Colorado Commission on Medicaid

Financing and program integrity

Wednesday, September 2, 2026 · 11:00 a.m. – 5:30 p.m. · LSB A

OPENING

What today has to produce

By the close of the day

- An understanding of the money map, and where flexibility might exist
- What checks apply before and after money goes out the door
- What the statutory trigger is, and what happens in the first thirty days
- A rural framework tested against the books of the people who wrote it
- Your savings lists, with owners and dates

Not today

- Eligibility and enrollment operations — October 7
- County administration and behavioral health — October 7
- Waivers, LTSS, case management — September 17
- The growth-trend analysis — September 17

AGENDA

The day

11:00	**Block A**	Open and orient
11:20	**Block B**	The money, as the Department describes it
12:30	**Block C**	How the state knows the money is spent properly
1:10	**Block D**	Eligibility changes and risks
1:55	**Block E**	The rural framework, and safety nets
3:40	**Block F**	Public comment
4:25	**Block G**	The first recommendation for consideration
5:20	**Block H**	Close

BLOCK B · MEMBER QUESTIONS

Carried from August 27 — asked first, by name

Today	The $450–455M in state directed payments — the figure, how it was budgeted, and the step-down year by year
Today	Where money leaves the Department for another agency by way of a RAE, and what is taken along the way
Today	Which statutes and rules of the past two years raised cost — and when the analysis lands, if not now
Sept 17	Waivers — Office of Community Living and 1115. A full session is being built, not a partial answer
Sept 17	A recommendation on pausing the waiver transition
Later	Pharmacy spend against $201 per prescription — with the managed care organizations on their return date

PUBLIC INPUT

What we have heard

Three channels, on financing and on program integrity

Please continue to share the survey and short form.

1 Office hours

They are on the Medicaid Commission webpage.

Virtual: September 3rd, 4 – 6pm

In-Person: September 10th, 11am – 1pm

2 Stakeholder survey

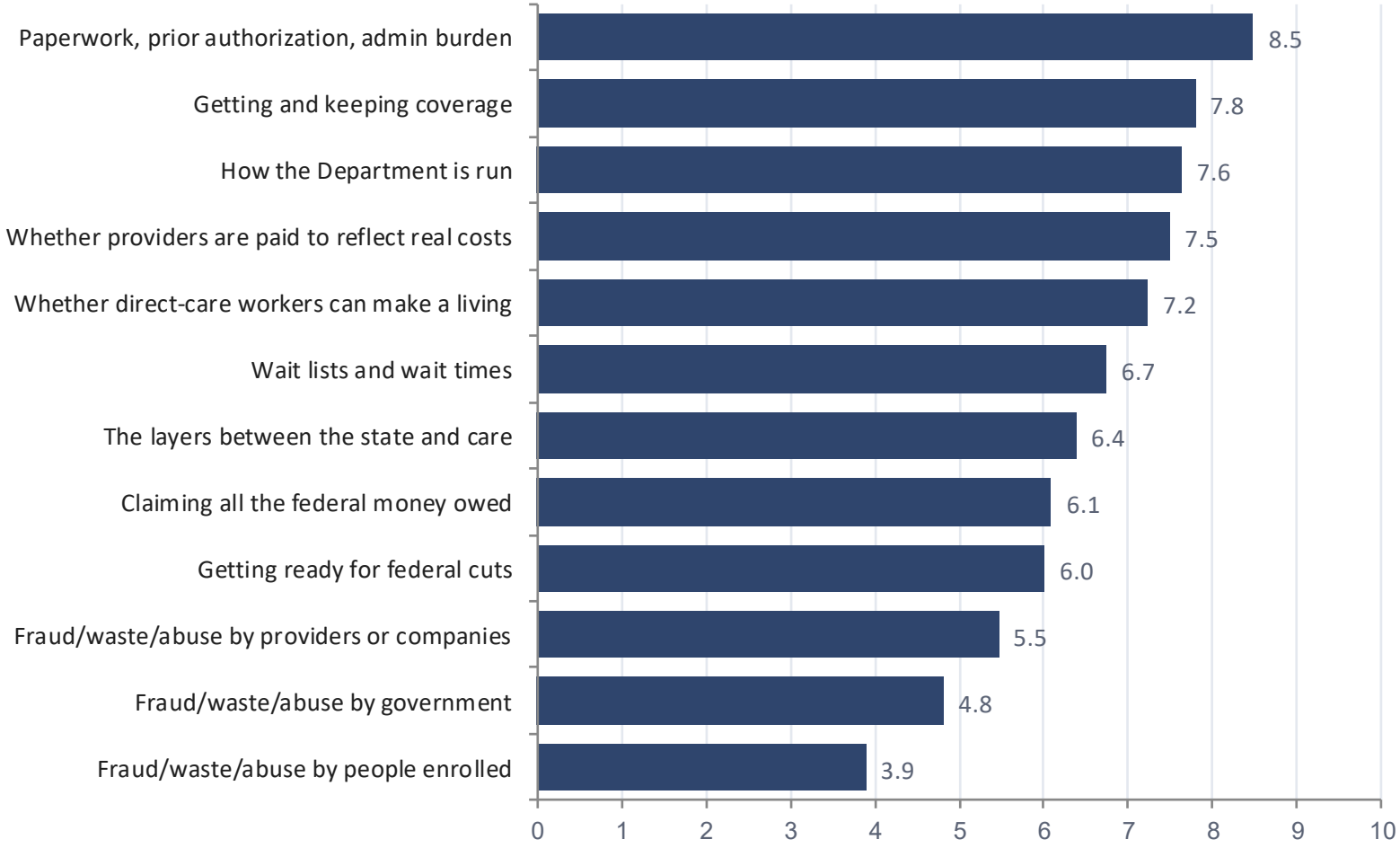
Targeted questions for hospitals, family caregivers, the disability community, and counties.

