FY 2025-26 Budget Briefing Summary

Health Care Policy and Financing

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

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

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

Summary of Request

Department of Health Care Policy and Financing

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Total	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
FY 2026-27 Requested Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Medical forecast	2,841,332,450	630,860,236	477,749,914	0	1,732,722,300	0.0
Eligibility & benefit changes	-203,585,062	-82,866,991	-5,345,281	0	-115,372,790	7.0
Provider rates	-341,182,268	-126,227,926	-17,665,178	0	-197,289,164	1.0
Administration	8,655,095	-7,133,048	2,291,649	2,455,447	11,041,047	11.3
Prior year actions	37,382,050	15,219,353	-4,075,326	-1,652,006	27,890,029	-2.6
Employee compensation common policies	8,693,320	2,544,524	1,436,917	0	4,711,879	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Impacts driven by other agencies	1,890,335	852,076	93,091	0	945,168	1.8
Total	$20,574,754,164	$5,988,845,075	$2,485,238,785	$144,810,897	$11,955,859,407	861.7
Increase/-Decrease	$2,357,463,218	$434,529,053	$454,959,208	$790,014	$1,467,184,943	18.5
Percentage Change	12.9%	7.8%	22.4%	0.5%	14.0%	2.2%

Medical forecast

The Department requests an increase for projected medical expenditures under current law and policy.

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R1 Medical Services Premiums	$2,282,305,964	$431,286,496	$443,437,319	$0	$1,407,582,149	0.0	EK
R2 Behavioral health	343,831,232	68,242,986	30,852,643	0	244,735,603	0.0	EP
R5 Office of Community Living	136,855,181	72,893,346	-1,713,868	0	65,675,703	0.0	TD
R4 Other programs & services	56,180,311	56,180,311	0	0	0	0.0	EK
R3 Child Health Plan Plus	22,659,762	2,757,097	5,173,820	0	14,728,845	0.0	EK
R6.05 Immigrant family planning	-500,000	-500,000	0	0	0	0.0	EK
Total	$2,841,332,450	$630,860,236	$477,749,914	$0	$1,732,722,300	0.0	

Eligibility & benefit changes

Eligibility and benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R18 3D mammograms	$635,758	$128,456	$37,885	$469,417	0.0	EK
R6.09 Outpatient psychotherapy prior authorization	-31,330,942	-12,241,619	-959,135	-18,130,188	0.0	EP
R6.04 Continuous coverage	-27,209,010	-11,226,343	-716,877	-15,265,790	0.0	EK
R6.10 Pediatric behavioral therapy reviews	-20,000,000	-10,000,000	0	-10,000,000	0.0	EP
R6.17 IDD youth transitions	-15,261,376	-7,630,688	0	-7,630,688	1.0	TD
R6.34 Community connector units	-15,092,224	-7,546,112	0	-7,546,112	1.0	TD
R6.08 Tests for specific drugs	-14,106,232	-1,876,129	-1,035,397	-11,194,706	0.0	EK
R6.30 HCBS hours soft cap	-13,891,297	-6,945,648	0	-6,945,649	3.0	TD
R6.20 Community health workers	-13,385,549	-3,196,962	-803,013	-9,385,574	0.0	EK
R6.36 IDD cost share	-12,641,818	-6,320,909	0	-6,320,909	0.0	TD
R6.25 Biosimilars	-12,316,324	-2,357,591	-1,240,468	-8,718,265	0.0	EK
R6.26 3rd party pay for drugs	-9,770,846	-2,944,176	-645,423	-6,181,247	0.0	EK
R6.18 IDD waitlist	-6,497,170	-3,248,585	0	-3,248,585	1.0	TD
R17 Community connector age limit	-5,229,310	-2,632,702	17,147	-2,613,755	0.0	TD
R6.29 LTSS presumptive eligibility	-2,775,871	-1,471,558	0	-1,304,313	0.0	TD
R6.31 Caregiving hours soft cap	-2,266,749	-1,133,374	0	-1,133,375	1.0	TD
R6.19 Senior dental grants	-2,000,000	-2,000,000	0	0	0.0	EK
R6.32 Homemaker hours soft cap	-446,102	-223,051	0	-223,051	0.0	TD
Total	-$203,585,062	-$82,866,991	-$5,345,281	-$115,372,790	7.0	

R18 3D Mammograms: The Department seeks to expand Medicaid benefits to cover three dimensional (3D) mammography for earlier and more accurate detection of breast cancer.

