Colorado Commission on Medicaid

Stakeholder Input – Combined Summary, July 28 through November 8, 2026

This document brings together four summaries of public and stakeholder input. They report what people told the Commission and do not reflect recommendations put forward by SHG Advisors.

Text in blue is new or updated since the October 6th version. All survey charts have been redrawn with data through November 8.

What is included

Public Input Survey. 1,196 responses in English and Spanish, July 28 to November 8 – the broadest measure of opinion here.

Form to Share Experiences with Medicaid. 76 written submissions, July 28 to October 29 – small and self-selected, best read as detailed testimony.

Community Meetings. Six sessions hosted by Commission members on September 24th, September 28th, October 1st, October 6th, and October 29th, from a handful of participants to nearly a hundred.

Office Hours. About 50 conversations with roughly 70 people over eight days, August 3rd to September 29th.

Some people took part in more than one; each summary counts people once within its own source, and counts are not added across sources.

What runs across all four

Protect home- and community-based services and the family caregivers who make them work. The largest theme in the form and office hours, raised in every community meeting, and the survey's most common answer to what the Commission should address if it could address only one thing. Everywhere the argument was the same: cutting paid hours does not remove the need for care; it moves the cost to families, emergency rooms or more expensive settings. The theme was stronger still among the survey respondents who arrived after October 1st, a group that leaned toward family caregivers and therapy providers.

Getting and keeping coverage is failing now, before the federal changes add to it. Survey respondents ranked eligibility, enrollment and renewals the top problem to fix, and every source described coverage lost over paperwork, late notices, and people with permanent disabilities re-proving them every year. The October 6th community session reported the first losses under the federal changes: about 5,700 to 6,000 lawfully present immigrants and about 275 refugees and asylees receiving long-term services lost coverage on October 1st.

The volume and pace of change is itself a cost. Survey respondents ranked administrative burden second. Community meetings and office hours both heard the count of 116 Department memos in 2025, and asked for input before changes, longer notice and fewer rule changes. Providers in the October 6th session added that no one can invest in a system that keeps changing, citing pilots whose terms changed after they joined.

Look at administration, contractors and intermediaries before members. More than half of survey respondents who said where to find savings pointed to the system side, and those who described fraud

most often attributed it to providers or agencies. Community meetings and office hours asked for audits, a way to remove bad actors, and for the Department and its contractors to share in reductions.

Regional entities create avoidable problems. Community meetings, office hours and the form described members reassigned between regions without notice, refused single case agreements, recoupments years after the fact and separate credentialing for each entity. One of the latter sessions added case management that fragmented (and caused additional confusion) when it moved from the county to the regional entity.

Providers want stability as much as a higher rate. Every source described rates that do not cover costs and a direct-care workforce paid below retail. The most repeated ask was a rate providers can plan against, with selective rather than across-the-board cuts, and rates that keep pace with inflation.

People do not trust the numbers. Participants asked to see how projections are built, for Department data to be published, and for independent review. Survey respondents who deal with eligibility, waivers and case management rated their treatment far lower than those who mainly use coverage.

Colorado Commission on Medicaid

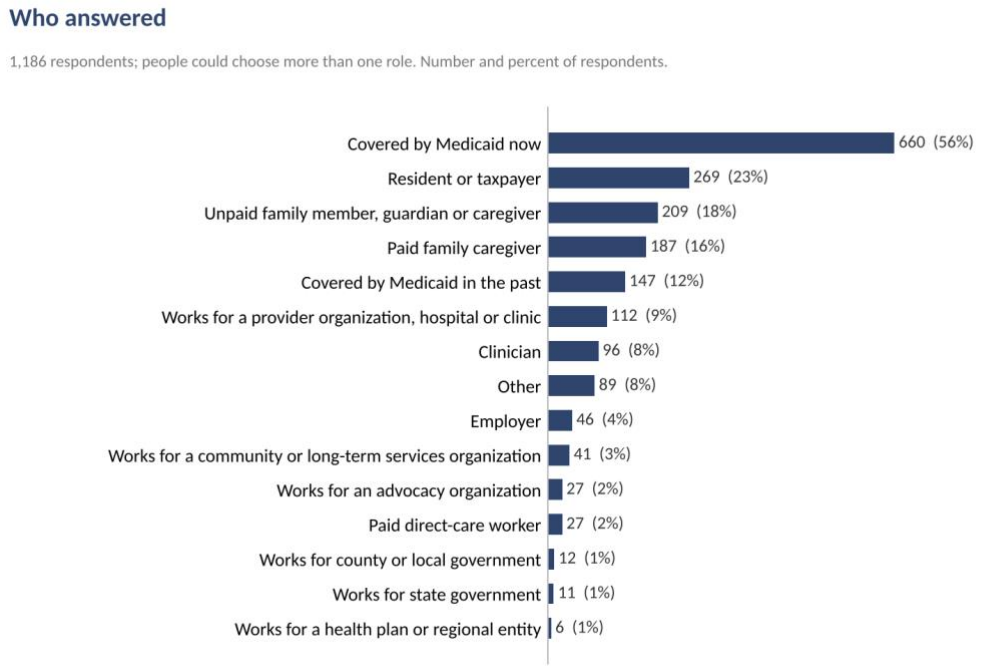
Public Input Survey – Summary of Results through November 8th

This summary includes the English and Spanish responses of the long-form survey that was disseminated throughout the summer. It is important to note that this is a summary of survey responses compiled by SHG Advisors and does not reflect recommendations put forward by SHG Advisors.

What this summary covers

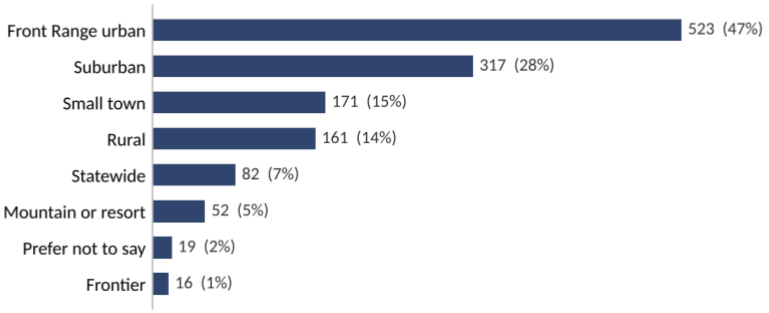
1,196 people responded between July 28th and November 8th: 1,193 in English and 3 in Spanish. The Spanish answers were translated and are counted with the English answers throughout. Every written answer was read and sorted into topics, and the counts below come from tallying those topics across all responses. 146 of the English responses arrived after the October 6th version of this summary. They were coded into the same topics and added to the earlier counts; figures from the multiple-choice questions are recalculated from the full export.

Who answered. Most respondents are people currently covered by Medicaid, followed by residents, family members and paid family caregivers. Nine in ten answered for themselves; 95 answered for an organization, most often a behavioral health practice or a disability, home care or case management agency. The organizations among the new respondents were mostly music therapy and pediatric therapy providers.



Where respondents live or work

1,123 respondents; people could choose more than one. Number and percent of respondents.



What the numbers say

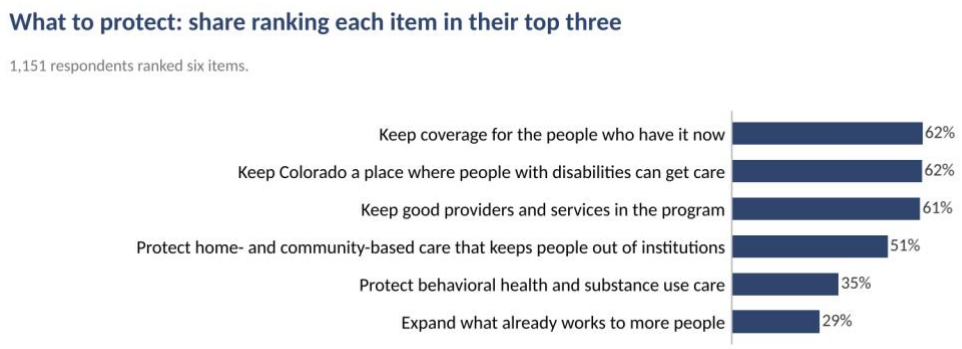
Getting and keeping coverage is the top need to fix. Asked to rank twelve problems, respondents put "getting and keeping coverage – eligibility rules, enrollment and renewals" first by a wide margin: 274 of 1,129 ranked it number one and nearly half put it in their top three. Paperwork, prior authorization and administrative burden came second. Fraud by people enrolled in Medicaid came near the bottom; 265 respondents ranked it last of the twelve.