3 Share your experience

A short form for anyone who wants to tell the Commission what Medicaid has been like for them.

WHAT WE HAVE HEARD

What people want fixed first



For today

Administrative burden ranks first of twelve.

Fraud by people enrolled in Medicaid ranks last of twelve — below fraud by providers, and below fraud by government.

177 respondents ranked twelve options. Higher score = higher priority.

WHAT WE HAVE HEARD

Where to look before cutting care

Four answers came back repeatedly.

Administrative layers

Duplicated positions, conflicting asks from multiple regulators, and entities that take a share of the dollar without delivering a service.

Contracts and overhead

Outside contractors and IT vendors, managed care administrative fees, and pharmacy benefit arrangements — named repeatedly.

Duplication in coordination

A single audit instead of several. One payment path instead of many. Care coordination that is not delivered three times over.

Look outside the program

A recurring answer was that Medicaid has already been squeezed and the savings should be found elsewhere in the budget.

What people call waste

- The most common answer was administrative: money spent looking for fraud that respondents do not believe is there, and paperwork described as a substitute for oversight rather than oversight itself.
- Where fraud was alleged, it was aimed at billing practices in specific service lines — peer support, skills training, some substance use services — not at people enrolled in the program.
- Several respondents question the quality and timeliness of medical loss ratio reporting from managed care organizations, and say the Commission cannot see where those dollars land.
- A repeated complaint about blunt enforcement: when a few providers bill inappropriately, limits are applied to every provider instead.

Two questions from the public

Why can a member see a line-item explanation of benefits from a commercial insurer, but not see what is billed in their name under Medicaid?

The Department has a new fraud, waste and abuse contract. What is it worth, is the contractor paid a share of what it recovers, and who recovers the money?

WHAT WE HAVE HEARD

On rates: it is how the rate is set

78%

say a service, benefit, hour or rate they depend on has been cut or capped

41%

of responding providers have closed or reduced a service line — another 29% are considering it

15–70%

the range providers report spending on administration rather than care

What they say the problem is

- The same code paid at different rates by different regional entities, and below the state rate — with no rate-setting method a provider can see.
- Annual resets that swing budgets, paying today for costs measured two years ago.
- Rural cost structure not reflected: distance, home visits, and mileage limits built for metro practice.

WHAT WE HAVE HEARD

Federal money: mostly “I don’t know” — and four leads

Most survey respondents said they had no specific knowledge. Four concrete leads came back, and each is checkable.

Administrative claiming

Available to school districts but not to local public health agencies. Other states allow it. Local agencies report delivering Medicaid services they never bill for, largely because billing is too complex to set up alone.

Dual eligibility

People in long-term services who also qualify for Medicare but are not identified or enrolled — Medicare being fully federal and generally the first payer.

Local match

County mill levy dollars raised for disability services, historically not claimed for federal match.

A disallowance to verify

A respondent points to a federal audit finding on visit verification and a repayment demand. Unverified here — but the Department can confirm or correct it in a sentence.

WHAT WE HAVE HEARD

What that means for today

Listen for the administrative dollar	The public's first answer on savings and its first answer on waste are the same answer. It is not benefits. It is the cost of running the thing.
Program integrity is not about members	Fraud by people enrolled ranks last of twelve priorities. Where the public points is at billing practices and at what it cannot see in managed care.
The rate is not only the rate	How it is set, how often it moves, and whether it reflects rural cost are raised as often as the number itself. That question belongs to this afternoon's provider blocks.

BLOCK B

Before the money map: two findings from the pre-read

Nobody has answered the question

NCSL could find no analysis anywhere apportioning Colorado's Medicaid growth between policy choices and health care inflation.

The cost-shifting assumption may not hold

A 2020 Colorado analysis found that raising Medicaid rates did not lower commercial rates. Emerging work suggests provider taxes and directed payments may push commercial rates up rather than down.

Block E, and one thing to know

1:55

The rural framework

Independent Rural Advocates

2:35

Urban and rural safety nets

Denver Health · Lincoln Health

3:40 P.M.

Public comment

Forty-five minutes. Before the working session, so the Commission hears from the public before it turns to trade-offs.

4:25 P.M. · MEMBER WORKING SESSION

The question

What did you hear today that this Commission could turn into savings — and what did you hear that sounded like savings but isn't?

3 min	Silent, on your card. Up to three places to look. One line each.
15 min	One round of the table. Each member reads their list. No responses during the round.
25 min	Sort the board together — out loud, as a room.
10 min	Read back what landed, and where we need more data.

4:25 P.M. · MEMBER WORKING SESSION

Sorting the board

We could size this

Real enough to put a number on. Needs a figure, from someone, by a date — and all three get written down.

Heard it, don’t believe it yet

Plausible but untested. It does not go near the December report until somebody checks it.

Not ours, or not savings

Outside the Commission’s scope — or a cost that moves onto families, counties, or the emergency room rather than disappearing.

What September 17 must produce

- The waiver transition proposition — written, on the screen, and counted
- The full waivers session: Office of Community Living and 1115
- The growth-trend analysis, and what tinkering with a given rate would actually do
- The sized items from today’s board, with the numbers attached
- Any carried item still unanswered — with a date on it