Year 1: The Department projects the new benefit will cost $635,758 total funds, including $128,456 General Fund.

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. However, randomized control trials comparing long-term outcomes and cost-effectiveness remain limited. 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. According to the Department, 3D mammography is the standard of care adopted by commercial insurers.

R6.04 Continuous coverage: The federal government rescinded the Department's authorization to provide continuous coverage for children to age three and for adults for one year after release from prison.

The federal action reduces the Department's forecast by:

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

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

R6.08 Tests for specific drugs: The Department implemented prior authorization requirements before paying for more than 16 urine tests in a year that determine the specific drugs in a patient.

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

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

From 2021 to 2024 the members receiving these services nearly doubled from 22,813 to 43,194. Spending increased 4.5 times from $12 million to $54 million. Based on medical guidelines, the Department believes much of the testing is unnecessary and lacks clinical justification.

R6.20 Community health workers: The Department proposes further delaying the start of coverage for community health workers from January 1, 2026 to January 1, 2028.

The request temporarily reduces the Department's forecast by:

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

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

The Department didn't identify this as requiring a bill, but the delay last year was done through a bill. The language added by S.B. 25-229 says the Department will reimburse community health workers beginning

January 1, 2026, "subject to available appropriations, upon receiving any necessary federal authorization". The Department argues that if there are no appropriations they don't need to implement the reimbursements by January 1, 2026, and therefore the proposed delay can be accomplished through the budget process.

R6.25 Biosimilars: The Department is developing policies that will require people to try certain lower cost biosimilar drugs before approving higher cost branded biologic drugs.

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

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

Similar to 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.

R6.26 3rd party pay for drugs: 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 plans to implement the limit January 1, 2026. The new limit reduces the Department's forecast by:

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

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

R6.19 Senior dental grants: The Department proposes reducing senior dental grants.

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

The senior dental grants currently provide approximately $4.0 million annually to community health centers, nonprofit dental clinics, and public health agencies. The grant recipients use the money for dental care to low-income elderly people. To receive services, a client must be 60 or over, must have income under 250 percent of the federal poverty guidelines, and must not have other insurance. The Dental Health Care Program for Low Income Seniors Annual Report indicates 25 grantees served 4,657 seniors in FY 2024-25.

Provider rates

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R13 Denver Health fed funds	$11,331,455	$0	$3,527,482	$7,803,973	0.0	EK
R14.2 IV nutrition rates	615,320	203,628	24,453	387,239	0.0	EP

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R6.11 Provider rates -1.6%	-160,972,816	-56,992,200	-8,810,550	-95,170,066	0.0	EK
R6.23 Rates above 85% Medicare	-53,241,533	-15,046,057	-3,780,149	-34,415,327	0.0	EK
R15 Home health/nurse rates	-26,582,980	-13,670,319	160,503	-13,073,164	1.0	TD
R6.16 Dental rates	-20,668,949	-3,774,150	-3,121,011	-13,773,788	0.0	EK
R6.33 Community connector -23%	-18,331,864	-9,165,932	0	-9,165,932	0.0	TD
R6.24 Drug rates	-15,805,934	-3,772,279	-1,178,513	-10,855,142	0.0	EK
R6.15 Pediatric behavioral therapy rates	-13,057,068	-6,528,534	0	-6,528,534	0.0	EP
R6.02 Behavioral health incentives	-12,644,332	-3,000,000	-3,322,166	-6,322,166	0.0	EP
R6.12 Community connector -15%	-12,052,939	-6,026,469	0	-6,026,470	0.0	TD
R6.13 Nursing minimum wage	-8,719,922	-4,359,961	0	-4,359,961	0.0	EK
R6.14 Individual residential srvcs & supports	-5,801,116	-2,284,479	-616,079	-2,900,558	0.0	TD
R6.01 Accountable care incentives	-2,325,290	-750,000	-412,645	-1,162,645	0.0	EK
R6.28 Drug dispensing fees	-1,690,905	-509,509	-111,694	-1,069,702	0.0	EK
R6.35 Movement therapy rates	-716,467	-358,234	0	-358,233	0.0	EP
R6.27 Specialty drug rates	-516,928	-193,431	-24,809	-298,688	0.0	EK
R6.03 Primary care stabilization	0	0	0	0	0.0	EK
Total	-$341,182,268	-$126,227,926	-$17,665,178	-$197,289,164	1.0	

