,323	1,142,323	1,142,323	
General Fund	0	761,549	761,549	761,549	
Federal Funds	0	380,774	380,774	380,774	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
Reentry Services	0	84,352	84,352	84,352		
General Fund	0	56,235	56,235	56,235		
Federal Funds	0	28,117	28,117	28,117		
SUBTOTAL - (II) Office of Children, Youth, and Families	22,061,459	16,721,233	16,728,153	16,728,153		
FTE	0.0	0.0	0.0	0.0		
General Fund	11,029,035	8,534,420	8,537,880	8,537,880		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	11,032,424	8,186,813	8,190,273	8,190,273		
(III) Office of Economic Security						
Administration	0	240,000	80,000	80,000		*
General Fund	0	72,180	24,180	24,180		
Cash Funds	0	47,820	15,820	15,820		
Reappropriated Funds	0	0	0	0		
Federal Funds	0	120,000	40,000	40,000		
Systemic Alien Verification for Eligibility	67,422	116,804	157,731	157,731		
General Fund	33,711	58,403	78,866	78,866		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	33,711	58,401	78,865	78,865		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
SUBTOTAL - (III) Office of Economic Security	67,422	356,804	237,731	237,731	
FTE	0.0	0.0	0.0	0.0	
General Fund	33,711	130,583	103,046	103,046	
Cash Funds	0	47,820	15,820	15,820	
Reappropriated Funds	0	0	0	0	
Federal Funds	33,711	178,401	118,865	118,865	
(IV) Behavioral Health Administration					
Community Behavioral Health Administration	503,686	926,843	952,468	952,468	
General Fund	251,843	463,421	476,233	476,233	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	251,843	463,422	476,235	476,235	
Children and Youth Mental Health Treatment Act	0	137,680	137,680	137,680	
General Fund	0	68,840	68,840	68,840	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	68,840	68,840	68,840	
SUBTOTAL - (IV) Behavioral Health Administration	503,686	1,064,523	1,090,148	1,090,148	
FTE	0.0	0.0	0.0	0.0	
General Fund	251,843	532,261	545,073	545,073	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	251,843	532,262	545,075	545,075	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(V) Office of Behavioral Health					
Mental Health Institutes	13,266,244	11,014,933	10,046,849	10,046,849	*
General Fund	6,633,122	5,507,466	5,023,424	5,023,424	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	6,633,122	5,507,467	5,023,425	5,023,425	
Mental Health Transitional Living Homes	0	5,165,032	5,165,032	5,165,032	
General Fund	0	2,582,516	2,582,516	2,582,516	
Federal Funds	0	2,582,516	2,582,516	2,582,516	
Mental Health Transitional Living Homes	2,582,515	0	0	0	
General Fund	1,291,257	0	0	0	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	1,291,258	0	0	0	
SUBTOTAL - (V) Office of Behavioral Health	15,848,759	16,179,965	15,211,881	15,211,881	
FTE	0.0	0.0	0.0	0.0	
General Fund	7,924,379	8,089,982	7,605,940	7,605,940	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	7,924,380	8,089,983	7,605,941	7,605,941	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(VI) Office of Adults, Aging, and Disability Services						
Administration	505,357	503,562	503,562	503,562		
General Fund	252,678	251,781	251,781	251,781		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	252,679	251,781	251,781	251,781		
Regional Centers for People with Developmental Disabilities	53,967,621	59,760,345	60,843,664	60,843,664		*
General Fund	25,151,982	27,991,270	28,532,930	28,532,930		
Cash Funds	1,888,903	1,888,903	1,888,903	1,888,903		
Reappropriated Funds	0	0	0	0		
Federal Funds	26,926,736	29,880,172	30,421,831	30,421,831		
Community Services for the Elderly	997,590	1,001,800	1,001,800	1,001,800		
General Fund	498,795	500,900	500,900	500,900		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	498,795	500,900	500,900	500,900		
SUBTOTAL - (VI) Office of Adults, Aging, and Disability Services	55,470,568	61,265,707	62,349,026	62,349,026		
FTE	0.0	0.0	0.0	0.0		
General Fund	25,903,455	28,743,951	29,285,611	29,285,611		
Cash Funds	1,888,903	1,888,903	1,888,903	1,888,903		
Reappropriated Funds	0	0	0	0		
Federal Funds	27,678,210	30,632,853	31,174,512	31,174,512		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation	
(VII) Other						
Federal Medicaid Indirect Cost Reimbursement for Human Services Programs	1,595,011	0	0	0		
General Fund	0	0	0	0		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	1,595,011	0	0	0		
Department of Human Services Indirect Cost Assessment	16,969,736	24,523,468	21,184,141	21,184,141		*
General Fund	8,484,868	12,261,734	10,592,071	10,592,071		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	8,484,868	12,261,734	10,592,070	10,592,070		