What to fix: share ranking each item in their top three

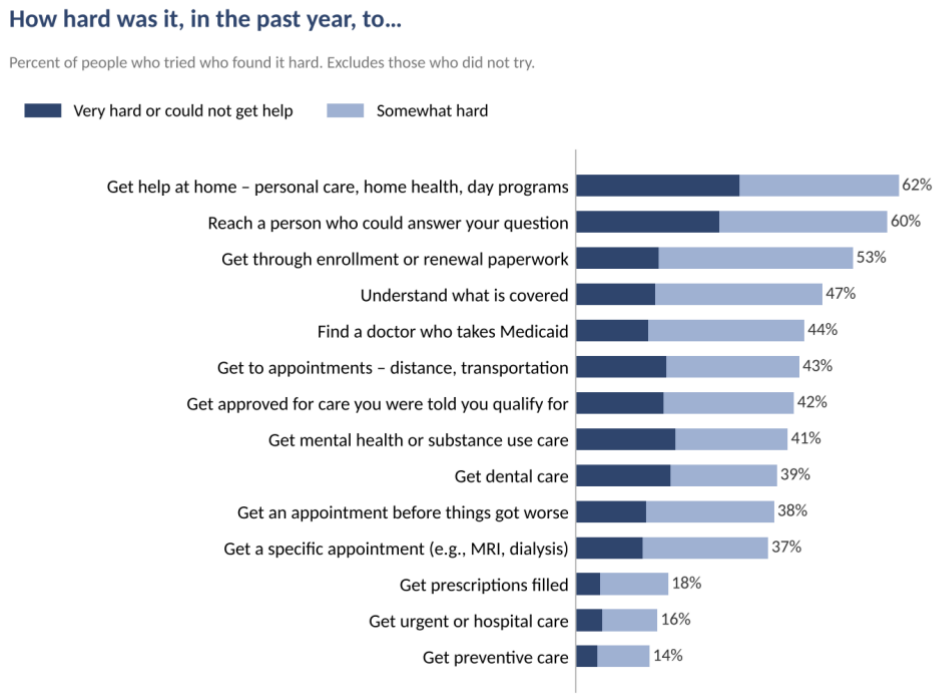
1,129 respondents ranked twelve items.



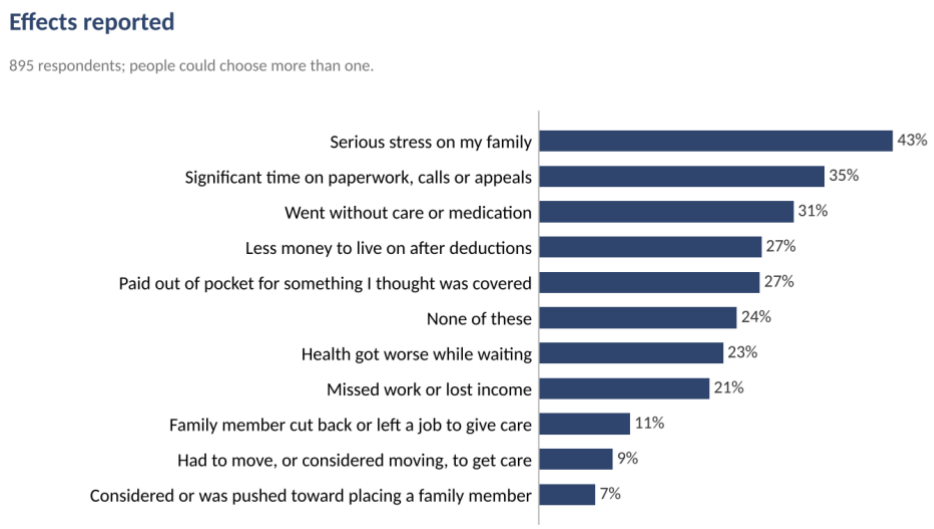
What to protect. Asked to rank six things to protect, respondents put keeping coverage for the people who have it now first (311 of 1,151 ranked it first), with keeping good providers in the program and keeping Colorado a place where people with disabilities can get care close behind.



Where people get stuck. Among people who tried to get each kind of help in the past year, the hardest was help at home (i.e., personal care, home health or day programs) which 62% found hard and 32% very hard or impossible. Next were reaching a person who could answer a question (60% hard), getting through enrollment or renewal paperwork (53%) and understanding what is covered (47%). Finding a doctor who takes Medicaid, getting to appointments, getting approved for care people were told they qualify for, and dental care were each hard for 39% to 44%. Prescriptions, preventive care and urgent or hospital care were hard for fewer than one in five.



Cuts are already being felt. 488 of 1,049 respondents (47%) said a service, benefit, number of approved hours or payment rate they depend on has been cut or capped, and another 333 were not sure. 895 answered the question on effects – most, but not all, describing a cut. The most common effects were serious stress on the family (43%), time on paperwork, calls or appeals (35%) and going without care or medication (31%). 100 said someone in the family cut back or left a job to provide care, and 62 said they considered or were pushed toward placing a family member out of the home.



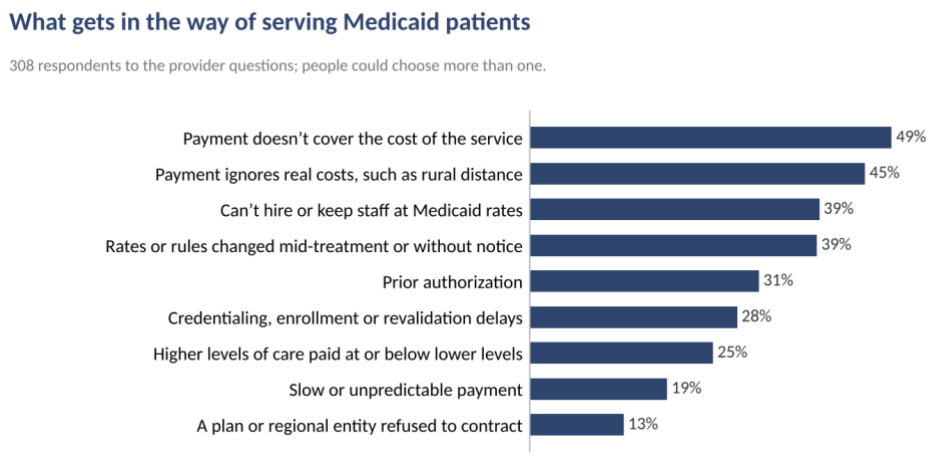
Of the 128 who said whether they were told in advance, 58 said they learned of the change without notice from the program, 21 that notice came too late or was unclear, and 56 that they were told. The newer respondents reported being told more often than the earlier group.

Waiting lists. 348 of 1,022 (34%) are on a waiting list now or have been. The developmental disabilities waiver drew the longest waits: among 19 people who gave a length for that waiver alone, the median was still about ten years, and three got off the list only through a crisis placement. Newer respondents also reported waits of 14 months to three years for the children's extensive support waiver and six months to more than a year to be assigned a case manager. Specialist waits, most often neurology and developmental pediatrics, ran from weeks to several years.

H.R. 1. 561 of 900 (62%) expect the federal changes to affect them, their family or the people they serve.

Treatment. Asked whether the state, a health plan, a county or a case manager had given them straight answers and treated them with respect, on a scale of 0 to 100, the 991 respondents averaged 66 and the median was 70. 173 (17%) scored below 40. Essentially, people whose main experience is having coverage and getting care generally report being treated well. People who have to work through eligibility, renewals, waivers and case management report a much worse experience. That matches "reaching a person who could answer your question" being the second-hardest thing respondents tried to do.

Providers. Of 248 who answered the provider questions, 111 can take all the Medicaid patients who need them, 93 limit how many they take, 11 have stopped and 33 never could. 99 of 289 (34%) have closed, reduced or stopped a service line because of Medicaid payment or rules, and 73 more (25%) are considering it. The barriers chosen most often were payment that does not cover the cost of the service and payment that ignores real costs such as rural distance.



Of 74 providers who estimated how much of their time or money goes to administration rather than care, the median was 30% and the middle half fell between 20 and 50%. Of 153 people who answered whether direct-care work provides a living – workers, family caregivers and agency owners – 81 said no, 55 said only barely or with a second income, and 17 said yes, most of the newer ones only if there are no further cuts.

Federal money. 981 of 1,137 (86%) did not know whether Colorado is missing federal funds; 120 said yes. Only 45 described a specific mechanism, listed under the written themes below.

Fraud, waste and abuse. 174 of 766 said they had seen something they would call fraud, waste or abuse directly and 126 had heard about it. Of the 259 who described what they saw, 128 (49%) attributed it to providers or agencies, 51 (20%) to members or applicants, and 56 (22%) to the state, counties or state policy.