R13 Denver Health fed funds [legislation]: The Department requests spending authority 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

R6.11 Provider rates -1.6%: The Department is undoing the 1.6 percent provider rate increase for Medicaid providers that was appropriated in FY 2025-26.

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

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

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

R6.23 Rates above 85% Medicare: The Department proposes reducing rates to 85 percent of the Medicare benchmark.

The reductions would take effect April 1, 2026, and reduce 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.

R6.16 Dental rates: The Department is implementing a 15.5 percent reduction for dental rates.

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

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

The reduction applies to codes that received a large targeted rate increase in FY 2024-25.

R6.24 Drug rates: The Department proposes changing the methodology used to determine drug rates in order to reduce expenditures.

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

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

Based on federal guidance, the Department must pay for most drugs at cost, but there are different ways to determine the "cost". The Department currently 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, but the amount varies by drug. The federal Centers for Medicare and Medicaid Services must approve any change to this drug payment methodology. 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.[1] 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.

R6.13 Nursing minimum wage [legislation]: The Department is ending a supplemental payment to nursing facilities that commit to pay all employees at least $15 per hour.

[1] The Department refers to the wholesale acquisition cost less the discount as the maximum allowable cost. So, restating the Department's request using the most possible acronyms would look something like: Pending CMS approval, HCPF wants to pay for drugs at the lesser of the AAC, the NADAC, or the WAC minus the discount (AKA the MAC). Despite appearances, these are acronyms for different measures of drug costs, rather than college football conferences.

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

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

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

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

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

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

R6.01 Accountable care incentives: The Department is reducing incentive payments through the Accountable Care Collaborative.

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

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

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

The Department's forecast has savings built into it from the historic performance of the Accountable Care Collaborative in improving health outcomes and reducing expenditures. Ostensibly, the incentive payments motivate and finance the PCMPs and RAEs to innovate, perform interventions, 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.

R6.28 Drug dispensing fees: The Department seeks to reduce drug dispensing fees for the highest volume pharmacies.

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

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

The Department pays pharmacies for the ingredients (the drugs) plus a dispensing fee for each prescription filled. The dispensing fees are tiered based on volume. The highest volume providers with the most economies of scale get paid the lowest dispensing fees. For the highest volume tier, the Department proposes reducing the dispensing fee from $9.31 to $8.72, or a 6.3 percent reduction. For the second highest volume tier, the Department proposes reducing the dispensing fee from $10.25 to $9.93, or a 3.1 percent reduction. This primarily impacts large chain pharmacies, but some independent pharmacies with large volumes will see reductions.

R6.27 Specialty drug rates: 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, 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 100 percent of costs that occurred in January 2024. The decrease primarily impacts Children's Hospital.

R6.03 Primary care stabilization: The Department is delaying the start of annual primary care stabilization payments to small, pediatric, or rural providers that do not receive cost-based reimbursements.

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

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

The stabilization payments are a new component of Phase III of the Accountable Care Collaborative. They are not the same as the payments from the Provider Stabilization Fund authorized by S.B. 25-290 that use a loan from the Unclaimed Property Trust Fund. These payments will go to primary care providers that are not Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs). The FQHCs and RHCs receive cost-based reimbursements. The Department estimates 271 primary care providers will qualify for the primary care stabilization payments.

