

Questions to Consider

Colorado Commission on Medicaid · Wednesday, September 2, 2026 · financing and program integrity

These are offered so that members have something in front of them rather than to prescribe what anyone asks. Nobody is expected to work through the list. Questions carried forward from August 27 are marked and should be asked first so that they are not crowded out again.

The day ends by asking what you heard that could turn into savings, and what sounded like savings but is not. It is worth listening for both while the answers are being given, rather than reconstructing them at 4:25.

Block B · The money map · 11:20

Carried from August 27

- The \$450–455 million in state directed payments: when did the state learn it was coming, was it built into the budget as new money or as balancing, and what does the step-down look like year by year? **[carried]**
- Where does money leave the Department for another state agency by way of a RAE, and what percentage is taken along the way? **[carried]**
- Which statutes and which rules of the past two years have raised the cost of the program or made care harder to obtain – and if the analysis is not ready, when will it be? **[carried]**

On flexibility

- Take the whole program dollar. What share of it can the state change without federal approval, and what share cannot move at all?
- Name the three places with the most genuine flexibility left. What is given up in each if we use it?
- What reduces the CHASE threshold, how fast does it bite, and how quickly does the state stop being able to meet its obligations?
- Which of the cash funds the program relies on are declining year over year, and on what schedule?
- Where has the state already reached the ceiling – intergovernmental transfers, supplemental payments – so that we are not told to look somewhere with nothing left in it?

On what nobody has answered

- The research memo in the packet reports that no analysis exists apportioning this program's growth between Colorado policy choices and health care inflation. What would it take for the Department to produce that, what would it cost, and by when?
- The same memo cites evidence that raising Medicaid rates did not lower commercial rates in Colorado, and that provider taxes and directed payments may push commercial rates up. Does the Department agree with that reading, and what does it change?
- How does the Department know whether a projected saving materialized? Name one policy change where the projection was checked against the outcome.

On federal money – leads from public input

Each of these came from someone outside this building. Each is checkable, and a short answer either way is useful.

- Administrative claiming is available to school districts. Other states extend it to local public health agencies. Why does Colorado not, and what would it be worth?
- Local public health agencies report delivering Medicaid services they never bill for, largely because the billing is too complex to set up alone. What would a shared billing arrangement cost, and what would it draw down?

- 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. How many, and how would we find out?
- County mill levy dollars raised for disability services, historically not claimed for federal match. Is that still the case, and why?
- A respondent points to a federal audit finding on electronic visit verification and a repayment demand. Can the Department confirm or correct that?

Block C • Program integrity • 12:30

Public input ranked fraud by people enrolled in Medicaid last of twelve priorities – below fraud by providers and below fraud by government. The most common answer on waste was administrative: money spent looking for fraud that respondents do not believe is there.

- What is the largest single recovery the integrity function has made in three years, and what did it cost to make?
- Which tool in the integrity toolbox are you not using, and why not?
- 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?
- When a small number of providers bill inappropriately, what stops the response from being a limit applied to every provider?
- What medical loss ratio data does the Department receive from each managed care organization, how current is it, and can this Commission see it?
- Can a member see what has been billed in their name? If not, what would it take – and what would it catch?
- How much does the Department spend on integrity functions in total, across staff and contracts, and what does it recover?
- Where are the gaps? Name a category of spending nobody is currently checking.

Block D • Eligibility changes and risks • 1:10

- If the trigger fires, what happens in the first thirty days? Name the week, who is told, and what stops.
- What decision would the Commission need to make before the trigger fires that it cannot make afterwards?
- Where does the October 1 transition stand today, and what is the most likely thing to go wrong?
- Which federal provisions land in 2027 and which phase in from 2028 – and what does the Commission need to have recommended before each?
- What is the administrative cost of the new eligibility and reporting requirements, to the state and to providers, and is that cost counted anywhere?

Block E • The rural framework • 1:55

To the panel

- Which of your strategies would you apply to Medicaid specifically, and what would it cost the state?
- Which rural services should stop being provided locally, and who tells a community that?
- Where do you disagree with the Department's account of rural financing?
- Your document states that no contributor holds an individual or business incentive. Several contributors have held executive roles at organizations this Commission examines. Where does each of you sit?
- If the Commission could carry only one of your recommendations in December, which one, and what does it save or cost?

Block E · Denver Health and Lincoln Health · 2:35

Both institutions answer the same six questions, in the same order, so that the answers can be laid side by side. The comparison is the point of the block.

- Take a single year. What does the hospital receive across all Medicaid channels – base rates, state directed payments, supplemental payments – and what does it pay in to generate them? What is the net figure?
- Of that net, how much is committed before you allocate any of it – debt covenants, required reserves, matched obligations?
- What does treating a Medicaid patient cost you relative to what you are paid, and how does that gap compare with your commercial and uninsured populations?
- When someone loses coverage and returns three months later, what does that churn cost you, and where does the cost land?
- If the CHASE fee ratchets down as scheduled, what stops first – name the service and the month.
- If supplemental payments were converted to base rate increases at the same total dollars, what would you do differently?

In addition

- To Lincoln Health: what is the smallest change in Medicaid payment that would change a service line decision, and how long before that decision becomes irreversible?
- To Lincoln Health: how far does a patient travel when a service stops being offered locally, and what happens to the ones who do not make the trip?
- To Lincoln Health: what can a hospital your size not do that a system can – in contracting, in billing, in appeals – and what does that gap cost you a year?
- To Lincoln Health: you helped write the report this morning's panel presented. Which of its recommendations would have changed the numbers you have just given us, and by how much?
- To Denver Health: the headline federal impact figure in your materials is an estimate from a national research organization. What is your own estimate?
- To both: give us your payer mix as a percentage. The Commission has that row for nine urban systems and none for a rural hospital.
- To both: name one thing this Commission could stop doing, simplify, or pay for differently that would save money without costing care.

The standing closing question

Asked of every panel, every meeting.

- What would the person you serve say about this?

Block G · The working session · 4:25

The question is what you heard today that this Commission could turn into savings, and what you heard that sounded like savings but is not. Three prompts if the second half is hard to get at:

- Does this saving reduce what the program spends, or does it move the cost onto a family, a county, a hospital, or an emergency room?
- Would we be able to put a number on it by October – and who would have to produce that number?
- Is this ours to recommend, or does it belong to another committee, another agency, or Congress?