What people wrote

1. What Medicaid makes possible

Asked what Medicaid makes possible when it works (991 substantive answers), the most common answers were access to care at all (40%), financial security and not having to choose between care and rent, food or gas (28%), living at home rather than in an institution (28%) and staying alive or managing a serious condition such as diabetes, MS, cancer, seizures or kidney failure (26%). One in five described what it makes possible for family caregivers – a parent or spouse able to keep working, or paid to provide care at home – and nearly one in five said it lets them work or study themselves; the buy-in for working adults with disabilities was named repeatedly as what makes work possible. About 13% said it keeps them out of the hospital or emergency room, and 68 people tied it to keeping their housing.

Asked what helps most (1,136 substantive answers), people named having coverage at all (24%), home- and community-based services and waivers (22%), prescriptions (17%), specialty and hospital care (15%) and zero copays (13%). Asked what the Commission must protect no matter what (752 answers), the largest groups named people with disabilities (28%), core benefits and access to care (23%), "the most vulnerable" without naming a group (20%), coverage itself (19%), children and families (16%) and home- and community-based services (16%).

Among the newer respondents, home- and community-based services moved ahead of prescriptions as what helps most, and two answers stood out that the earlier summary did not capture. About 20 named paid family caregiving itself – the parent CNA, in-home support services and the self-directed attendant program – as the benefit that helps most, usually because the parent cannot work outside the home. And 42 named music therapy (called movement therapy in the waivers), crediting it with gains in speech, motor skills, regulation and social connection, sometimes as the only therapy a child will engage with; see the note on organized input under section 7. Smaller numbers named the Medicare Savings Program and Medicaid filling Medicare's gaps, and two caregivers said that without home- and community-based services their families would turn to SNAP or TANF instead.

2. The rules people say hurt most

1,025 people named a rule that hurts. The most common was the income and asset limits (178, or 17%): monthly limits people described as far below Colorado living costs, the $2,000 asset limit, and the benefits cliff – people turning down raises, hours or overtime to stay covered, or losing coverage over a small increase. Next, and now nearly as common, were rules governing home- and community-based services and family caregivers (172, 17%), led by the cap on paid family caregiver hours and the post-eligibility treatment of income on the developmental disabilities waiver, along with age-based hour calculations and community connector limits. Then renewals and eligibility processing (135, 13%); benefit limits (128, 12%), mostly the adult dental cap and the lack of adult glasses; H.R. 1 work requirements (109, 11%); and provider rates (104, 10%).

Asked whether a rule is pushing them toward an option they would not otherwise choose (653 substantive answers), the leading answers were the caregiver hour cap (17%), administrative and billing burden (14%), rates pushing providers out of Medicaid (14%) and pressure toward institutional or out-of-home placement (91 people, 14%). The repeated point on the caregiver cap was that capping a parent's paid hours does not produce another caregiver; the care still happens, unpaid, or the parent takes a second job.

Newer respondents added specifics on the rules now arriving: the caregiver hour step-down from 84 hours a week to 70 in January and 56 in July 2027, with exceptions partly approved or taking about two months; a 40-hour weekly soft cap on personal care and proposed seven-hour limits on homemaker and parent-provided personal care, with agencies unsure whether services already authorized still count; a community connector rule limited to "age-appropriate" activities that leaves out children with developmental delays and bars outings involving food; electronic visit verification and clock-in rules that do not fit a parent providing care all day, or caring for two children at once; and an authorization calculator that requires each homemaker task to be approved separately. Several asked that exceptions for needs that will not change be automatic or last longer, so families and case managers are not redoing paperwork, and that the staff cost of running exception processes be netted against the projected savings. Outpatient therapy providers described sharp cuts this spring to physical, occupational and speech therapy codes, and said home health agencies are paid about twice the outpatient rate for the same therapy, drawing therapists out of clinics.

3. Coverage, renewals and the benefits cliff

This is the thread that runs through the most questions. People described renewal documents submitted and lost, being asked again for documents already sent, coverage ended despite on-time paperwork, notices that arrive late or are hard to understand, and long phone holds with no way to reach a person. About 26 asked that people with lifelong or permanent disabilities stop having to re-prove them every year or six months, and about 15 asked the state to use income data it already holds from taxes, wages or SNAP.

Among the recurring stories, 47 people described losing coverage or services, or waiting months, because of paperwork, and 33 described the income cliff. Asked what the state most needs to get right under H.R. 1 (561 answers), the largest groups asked for protection of people with disabilities, older adults and caregivers through exemptions that work (22%), for keeping coverage and funding (21%), said work requirements are unrealistic for them (16%), or asked the state to protect specific services and rates (17%) and to simplify renewals (16%). Several asked that exemptions be identified automatically from data the state already has. Self-employed, gig and seasonal workers asked for a way to show income that fits irregular pay.

Newer respondents asked the state to track how many people lose coverage for procedural reasons and are later reinstated; to offer a simple physician's form for people who cannot work but do not receive disability benefits; to train eligibility workers to accept the same proof of work everywhere; and to give providers several months' notice of changes. They noted that a supported job of ten hours a week falls short of the work threshold and that the vocational rehabilitation waitlist limits help finding work. Members on the buy-in for working adults with disabilities described notices saying they are over income for the Medicare Savings Program, which led them to believe they had lost Medicaid. Oregon's continuous eligibility from birth to age six and 24-month renewals, Washington's and New Mexico's multi-year eligibility for children, and California's gains in automatic renewals were offered as models.

4. Home- and community-based services and family caregivers

If the Commission could address only one thing, the largest group (208 of 1,093, 19%) named home- and community-based services, disability services and caregivers. Specific asks included revisiting the caregiver hour cap, ending post-eligibility treatment of income on the developmental disabilities waiver, shortening the waitlist, and letting children move from the children's extensive support waiver to the developmental disabilities waiver at 18 without a gap. 84 people told a version of the same story: a parent or relative caring around the clock for a child or adult with a disability or complex medical needs, able to keep an income and avoid institutional placement because of waiver services and paid caregiving, and now afraid of the cap and of what happens when they die. Among the newer respondents this group was a third of all answers, almost twice the earlier share, reflecting a cohort that leaned heavily toward family caregivers.

Among paid family caregivers (217 answers), about half said approval, recording and payment work well once set up, and many credited their agency or the self-directed option. The complaints were documentation (18%), slow approvals (12%) and confusing or inconsistent rules (13%). On whether waivers and long-term programs fit together (239 answers), 27% called them confusing or constantly changing, 24% described design gaps that force choices – no respite on the developmental disabilities waiver, services that cannot be combined, transportation caps that force a choice between day program and work – and 25% said they fit together without problems. A minority across several questions said some families are authorized more hours than they need, or that pediatric homemaker and community-based authorizations have grown too fast.

Newer caregivers described approvals that took more than a year with no one telling the parent they could be paid in the meantime, pay held up for 30 to 60 days by renewal delays, and daily electronic charting that doubled documentation time as hours were cut. Families described choosing a waiver for one service at the cost of others – the supported living waiver over the developmental disabilities waiver to get respite, or the complex health waiver over the children's extensive support waiver to protect parent caregiver hours – and

a pending home modification that blocked a waiver change and left a family four months without services. Three reported respite removed entirely, including for children in foster care.