Administration

Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R7 Eligibility administration	$16,626,704	$1,503,264	$1,560,567	$2,455,447	$11,107,426	3.0	TD
R9 Provider directory	5,955,875	451,455	248,360	0	5,256,060	0.0	EK
R10.1 Disability determinations	1,381,020	837,000	-146,491	0	690,511	0.0	TD
R11 Salesforce support	700,172	223,727	120,059	0	356,386	1.8	EK
R14.1 Chronic pain management	290,738	94,867	50,502	0	145,369	1.0	EP
R12 Home health administration	95,738	31,237	16,631	0	47,870	1.0	EK
R8 Single assessment	-11,668,682	-6,192,265	60,986	0	-5,537,403	2.7	TD
R6.21 Children in Rocky PRIME	-3,476,470	-1,738,235	0	0	-1,738,235	0.0	EK
R6.07 Immigrant services outreach	-750,000	-262,500	0	0	-487,500	0.0	EK
R6.06 SBIRT training grants	-500,000	-500,000	0	0	0	0.0	EP
R16 Unspent grant admin	0	-800,000	800,000	0	0	0.0	EP
R10.2 3rd party insurance	0	-781,598	-418,965	0	1,200,563	1.8	EK
R6.22 Provider credentialing ACC	0	0	0	0	0	0.0	EK
R19 Line item consolidation	0	0	0	0	0	0.0	TD
R20 CHP+ Trust consolidation	0	0	0	0	0	0.0	EK
Total	$8,655,095	-$7,133,048	$2,291,649	$2,455,447	$11,041,047	11.3	

R9 Provider directory: 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.

Year 1: The Department requests $6.0 million total funds, including $451,455 General Fund.
Year 2: The estimated ongoing costs are $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 Medicaid claims 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.

R11 Salesforce support: The Department requests funds for licenses, data storage, and staff 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. According to the Department, each individual expansion was properly funded, but 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

R12 Home health administration: The Department requests one new position for policy oversight of long-term home health and one term-limited position for a projected surge in appeals.

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

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

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

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

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

R6.21 Children in Rocky PRIME: 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 higher due to expectations for greater care coordination. In addition, the Department identified 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. Absorbing the one-time costs proved infeasible under federal regulations and the Department projects lower annual costs from keeping the children in fee-for-service.

R6.07 Immigrant services outreach: The Department wants to stop three grants to nonprofits that pay for outreach related to health services for undocumented children and pregnant people.

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

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

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

R10.2 3rd party insurance: 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 cases where a third-party insurer should pay, not Medicaid.

Year 1: No change in total funds, but a decrease of $781,599 General Fund and an increase of 1.8 FTE.

The Department argues pre-payment 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.

R6.22 Provider credentialing ACC: The Department no longer plans to implement a centralized, statewide program for credentialing behavioral health providers for participation with all Regional Accountable Entities (RAEs).

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

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

R20 CHP+ Trust consolidation: 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.

Prior year actions

The request includes a net increase of $37.4 million for the impact of prior year budget decisions and legislation. Items with no priority number or bill number were initiated by the General Assembly through the budget process.