SUBTOTAL - (VII) Other	18,564,747	24,523,468	21,184,141	21,184,141		
FTE	0.0	0.0	0.0	0.0		
General Fund	8,484,868	12,261,734	10,592,071	10,592,071		
Cash Funds	0	0	0	0		
Reappropriated Funds	0	0	0	0		
Federal Funds	10,079,879	12,261,734	10,592,070	10,592,070		
SUBTOTAL - (D) Human Services	129,519,998	138,354,207	141,351,269	141,344,535		
FTE	0.0	0.0	0.0	0.0		
General Fund	62,128,970	67,395,195	68,925,726	68,922,359		
Cash Funds	1,888,903	1,955,713	1,923,713	1,923,713		
Reappropriated Funds	0	0	0	0		
Federal Funds	65,502,125	69,003,299	70,501,830	70,498,463		

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(E) Local Affairs					
Administration	0	225,100	205,090	205,090	
Cash Funds	0	112,550	102,545	102,545	
Federal Funds	0	112,550	102,545	102,545	
Home Modifications Benefit Administration	278,322	313,881	313,881	313,881	
General Fund	139,161	156,941	156,941	156,941	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	139,161	156,940	156,940	156,940	
Host Home Regulation	89,865	325,578	325,578	325,578	
General Fund	89,865	162,789	162,789	162,789	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	162,789	162,789	162,789	
Health-Related Social Needs	0	12,900,408	12,900,408	12,900,408	
General Fund	0	7,622,681	7,622,681	7,622,681	
Federal Funds	0	5,277,727	5,277,727	5,277,727	
SUBTOTAL - (E) Local Affairs	368,187	13,764,967	13,744,957	13,744,957	
FTE	0.0	0.0	0.0	0.0	
General Fund	229,026	7,942,411	7,942,411	7,942,411	
Cash Funds	0	112,550	102,545	102,545	
Reappropriated Funds	0	0	0	0	
Federal Funds	139,161	5,710,006	5,700,001	5,700,001	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
(F) Public Health and Environment					
Facilty Survey and Certification	8,039,935	9,279,704	9,279,704	9,279,704	
General Fund	3,020,180	3,861,449	3,861,449	3,861,449	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,019,755	5,418,255	5,418,255	5,418,255	
Prenatal Statistical Information	6,196	6,196	6,196	6,196	
General Fund	3,098	3,098	3,098	3,098	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	3,098	3,098	3,098	3,098	
SUBTOTAL - (F) Public Health and Environment	8,046,131	9,285,900	9,285,900	9,285,900	
FTE	0.0	0.0	0.0	0.0	
General Fund	3,023,278	3,864,547	3,864,547	3,864,547	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	5,022,853	5,421,353	5,421,353	5,421,353	
(G) Regulatory Agencies					
Nurse Aide Certification	309,390	324,041	324,041	324,041	
General Fund	147,369	147,369	147,369	147,369	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	14,652	14,652	14,652	
Federal Funds	162,021	162,020	162,020	162,020	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
Sunset Reviews	0	3,750	3,750	3,750	
General Fund	0	1,875	1,875	1,875	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	0	0	0	
Federal Funds	0	1,875	1,875	1,875	
SUBTOTAL - (G) Regulatory Agencies	309,390	327,791	327,791	327,791	
FTE	0.0	0.0	0.0	0.0	
General Fund	147,369	149,244	149,244	149,244	
Cash Funds	0	0	0	0	
Reappropriated Funds	0	14,652	14,652	14,652	
Federal Funds	162,021	163,895	163,895	163,895	
(H) Revenue					
Hospital Tax Exemptions	100,000	100,000	100,000	100,000	
General Fund	0	0	0	0	
Cash Funds	50,000	50,000	50,000	50,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	50,000	50,000	50,000	50,000	
SUBTOTAL - (H) Revenue	100,000	100,000	100,000	100,000	
FTE	0.0	0.0	0.0	0.0	
General Fund	0	0	0	0	
Cash Funds	50,000	50,000	50,000	50,000	
Reappropriated Funds	0	0	0	0	
Federal Funds	50,000	50,000	50,000	50,000	

	FY 2023-24 Actual	FY 2024-25 Actual	FY 2025-26 Appropriation	FY 2026-27 Request	FY 2026-27 Recommendation
TOTAL - (1) Transfers to Other State Department Medicaid-Funded Programs	142,773,688	175,053,052	177,967,664	177,960,930	
FTE	0.0	0.0	0.0	0.0	
General Fund	67,743,634	86,176,582	87,707,113	87,703,746	
Cash Funds	1,938,903	2,395,303	2,322,078	2,322,078	
Reappropriated Funds	0	14,652	14,652	14,652	
Federal Funds	73,091,151	86,466,515	87,923,821	87,920,454	
TOTAL - Department of Health Care Policy and Financing	12,976,911,141	14,451,234,986	16,150,089,317	18,549,102,324	17,350,742,805
FTE	805.2	840.7	808.3	895.2	843
General Fund	2,586,695,150	2,991,889,389	3,331,833,611	4,163,735,856	3,581,132,529
General Fund Exempt	1,180,204,749	1,248,839,667	1,293,261,386	1,293,261,386	1,293,261,386
Cash Funds	1,690,724,176	1,735,901,639	2,094,633,620	2,325,141,977	2,319,461,824
Reappropriated Funds	108,720,288	151,467,742	160,569,398	173,201,256	158,419,014
Federal Funds	7,410,566,778	8,323,136,549	9,269,791,302	10,593,761,849	9,998,468,052