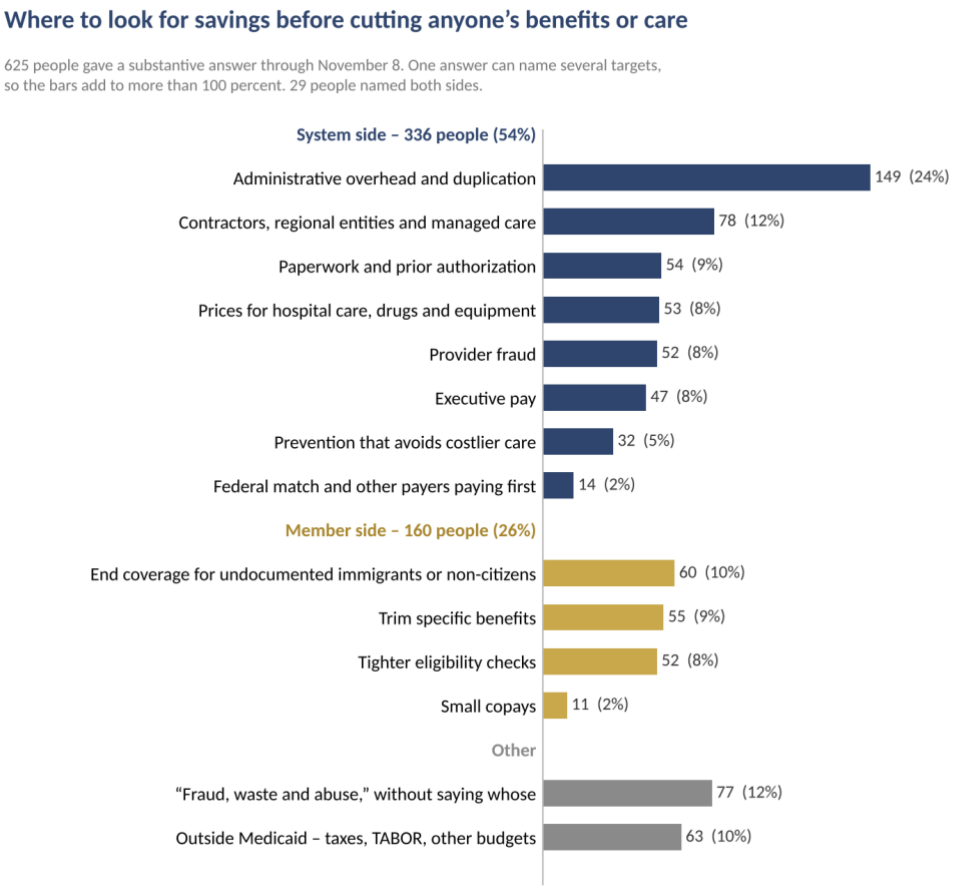
5. Making the agency more efficient

Asked what the state Medicaid agency could do more efficiently (912 answers), people named eligibility and renewal processing (18%), customer service and communication (17%), long-term services and waiver administration (16%), fragmentation across the state, regional entities, behavioral health administrative organizations and case management agencies (11%), management and oversight of the Department (10%) and its IT systems (9%). Specific fixes included confirming receipt of documents and not re-requesting them, more staff on the phones, electronic notices, one point of contact for families with complex needs, finishing rates and rules before rollout, and one credentialing decision honored by every regional entity. Asked what they would change about administration and oversight (154 answers), people most often named how policy is made – stakeholder sessions that do not change anything, and rollouts without pilots (19%) – followed by Department management (17%), reducing administrative layers (14%) and long-term services administration (14%). About 12 asked for stronger accountability for contractors and regional entities, a few of them through oversight independent of the Department.

Newer respondents described case management agencies too overloaded to respond, with plans lapsing and children losing services, and linked turnover to case manager pay of about $23 an hour. Others described several state bodies and regional entities auditing the same provider under different documentation rules; eligibility staff in small counties less trained than those in large ones; counties without read-only access to the state eligibility system; coverage left running for months after a member reported new employer coverage; and therapy providers advising families to drop private insurance so Medicaid pays first. Specific asks included real-time eligibility checks in the provider portal, the disability review date shown in the member portal, a current directory of waiver service providers, and automated billing between Medicare and Medicaid.

6. Where to look for savings

Asked where the state should look for savings before cutting anyone's benefits or care (625 substantive answers), 336 (54%) pointed at the system side (i.e., administration, contractors, providers, prices, prevention or other payers) and 160 (26%) at members, eligibility groups or benefits; 29 named both. The most common single target was administrative overhead and duplication (149, 24%), followed by contractors, regional entities and managed care (78, 12%), paperwork and prior authorization (54), prices paid for hospital care, drugs and equipment (53), provider fraud (52) and executive pay (47). 77 said only "fraud, waste and abuse" without saying whose. On the member side, 60 (10%) would end coverage for undocumented immigrants or non-citizens, 55 named specific benefits to trim, 52 called for tighter eligibility checks and 11 for small copays. 63 looked outside Medicaid altogether, to taxes, TABOR or other budgets.



New suggestions included using the federal compassionate-allowance list to stop re-evaluating people whose conditions will not improve, capping equipment suppliers' margins, drug rebates and biosimilars, and replacing for-profit intermediaries, including private equity – owned home health companies, with public or nonprofit entities. Benefits newly named for trimming included music and equine therapy, respite, homemaker and community connector services, and peer support.

On federal money, the 45 who described a mechanism named classifying non-emergency medical transportation as an administrative rather than a medical cost, which draws a lower match; Medicare-eligible members not enrolled so that Medicaid pays first; county developmental disability mill levy funds never claimed for match; extending Medicaid administrative claiming beyond school districts to local public health; and federal audit recoveries. 12 asked for a public accounting of what Colorado could claim and what it does claim. Newer respondents asked whether funds identified in federal audits of personal care documentation and applied behavior analysis billing are being recovered, and three tied the question to keeping the enhanced federal match on Community First Choice.

7. Providers and the direct-care workforce

Providers said the base rate is too low and the method ignores real costs: no-shows of 20 to 30% in safety-net behavioral health, unpaid documentation and travel time, no acuity tiers, standby capacity for crisis services paid only per client, and regional entities paying different rates for the same service. Two worked examples were offered: a homemaker rate that leaves under $3.50 an hour for all overhead after caregiver

costs, and a rural transportation trip where driver pay and fuel consume nearly the whole payment. Service lines reported closed or cut included aquatic therapy, day programs, peer support, residential and crisis programs, long-term care pharmacy, outpatient substance use groups and a psychiatry program serving about 2,000 patients. Billing, claims and denials were the largest administrative cost, followed by documentation and prior authorization. Direct-care workers said pay is below fast food or retail, travel between homes is unpaid, and many rely on a spouse's income or a second job.

Asked for practices from other states, 32 named one. Minnesota and California were named most (five each, for self-direction including hiring family, California's county-employer home care model, and Minnesota's ban on for-profit Medicaid plans), followed by Ohio (four, including single statewide provider credentialing). Oregon, Washington, New Mexico and Massachusetts were each named once among the newer respondents. Colorado's own self-directed attendant program, the buy-in for working adults with disabilities and the children's early screening benefit were praised as things that work.

Music therapy and other therapies (new since October 6). Music therapy did not appear in the earlier summary. Among the 146 newer respondents, 46 mentioned it somewhere in the survey, families and therapists alike. Providers said music therapy is paid about half the rate of comparable therapies, that rates differ by waiver for the same service, that it was nearly cut by 40 percent, and that therapists have left the field; the largest provider reported a margin of 1 to 2 percent and said any cut would force it to close. A smaller group of about a dozen wrote about massage therapy. These responses arrived in clusters in early and late October, and several music therapy organizations were among the respondents, which suggests outreach through a professional network. They are best read as organized testimony from one service line rather than a measure of how widely the view is held. Outpatient therapy clinics added that physical, occupational and speech therapy rates have had no inflation adjustment in many years. Newly reported closures included a youth mentoring program for foster and at-risk youth that lost its billing code and could not afford the certification and clinical supervision required when it returned, home visits to homebound clients dropped because mileage is not paid, and speech therapy for children over three.

8. Fraud and accountability

Among the 259 who described fraud, waste or abuse, the most common practices were overbilling and upcoding (21%), misrepresenting eligibility (14%, almost all attributed to members), administrative waste (15%, mostly attributed to the state), unnecessary services (14%) and billing for services not delivered (12%). Several said reports they made went unanswered, and across the survey a handful asked that members receive statements of what is billed in their name so they can spot false charges. 19 said they had seen no fraud or that it is overstated, and 26 described their account as secondhand. Newer respondents described, by type, peer outreach billed as hours of service for brief contacts, overcharging for medical rides, home health agencies paying people to enroll, an equipment vendor filling in a clinician's justification for a costly device, therapy hours clocked without care being delivered, and one person serving as guardian, paid caregiver and overseer at once.

9. Contrasting views

A consistent minority wants eligibility narrowed. The largest strand is ending coverage for undocumented immigrants or non-citizens: 60 people in the savings question, 41 in the one-thing question, about 27 in the efficiency question and 15 to 18 in the protect question, with substantial overlap among them. Smaller numbers favored work requirements for adults who can work, a residency waiting period before waiver or caregiver benefits, small copays, more frequent income checks, and limits on specific benefits including

applied behavior analysis hours and gender-affirming care. Newer respondents added drug testing at enrollment, a household income test for paid parent caregivers, charging copays on the buy-in for working adults with disabilities, and limits on pandemic-era parent-provided homemaker and community services. A few respondents asked for the opposite on the same issues. In the efficiency question, about 60 said the agency works well for them or that they see no waste, and several said the Department rather than members is where accountability belongs. Their views are reported in the counts above alongside everyone else's.

Notes on the data

Nothing in this summary is quoted. Written answers were coded into themes by question, with every response read; counts were then computed from the coded data. Accusations against named agencies, providers or individuals are described by type only. The three Spanish-language responses raised the same themes as the English responses, chiefly benefit processing times and keeping people insured.

The 146 newer responses were coded separately and added to the earlier counts, so percentages in the written themes are approximate. The newer group leaned heavily toward family caregivers and therapy providers, which lifts the shares for home- and community-based services. No response was duplicated, but several sets of long, similarly structured answers suggest shared talking points among parent caregivers, and the music therapy responses described in section 7 appear to reflect organized outreach. Figures respondents cited, including federal audit amounts, have not been verified.