Prior year actions

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
HB 23-1300 Continuous eligibility	$13,604,506	$5,613,172	$358,438	$0	$7,632,896	0.0
FY 25-26 Provider rates 1.6% adjustment	12,242,841	4,361,085	645,728	0	7,236,028	0.0
FY 23-24 BA7 Community access	10,775,256	-300,890	714,063	0	10,362,083	0.1
SB 24-116 Discounts for indigent patients	7,906,592	846,995	621,261	0	6,438,336	0.0
SB 25-229 Community health workers	5,713,346	1,364,558	342,750	0	4,006,038	0.0
HB 24-1038 High acuity youth	4,354,000	2,177,000	0	0	2,177,000	0.0
FY 25-26 Early intervention	4,000,000	2,000,000	0	0	2,000,000	0.0
HB 24-1045 Substance use disorder	3,986,324	807,379	236,968	0	2,941,977	0.0
FY 25-26 R6 Accountable Care Collaborative	2,617,821	1,500,829	-314,251	0	1,431,243	0.0
SB 23-002 Community health services	1,958,861	467,847	117,514	0	1,373,500	0.0
SB 24-168 Remote monitoring	1,711,462	98,758	102,872	0	1,509,832	-0.3
HB 23-1136 Prosthetic devices	1,526,304	0	152,630	0	1,373,674	0.0
SB 24-110 Limit prior authorization	358,420	94,020	21,541	0	242,859	0.0
FY 25-26 BA14 All Payer Claims Database	234,118	195,701	20,073	0	18,344	0.0
SB 25-084 Parenteral nutrition	109,662	54,831	0	0	54,831	0.0
FY 25-26 BA10 System of care	95,000	47,500	0	0	47,500	0.0
FY 25-26 R14 Change contracts to FTE	82,974	7,869	4,021	35,937	35,147	0.7
FY 24-25 BA9 Adj community access	64,886	28,707	0	0	36,179	0.2
FY 25-26 Step Plan	0	0	0	0	0	0.0
FY 25-26 Salary survey	0	0	0	0	0	0.0
FY 25-26 R7 Eligibility determinations	-8,316,037	-237,034	-165,266	-1,687,943	-6,225,794	0.5
SB 25-290 Safety net stabilization	-5,000,000	0	-5,000,000	0	0	0.0
FY 25-26 BA7 HRSN & reentry services	-3,989,194	-810,485	-236,789	0	-2,941,920	0.0
FY 24-25 R10 3rd party pay for nursing	-3,791,834	-947,958	0	0	-2,843,876	0.0
FY 25-26 R9 Provider rates	-3,789,154	-1,133,482	-762,495	0	-1,893,177	0.0
FY 25-26 R11 OCL benefits	-2,442,608	-1,081,304	0	0	-1,361,304	0.0
FY 24-25 Stabilize case management	-2,156,548	-258,705	0	0	-1,897,843	-2.0
FY 25-26 BA12 Transport true up	-1,659,650	-497,895	-331,930	0	-829,825	0.0
FY 25-26 R10 HAS fee admin & refinance	-990,438	0	-495,219	0	-495,219	0.3
HB 22-1302 Practice transformation	-610,441	-305,221	0	0	-305,220	-2.5
FY 25-26 R13 Contract true up	-340,000	-170,000	0	0	-170,000	0.0
FY 24-25 R9 Access to benefits	-307,039	-153,520	0	0	-153,519	-1.0
SB 25-183 Pregnancy-related services	-286,250	1,476,896	-41,650	0	-1,721,496	0.0
SB 25-308 HRSN & reentry services	-102,460	0	-51,230	0	-51,230	0.0
FY 25-26 Update payment rules	-94,298	-28,289	-6,601	0	-59,408	0.0
FY 24-25 BA7 Transport credentials	-32,317	-9,695	-6,463	0	-16,159	-0.5
HB 25-1328 Direct care workers	-30,036	16,415	0	0	-46,451	0.5

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 25-26 R8 IT administration	-11,446	-1,145	-590	0	-9,711	1.4
FY 25-26 BA17 Personal service reduction	-10,573	-4,586	-701	0	-5,286	0.0
Total	$37,382,050	$15,219,353	-$4,075,326	-$1,652,006	$27,890,029	-2.6

Employee compensation common policies

The request includes a net increase of $8.7 million for employee compensation common policies. A common policy refers to general policies applied consistently to all departments.

Employee compensation common policies

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Health, life, and dental	$4,028,172	$1,064,199	$736,760	$2,227,213	0.0
Salary survey	3,153,644	1,229,899	260,274	1,663,471	0.0
Unfunded liability amortization payments	1,362,879	227,601	400,858	734,420	0.0
Step plan	71,157	26,074	8,287	36,796	0.0
Paid family and medical leave insurance	40,013	10,241	7,382	22,390	0.0
PERA direct distribution	23,966	-15,026	18,419	20,573	0.0
Short-term disability	13,489	1,536	4,937	7,016	0.0
Total	$8,693,320	$2,544,524	$1,436,917	$4,711,879	0.0

Operating common policies

The request includes a net increase of $4.3 million for operating common policies.

Operating common policies

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
Office of Information Technology services	$2,912,252	$827,101	$210,456	$0	$1,874,695	0.0
Legal services	1,949,354	643,287	331,390	0	974,677	0.0
Workers' compensation	136,364	47,238	24,334	-6,781	71,573	0.0
State accounting system (CORE)	133,091	43,921	22,625	0	66,545	0.0
Administrative law judge services	-720,345	-237,715	-122,458	0	-360,172	0.0
Risk management & property	-133,418	-43,003	7,075	-6,646	-90,844	0.0
Total	$4,277,298	$1,280,829	$473,422	-$13,427	$2,536,474	0.0

Impacts driven by other agencies

Impacts driven by other agencies: The request includes a net increase of $1.9 million for requests from other state agencies. These are also called "non-prioritized requests."