Colorado Commission on Medicaid

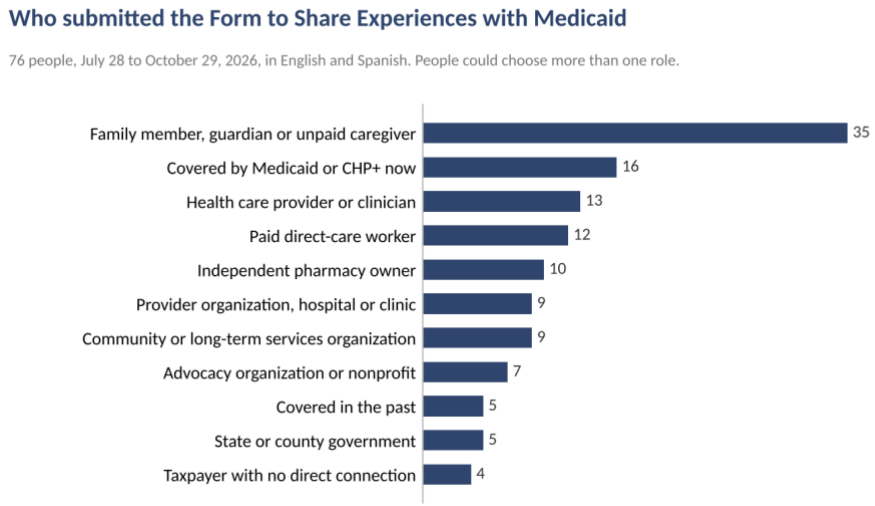
Form to Share Experiences with Medicaid – Summary of Submissions through October 29th

This is a summary of the short form that people completed to share their experience with the Medicaid system. It is important to note that this is a summary of survey responses compiled by SHG Advisors and does not reflect recommendations put forward by SHG Advisors.

What this covers

76 people submitted the form between July 28th and October 29th, 2026, 74 in English and 2 in Spanish. Nine of them arrived after the October 6 version of this summary. The form is separate from the public input survey. It asks three open questions: (1) what to change, (2) what is working and should be protected, and, (3) anything else – along with who the person represents, where they are and which part of Medicaid their input concerns. This is a small, self-selected group, so the results read best as detailed testimony rather than a measure of opinion.

Who submitted. People could choose more than one role. 62 wrote for themselves and 11 for an organization:



What they wrote about. Long-term services and supports was the most common topic (42 of 76), followed by services for people with intellectual and developmental disabilities (33), physical health care (32), payment rates and claims (28), behavioral health (27), eligibility and renewals (24), how the state agency operates (21) and children with complex needs (18).

What people wrote

1. Home- and community-based services and family caregivers

This is the largest theme: 30 of 67 people (45 percent) wrote about long-term services, disability waivers or family caregiving, and 14 wrote specifically about paid family caregivers. Their central point was that reducing paid hours does not reduce the need for care. Nine argued that cuts move the cost to families,

emergency rooms and institutions rather than saving it, and several described leaving careers or professional licenses to provide round-the-clock care for a child or adult child.

On the family caregiver hour cap, respondents asked the Commission to revisit it and, if it stays, to make the exception process work: decisions based on individual medical need rather than proof that no other caregiver can be hired, a clear appeal that family caregivers can take part in, an independent review and a written reason for any denial. Two said providers are reluctant to submit exception requests even when the clinical documentation is strong. Respondents asked the Department to report exception requests, approvals, denials and decision times, and to report approved private duty nursing hours against hours actually staffed. One advocacy organization offered a modeling approach: using the Department's own cost difference between home and institutional care, it estimated that about 33 failed family caregiving arrangements statewide would erase the projected savings from the cap, and it asked that this kind of modeling be done before the next phase takes effect on January 1, 2027.

Six described problems with waiver design: children's waiver services reduced and requests routinely denied; post-eligibility treatment of income on the developmental disabilities waiver; a single room-and-board allowance regardless of support level or the utility costs of life-sustaining equipment; services split across waivers so that equipment and home modifications are unavailable on the developmental disabilities waiver; family caregivers unable to be paid during a hospital stay on one waiver but able to on another; and gaps when a young person moves from a children's to an adult waiver. Three wrote about aging caregivers – parents in their seventies who have provided care for decades, some running their own small provider agency to serve one adult child – and asked what happens when they can no longer do it.

Seven wrote about case management: not enough caseworkers, so approved people wait to be assigned; assessments done remotely that miss what an in-person visit would catch; county case managers carrying too many cases and leaving the field; and coverage lost because an outsourced agency mishandled renewals. One asked that case managers, who say they cannot comment publicly, be heard directly.

What to protect: the ability of families to be paid caregivers, the consumer-directed and supported living programs, homemaker and respite services, the buy-in for working adults with disabilities, virtual visits for people who are bed-bound, and separate nursing and aide rates for in-home care.

New since October 6th: A parent of an adult on the developmental disabilities waiver with the highest support level, now living in a host home, asked the Commission to stop any move toward paying family caregivers and host homes a group rate when more than one person is served in the home. Using a host home daily rate of about $300 for a high-support client, roughly $25 an hour for round-the-clock care that often needs two staff, the parent said a lower rate would close host homes with no alternative behind them. The same parent described private duty nursing approved for 23 hours a day of which the agency could staff only about half the shifts, opposed the proposed blended nursing and aide rate on the grounds that a nurse is assessing the patient even during aide-level tasks, and asked that adult family caregiver programs be protected because families are filling a gap no provider can.

2. Independent pharmacies

All 10 pharmacy owners asked the Commission to change how Medicaid defines a rural pharmacy for the purpose of the dispensing fee. Seven asked that the 20-mile distance to the next pharmacy be cut to 10 miles; three asked that mileage be replaced with a population-based measure or federal shortage designations. All 10 asked that service to a health professional shortage area count. They said 20 miles can

be 30 to 50 minutes in the mountains or in winter, that one pharmacy lost its higher fee because its volume rose after a nearby chain store closed, and that one owner decided not to open in a heavily Medicaid town because of the rule. Nine asked the Commission to protect cost-based reimbursement – acquisition cost plus a dispensing fee – and two pharmacists asked that the acquisition cost benchmark be updated more often so payments keep up with prices. One owner reported a day on which the store paid about $7,800 for the drugs it dispensed and cleared about $230 before any operating expense.

3. Behavioral health

11 wrote about behavioral health, most of them providers. Five criticized the regional entities: care that varies by region, closed networks that keep state-enrolled providers from seeing members – which respondents said falls short of parity with physical health – and one regional entity said to pay about 30 percent less than others. Two asked for a single statewide behavioral health system. Others asked to restore enhanced rates for essential safety net providers, raise rates for private practices, keep outpatient behavioral health free of prior authorization, end prior authorization for people on the supported living waiver or with serious mental illness, and lift the cap on peer support in substance use treatment. Providers also described supervision and authorization rules changing several times a year. In contrast, one rural respondent asked that managed care for behavioral health be protected. A new submission did the same for its regional entity, crediting it with referrals to specialists and equipment suppliers and with finding resources. Another, from the guardian of a sibling with serious mental illness living in a nursing facility, said Medicaid is what keeps her sister housed and alive, and described a behavioral health provider serving nursing facility residents that drops people after a missed appointment, will not speak with families and does not coordinate care.

4. Coverage, renewals and enrollment

12 wrote about getting and keeping coverage. Their points echo the survey: people with lifelong disabilities re-proving them every year, notices arriving after their due date, a loss-of-benefits letter that proved wrong, no way to check the status of a buy-in application, and coverage that drops and is later reinstated. One asked for a longer grace period, and one asked for a simpler process for people with brain disorders. One parent, writing in Spanish, said they fear their daughter will lose coverage while she is still in treatment for a heart condition.

One advocacy organization raised the replacement of the eligibility system. It said decisions are being made largely within the system team, outside the Department's control, that the timing overlaps with the January 2027 federal changes, and that the role of the philanthropic funders is unclear. It asked for legislative oversight and for the new system to be designed with members.

New since October 6th: A parent asked the state to stop requiring a six-month form from people it has already found exempt from the H.R. 1 work requirements, since a missed form ends both Medicaid and waiver services. A state employee asked that professionals working with members be able to see application status, approvals and denials directly. A family member described the renewal phone line as nearly impossible to get through, especially for people without a computer. A Spanish-language submission asked for interpreters so people get better care, and named medications and appointments as what is working.

5. How the agency operates

13 wrote about agency operations and accountability. Points included new initiatives launched without lasting funding, frequent rule changes, many vendors doing overlapping work on the federal changes, contracts that are not published, rural health grants awarded with little input from the advisory council, and slow or limited communication. One asked for a public list of who manages each program, and one asked the Commission to pause pending changes until the system can absorb them. One praised the Department's openness and transparency.

New since October 6th: Two submissions said the Department asks for input through webinars, surveys and rules hearings and then proceeds as planned, citing the private duty nursing assessment contract, which families say they warned would fail. One proposed that the Department publish all community input with its reasons for accepting or rejecting it, or that an independent group review input and the Department's response. One asked that the Department be required to widen who it invites to the table. A former state procurement employee, responding to the October 7 discussion of replacing IT systems, urged licensing systems that already work in other states rather than custom builds, and questioned how many overlapping databases the state maintains. A family member asked that the state evaluate whether nursing facilities deliver the therapy, activity and behavioral health services Medicaid pays for, and compare executive pay with what residents receive.

Four attributed fraud or misuse to providers and agencies rather than members – excessive therapy hours, agencies that inflated or cut hours, and out-of-state providers that arrive to bill Medicaid – and asked for audits and recovery of funds into home- and community-based services. Two asked for public reporting of fraud findings, recoveries, contractor payments and how recovered money is used. No respondent attributed fraud to members. Two described concerns about retaliation after families complained or appealed, and asked for independent review of adverse actions and a way to escalate outside the case management agency.

6. Provider rates, rural access and transportation

Nine wrote about provider rates and access outside pharmacy: low rates driving closures, provider directories that list doctors and dentists not accepting new Medicaid patients, no incentives for pediatric or specialty care in rural areas, care coordination available mainly in cities, limited broadband for telehealth, and claims systems that do not apply state policy correctly. One provider organization said Colorado now pays among the lowest rates relative to Medicare. A rural organization said primary care requirements have grown faster than funding and asked why a Western Slope payment model it described as saving money is not available elsewhere. Six wrote about transportation, mostly rural and Western Slope gaps; one suggested redirecting some ride spending to public transit. One provider organization asked that family planning and abortion services be protected.

7. Contrasting views

A few respondents asked for tighter rules: two – both strong supporters of long-term services – suggested a residency requirement for waiver services to discourage people moving to Colorado for them, one asked for drug testing at enrollment, one asked that funding for non-citizens be cut first, and one suggested considering wealth in the buy-in program and applying any rate cuts only to new enrollees. Four asked the state to stop cuts and raise revenue, including through changes to TABOR. One new submission asked that Medicaid be limited to U.S. citizens.

Colorado Commission on Medicaid

Community Meetings Summary (September 24th, September 28th, October 1st, October 6th, and October 29th sessions)

This is a summary of the community meetings held to date through October 29th, 2026. Input is reported by theme and paraphrased. No participant or organization is identified. Where a point came up in more than one session, I have said how many, because repetition across unconnected rooms is the closest thing we have to a signal of weight. It is important to note that this is a summary of survey responses compiled by SHG Advisors and does not reflect recommendations put forward by SHG Advisors.

What this covers

Six Commission members have now hosted community meetings: Representative Brown (virtual session), Senator Frizell (hybrid meeting – mostly in person), Senator Amabile (virtual), Representative Gilchrist (virtual), Senator Mullica (October 6th) and Representative Taggart (in person in Grand Junction, October 29th).

The four sessions drew different mixes of participants, from small invited groups to an open public session. Sessions ranged from a handful of participants to nearly a hundred. Together they included Medicaid provider organizations (community health centers, hospitals, home care, disability, case management and community behavioral health agencies), advocates, county human services staff, people with disabilities, parents and family caregivers of children and adults with disabilities, and peer support and recovery providers. One participant attended two sessions; their points are counted once.

Two things stood out. First, the Community First Choice discussion at the September 17 meeting reached these rooms quickly and was raised unprompted in two of the four sessions, by people on both sides of it. Second, for the first time, providers volunteered reductions in their own sector. In the in-person session several agencies said plainly that some Community First Choice authorizations are excessive and should come down. One behavioral health participant said that if cuts must be made, people in long-term services should be protected ahead of behavioral health, which has other funding avenues – though another provider in the same room said those avenues are scarce, with one small grant in two years of weekly applications.

The two later sessions added different rooms. Senator Mullica's drew county human services, disability and immigrant rights advocates, health centers, a hospital and a pediatric practice, and was the first to report H.R. 1 coverage losses already under way. Representative Taggart's was mostly parents of children and adults on waivers and long-term services agencies, with a broker, a hospital staff member, a primary care provider, a transportation advocate and one Health First Colorado member; the chief executive of the region's accountable entity attended and spoke briefly, and no Department staff attended. It added a Western Slope view: case management and care coordination moving from the county to the regional entity, the UnitedHealthcare acquisition of Rocky Mountain Health Plans, and rural transportation. Adults in the expansion population and behavioral health providers remained thinly represented across the series.

The themes

1. Community living is what works, and family caregivers are holding it up (noted in five of six sessions)

Every room named home and community-based services as what Colorado does best and what most needs protecting: people with disabilities living at home or in the community, with choice and dignity of risk. The argument was made on cost as well as values. Colorado has no institutions to fall back on, the alternatives that exist have long waits and cost the state more, and when a family caregiving arrangement fails the cost moves to a more expensive setting. Family caregivers were described as a workforce that cannot be replaced – agencies in two sessions said they cannot staff personal care hours at current rates, and families in the evening said no one is coming. The aging caregiver problem came up in three of the four: parents in their sixties, seventies and eighties caring for adult children, with no plan for when they cannot. A parent asked that the supports that let people with disabilities work – a job coach, for example – be protected as work requirements arrive, noting a nine-year wait for the waiver her son needs. One participant asked the Commission to count both sides of the ledger – what the services cost, and what the state loses in wages, jobs and tax revenue when caregivers leave work or services end.

In one community, parents of children on the children's habilitation residential waiver, the children's extensive support waiver and Community First Choice described community connector, mentorship, respite and therapy hours as what keeps their families intact; for one adoptive parent, mentorship hours are currently her expelled daughter's only education. A counselor who specializes in prenatal alcohol and drug exposure argued that a few hours of these services keep children out of residential treatment, inpatient care, emergency departments and juvenile justice, and asked above all that Colorado keep determining developmental disability on adaptive functioning as well as IQ. A parent who formerly worked in adult services said homemaking, mentorship and supported living keep adults without family support independent and healthy, and that cutting them would cost more within five years; she asked that early intervention be protected too. A caregiver who left a well-paid career to provide care made the same tax-base point raised earlier.

2. Community First Choice is both the most defended and the most criticized program – three sessions

Families on the supported living services waiver and the developmental disabilities waitlist described Community First Choice as the first time personal care and homemaker services were available to them, and said a pause would be a crisis. Several families said they were moved into it after private duty nursing or nurse aide hours were denied, and now fear losing it too. At the same time, providers said the authorization calculator has produced hours no one could use, that services are layered across the waiver, the state plan and nursing with no one able to see a person's total spend, and that the growth needs to be understood by population before anything else is done. One provider asked that any reduction be made once rather than stepped down in stages. One participant noted that the program is federally governed and cannot simply be paused.

The proposals converge more than the positions do. Participants in two sessions independently proposed assessing acuity at entry and tying it to an individual budget, with the family choosing services within it. Others asked that any reduction protect people already relying on services for health and safety, aging caregivers and people who waited years on the waitlist, and look first at new authorizations. The October 6th session proposed the same idea in broader form – a global budget for long-term services within which people choose, modeled on the self-directed attendant program. In Grand Junction, a parent of a son on the complex care waiver said she could accept some reduction if needed, while a provider agency proposed

reasonable caps on personal care hours in place of a waitlist, citing a family whose hours rose from about six to almost sixty a week after the new assessment tool was introduced.

3. Eligibility and redetermination are failing now, before H.R. 1 adds to them (noted in all six sessions)

Providers and families described people losing coverage for paperwork reasons: forms submitted and lost, denials issued before the review period ends, notices never received, and providers learning sixty days later that they cannot bill. For waiver members, functional and financial eligibility run on different dates, so people face two chances a year to fall off, and the systems involved do not talk to each other. One provider said its write-offs for uncovered care tripled in 2025 and that it now employs full-time benefits specialists to get people back on. Losing federal disability income was described as suspending Medicaid for people whose disability has not changed.

Worry was expressed about adding work requirements and more frequent renewals to this system; about how adults who are disabled but not certified as disabled will prove medical frailty, and who pays for the documentation; and about notices already arriving – a family caregiver of an adult on the developmental disabilities waiver had received a work requirement notice and did not know how to respond. Confusion about the caregiver hour limit (whether it applies to the caregiver or the member) and about post-eligibility treatment of income also surfaced. Meeting participants raised the benefit cliff: clients turning down work or extra hours because a dollar more in income ends their coverage, and providers left choosing between serving them free or not at all. They proposed a step-down in benefits instead.