Impacts driven by other agencies

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
Human Services programs	5,160,862	2,612,431	-32,000	2,580,431	0.0
NP Eligibility appeals	722,970	234,966	126,519	361,485	0.0
NP7B SB24-205 AI compliance	233,962	76,342	40,639	116,981	1.8

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE
NP7A SB24-205 AI compliance	97,883	32,301	16,640	48,942	0.0
NP Statewide enable AI	49,119	16,209	8,350	24,560	0.0
NP State accounting system (CORE) staff	27,459	9,061	4,669	13,729	0.0
NP IT accessibility	20,000	10,000	0	10,000	0.0
NP Underspent early intervention funds	-4,000,000	-2,000,000	0	-2,000,000	0.0
NP IT efficiencies	-298,178	-98,399	-50,690	-149,089	0.0
NP IT operating offset	-123,742	-40,835	-21,036	-61,871	0.0
Total	$1,890,335	$852,076	$93,091	$945,168	1.8

Future budget reductions

The Governor's budget transmittal letter and executive orders reference some additional budget reductions that were not captured in the Department's November 1 request. The Department explains that these items will be included in January budget amendments.

Cap dental services [legislation]: The Department proposes capping dental services at $3,000 per year for Medicaid adults and $750 per year for Cover All Coloradoans. The later would require legislation to provide different benefits from standard Medicaid.

Current year: The Spending Reduction Letter estimated the adult dental cap would save $250,000 General Fund and the Cover All Coloradoans cap would contain future growth.
Year 1: The budget amendment will include the projected savings for FY 2026-27.

Behavioral health for immigrants [legislation]: For people eligible through Cover All Coloradoans, the Department proposes paying for behavioral health on a fee-for-service basis rather than through managed care.

Current year: The Spending Reduction Letter estimated this will save $75,000 General Fund.
Year 1: The budget amendment will include the projected savings for FY 2026-27.

The change will require legislation to provide different benefits from standard Medicaid. People eligible through Cover All Coloradoans use fewer behavioral health services than the standard Medicaid population. Paying for behavioral health on a fee-for-service basis will avoid managed care administrative costs. At the same time, the Department will not pay a third party to manage the care of the members. Part of the theory behind managed care is that it improves health outcomes.

Additional reductions: The Department plans to submit additional budget reductions in January totaling $124.3 million General Fund. The Governor's budget transmittal letter assumes these savings.

The request mentions that the Department plans to review provider fees for ways to address budget sustainability but provides no further details.

Controlling growth [legislation]: The Department plans to request legislation in January to establish a year-over-year growth rate target for Medicaid General Fund. The Department says the target growth rate should align with growth in the TABOR cap.

Issues Presented

This is a summary of the briefing issues presented to the Joint Budget Committee by their dedicated non-partisan staff.

Forecast overview

Requests R1 through R5 are based on the Department's most recent forecasts of enrollment and expenditures under current law and policy. Combined they drive a $2.8 billion increase in total funds, including a $630.2 million increase in General Fund, in FY 2026-27. This issue brief discusses the major contributors to the increase in the forecast.

Key Medicaid provisions in H.R. 1

This issue brief summarizes the major changes to Medicaid policy in H.R. 1 and the fiscal years when those new policies take effect. It highlights the work requirements for their impact on eligibility and the provider fee phase down for the fiscal impact.

Budget reduction options

The Executive Budget Request includes reductions of $220.2 million General Fund for the Department of Health Care Policy and Financing, representing 4.0 percent of the current General Fund appropriations in this section of the budget. This issue brief reviews these proposals.

For More Information

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To read the entire briefing: Go to https://content.leg.colorado.gov/index.php/content/budget to use the budget document search tool. Select this department's name under Department/Topic, "Briefing" under Type, and select a Start date and End date to show documents released in November and December of 2025.