One community reported that the federal changes have begun to bite. County human services said SNAP enrollment fell almost 6 percent after the federal changes and expects the same in Medicaid as refugee and asylee eligibility ends and work requirements start in January; to protect eligibility staff, the county cut elsewhere in the department. Disability advocates said about 275 refugees and asylees receiving long-term services lost them on October 1, some of them in institutions. An immigrant rights coalition put the number of lawfully present immigrants who lost Medicaid on October 1 at about 5,700 to 6,000, and said fear of federal data sharing with immigration authorities is keeping eligible families away. Providers expect most people who lose Medicaid to become uninsured rather than leave care; one health center said nearly three-quarters of its patients who lost Medicaid after the pandemic became uninsured. Participants asked for investment in county eligibility technology so redeterminations do not create backlogs, and for a basic health plan for people who lose Medicaid.

In another community, a broker said Connect for Health Colorado requires people with incomes near the Medicaid range to apply for Health First Colorado and be denied before buying an exchange plan, and asked that the administrative cost be measured; she also described a family at the top of CHP+ eligibility unable to buy subsidized coverage for their children alongside their own, and asked that the CHP+ income limit be reviewed. A hospital staff member said case management is asking families of incapacitated patients to file long-term care applications themselves because it is faster.

4. The administrative load is too heavy, and it changes too fast (noted in all six sessions)

The figure that landed hardest: one case management agency counted 116 operational memos in 2025, 65 of them affecting case management, on top of rules, waiver amendments and job aids, each requiring retraining. Providers said eight case management agencies interpret the same rules eight ways, and that asking two state agencies the same question produces different answers. A hospital participant said state-specific quality measures consume staff time proving care is good rather than delivering it. Several

participants called the Class B license requirement for non-medical personal care a medical model applied to community care; group home operators said their regulations do not fit their residents. Participants asked repeatedly for a slower pace, for public input before a change rather than after, and for 60 to 90 days' notice before a cut takes effect. Thirty days was described as not enough time to find another arrangement. Behavioral health providers added audits: one small practice spent two weeks producing thirty full client files, then was asked for more after the reviewer's own error and told it now faced closer scrutiny. A consultant said several agencies are laying off staff because they cannot sustain the administrative cost of being a Medicaid provider.

The later sessions added duplication. In Grand Junction, a parent counted four case managers for one child – for the waiver, for family support services, for the region and one overseeing the rest – all asking the same questions; a provider agency said providers inspect caregivers' homes and the state inspects them again, with no evidence the second inspection adds safety, and proposed leaving that oversight with CDPHE; and a broker proposed analyzing overlap among the children's waivers and consolidating them into one children's waiver that keeps the covered conditions. The October 6th session proposed an executive order requiring departments to align and to cut regulations that go beyond federal requirements, modeled on one from the Hickenlooper administration, and a simpler system for members to use.

5. Oversight is weakest where it would do the most good (noted in four of six sessions)

Participants were emphatic that fraud should be pursued and that members should not pay for it. Providers described agencies that pass a check through to family caregivers with no documentation or keep a large share of the rate, drawing business away from agencies that follow the rules, with no practical way for a case management agency or the Department to remove them. Surveys were described as late, inconsistent and focused on process rather than outcomes. Private equity entry into home care came up in two sessions, with a proposal for a reasonableness standard on administrative costs by provider type. Misclassifying caregivers as contractors was raised as both a worker protection issue and lost payroll tax. Families asked for rate transparency: the rate shown in the service plan, and a way to see what is billed on their behalf. Participants in three sessions said fraud they reported went unaddressed, and participants in two asked that enforcement not paint ethical providers with the same brush.

Peer support drew the sharpest version of this. Peer providers and people who use peer services said peer support saves lives and that they want bad actors removed, but that the state gave little guidance on what peers may bill, that fraud reported years ago went unaddressed, and that nearly all peer services bill under one code, so no one can see what is happening in recovery housing, hospitals, justice settings or harm reduction. Their recommendation was to break out the codes rather than cut the service.

6. Participants do not trust the numbers – two sessions

Participants asked that the Department show how it reached its projections, that someone independent review them alongside the Commission, that the state auditor examine large contracts, and that an independent ombuds office handle member complaints. Several asked whether the Department and its contractors will take reductions alongside providers. Families in the evening said that "no decisions have been made" is not believed, that the term "high utilizer" implies their children take more than their share, and that a recent survey felt like being asked to rank their own cuts. They asked for families and people with disabilities to have a seat where decisions are made.

7. Provider stability matters as much as the rate – all six sessions

Providers described successive rate cuts, rates that do not cover overhead (electronic visit verification, workers' compensation, nursing staff, minimum wage increases), pediatric therapy cuts of 8 to 24 percent backdated to April with a further coding change coming in January, and clinics closing. A safety-net clinic warned that year-by-year squeezing is destabilizing the parts of the system that produce savings over time – primary care, behavioral health, adult dental – and that people who lose coverage still use care, only somewhere more expensive. Shared savings models were described as rewarding only year-over-year improvement, which leaves high performers nothing to earn. One participant proposed that any rate reduction be absorbed by agencies rather than passed on to family caregivers, and be paired with a minimum share of the rate going to wages.

In one session, small and safety-net providers called the cuts existential. A pediatric practice said it was not exempted from the 2 percent across-the-board cut and that its average Medicaid payment per visit is down about half from a year ago, with behavioral health visits down about 30 percent; two nonprofit pediatric practices have asked it to take over their operations. A hospital said hospitals receive a much smaller share of Colorado's Medicaid spending than the national average and that the uninsured rate doubled after post-pandemic disenrollment. In Grand Junction, home health, assisted living and transportation agencies said reimbursement is falling while food, utilities, fuel and insurance rise, and one participant thanked the Joint Budget Committee for analyzing the program rather than cutting across the board.

No one can invest in a system that keeps changing. That was one community's shorthand, backed by detailed examples of providers joining a Department initiative in good faith and then seeing the terms change. One health center joined a primary care capitation pilot; a year and a half in, the Department moved the rate method back to billable visits and the center laid off 11 percent of its staff. Shared savings for labor and delivery rewarded only improvement on a provider's own past performance, so a top performer could earn nothing – the same point raised in an earlier session. The pediatric practice described the same experience with the access stabilization fund and with integrated care billing codes that did not support the model it had been trained on. Participants asked the state to borrow what works elsewhere and to abandon pilots quickly when they fail, citing non-emergency transportation as a problem left running for years.

8. Regional accountable entities: duplicated coordination and inconsistent administration (noted in four sessions)

Home and community-based providers said they rarely see regional entity care coordination for the people they serve, while carrying their own nurses inside their rate. A behavioral health provider said that in nine years of contacting primary care providers as required, she has never had a call back, and that a regional care coordination line accepts calls only from members, not from providers acting for them. Participants suggested matching coordination intensity to complexity rather than paying for it across the board.

Meeting participants described administrative problems that fall on members as well as providers. Practices lost regional contracts without cause, and because the entity would not offer single case agreements, seventeen clients at one agency had to be told on a single day that their treatment there was ending. Members were reassigned between regions without their knowledge, which providers discovered only when claims were denied and which cut payment by about 20 dollars per client. One entity was described as recouping payments back to 2021 for other coverage it discovered years later, past the point where the practice could bill the other payer; participants understood a 2023 law limiting recoupment to one year to

carry an exception for this. Another practice described a year of denied claims, about $24,000, after the Department confirmed its contract was in order. Experiences differed by entity – a practice with no problems at one entity had serious problems at another. Separate credentialing for each entity came up here and in the evening chat, as it did in office hours.

The proposals: one credentialing process and portal across all regions; fewer regional entities to reduce duplicated administration; reporting on how much of what the for-profit entities receive is spent on care; single case agreements for members mid-treatment; and no recoupment beyond the window in which a provider can still bill the other payer.

In one community, agencies and families described case management under the county as collaborative and under the regional entity as hard to reach; one agency said it now spends more time trying to reach a case manager and chasing electronic visit verification billing than providing care, and that care quality depends on which case manager a person gets. Furthermore, there is confusion about various identification numbers that cause failed lookups, and the regional entity's formulary and prior authorization path were described as harder to follow than the Department's. The one member who spoke said she has received many care coordination letters and calls, followed up, and never had a call returned. Participants asked the Commission to evaluate what went wrong.

9. Community behavioral health depends on small practices (noted in one session)

Small community practices said they are reaching children and teenagers others cannot – including through schools, where nearly every child they serve is on Medicaid – and are seeing real progress in trauma treatment. They described children arriving after a year or more on hospital-based waitlists for assessments billed at about $3,200 each, and asked why routine assessments are not moved to community practices that could see the child sooner. They are concerned that a push toward integrated care in large organizations will shut them out, when those organizations carry the longest waits.

10. Rural transportation is a barrier to care (noted in two sessions)

In Grand Junction, participants said non-emergency transportation has become unreliable, that people pay up to 100 dollars for a one-way ride, that some skip care because they fear they cannot get home, and that paratransit eligibility is limited by area. A participant said Medicaid in Denver could provide a monthly bus pass, which costs less than a private ride and gets people to work. An agency said it could not enroll as a transportation provider because the state reviewer did not account for its rural location. Representative Taggart said a local transportation provider has not been removed from Medicaid but disputes its rate, and that a solution is being sought. The October 6th session cited non-emergency transportation as the example of a problem left running for years.

11. What participants want protected

Participants named value-based primary care, which a primary care provider said should be spread statewide because it lowers total cost of care; dental, including for older adults; choice of provider agency, especially for people with complex needs where providers are few; the eligibility process for children with neurodevelopmental disabilities; and Health First Colorado itself – the member who spoke described her access to quality care across the state as excellent. The October 6th session asked for a few shared goals for the whole system with each sector owning its part, a primary care pool to which every payer contributes per member with one simple set of measures, and Colorado's large health foundations as funding partners.

Recommendations, as participants put them

Grouped and lightly edited toward the form the report needs: who acts and what they do. None has been costed or checked for legal authority.

1. Align functional and financial eligibility dates for waiver members, and do not issue a denial before the review period closes.
2. Give members at least 60 to 90 days' notice before a benefit reduction takes effect.
3. Tie Community First Choice authorizations to an acuity assessment at entry and an individual budget with family choice; review growth by population before any pause; protect people already relying on services for health and safety. A global budget for long-term services, modeled on the self-directed attendant program, was proposed again on October 6th.
4. Remove the Class B license requirement for non-medical personal care, and write a regulatory subset for group homes that fits their residents.
5. Consolidate oversight of home and community-based services in one entity with a single interpretation of the rules, and move surveys toward outcomes.
6. Create a practical route to remove bad-actor providers; show rates in service plans and let members see what is billed for them; set a reasonableness standard for administrative costs by provider type.
7. Break peer support into distinct billing codes, issue clear guidance on what may be billed, and act on fraud reports.
8. Use national quality measures in place of state-specific ones, and let shared savings reward high performance, not only improvement. Raised again on October 6th.
9. Require the Department to show its math on projections with independent review; ask the state auditor to examine large contracts; create an independent member ombuds office.
10. Apply reductions to the Department and its contractors alongside providers.
11. Pursue revenue before cuts: enhanced federal match through Community First Choice and the new H.R. 1 waiver authority for people below institutional level of care; 340B rebates owed to Medicaid, without harming health centers; restructured buy-in premiums, which participants here and in office hours argued are inequitable.
12. Bar recoupment beyond the window in which a provider can still bill the other payer, closing the exception in the 2023 recoupment law.
13. Require regional entities to offer single case agreements for members mid-treatment when a contract ends or a member is reassigned, and to notify members and providers before any reassignment.
14. Create one credentialing process and portal across all regional entities, consider fewer entities, and report what share of each entity's payment goes to care.
15. Replace the eligibility cliff with a step-down in benefits as income rises.
16. Measure the effect of cuts already underway – the caregiver hour limit, nursing and aide denials, the cap on health maintenance activities – before adding more, and protect adult dental, the CCBHC demonstration and primary care on the strength of their longer-term savings.

17. Protect community connector, mentorship, respite and therapy hours in the children's waivers, and the adaptive-functioning standard in developmental disability determination; weigh changes to protective oversight against the higher levels of care they may drive. (Department)
18. Analyze overlap across the children's waivers and consider a single children's waiver covering the same conditions. (Department; legislature)
19. Reduce the number of case managers per member and give each family one point of contact. (Department)
20. Evaluate the regional entity transition and the acquisition on the Western Slope; give members one identification number; publish a clear formulary and prior authorization process. (Department, through regional entity contracts)
21. Set reasonable caps on personal care hours rather than using a waitlist. (Department)
22. Remove duplicate home inspections for caregivers and rely on CDPHE oversight. (Department; CDPHE)
23. Measure the cost of requiring exchange applicants to obtain a Medicaid denial, and review the CHP+ income limit. (Department; Connect for Health Colorado)
24. Allow monthly transit passes for ambulatory members, make it easier for rural transportation providers to enroll, and end pilots quickly when they do not work. (Department)
25. Spread value-based primary care statewide, and consider treating primary care as a public utility, with every payer contributing per member to one pool and one simple set of measures. (Department; legislature)
26. Account for inflation in provider rates, and hold the terms of initiatives steady for providers who join them. (JBC; Department)
27. Systematically identify Medicaid members who are also eligible for Medicare so Medicare pays first. (Department)
28. Issue an executive order requiring departments to align and to cut regulations beyond federal requirements. (Governor)
29. Offer a basic health plan for people who lose Medicaid, and invest in county eligibility technology so redeterminations do not create backlogs. (Legislature; Department; counties)
30. Set a few shared goals for the whole system, with each sector owning its part, and bring Colorado's health foundations in as funding partners. (Commission; Department)
31. Replace printed member survey mailings with electronic outreach. (Department)
32. Include continuing focus groups with families and people with lived experience, and make future forums accessible to people who cannot attend in person because of caregiving or disability. (Commission)

Raised once each: tiering services by acuity and applying a budget neutrality factor to the least acute; a financial-strength threshold for provider enrollment; tighter entry to the children's extensive support waiver with priority for aging caregivers; a durational residency requirement; tightening qualifications to focus on children and people unable to work; universal primary care or a Medicaid public option; and reining in employers whose workers rely on Medicaid. Spending outside Medicaid – universal preschool, school meals, cannabis revenue – came up in two sessions and is outside the Commission's scope, but it

tells you participants see Medicaid carrying cuts other programs are not. Raised once each in the later sessions: expanding coverage to functional medicine; cutting the regional entity's administrative spending; and investigating dual special needs plan marketing, which Representative Taggart ruled outside the Commission's scope.

Colorado Commission on Medicaid

Office Hours Summary – All Sessions, August 3 through September 29

This is a summary of the office hours held during the summer of 2026. Input is reported by theme and paraphrased. No participant or organization is identified. It is important to note that this is a summary of themes resulting from the office hours conversations as compiled by SHG Advisors and does not reflect recommendations put forward by SHG Advisors.

What this covers

Eight office hours days: in person on August 3 (drop-in) and August 19 (booked slots), a virtual open forum on August 4, back-to-back fifteen-minute virtual slots on August 20, September 3, September 14 and September 29, and a mixed in-person and virtual day on September 10. Across them, about 50 conversations and about 80 participants – roughly 70 different people, because several came more than once. They came from every region, with the Western Slope, the southwest corner, Colorado Springs and the Denver metro area most represented, and from families, members, direct-care workers, independent practices, FQHCs, hospitals, home care and senior living providers, behavioral health providers, local public health, a health information exchange, associations, advocates and contract lobbyists.

How to read it. A handful of people returned two or three times; their points are counted once per theme. Where an issue was raised by unconnected people in separate sessions I have said so, because that is the closest thing this input offers to a measure of weight. The format changed along the way. The first drop-ins produced long waits and the open forum produced few speakers, so from mid-August sessions moved to booked slots, which filled every time.

The input also changed over time. Early on, many people described problems. By September nearly everyone arrived with a recommendation, often in writing, and by late September some were asking where to direct advocacy once the Commission's list is public.

The themes

1. The state's own data

This was the most repeated point across the sessions, and it came from every kind of participant. A family caregiver, a behavioral health credentialing body, a private duty nursing provider and a county Arc chapter said the same thing in one session: the Department either does not hold basic program data or will not release it. Specific examples followed in later sessions. No one could get the private duty nursing fill rate – authorized hours actually staffed. The dental association cannot get utilization data to identify the least harmful cuts. Local public health cannot be identified in claims because it has no provider type. Advocates asked for months for a restated post-eligibility treatment of income estimate. And no one can see whether regional entities meet their required medical loss ratio. One association built its own fraud dataset from federal sources because Colorado's was not available. A coalition of safety net providers and consumer groups offered a concrete fix: a shared coverage and access dashboard of about five measures, combining Department data with hospital and clinic data, kept by a neutral party and reported monthly through the federal changes, which the coalition believes could be paid for with private dollars.

2. How changes are made

Providers in every sector described the volume and manner of change as a cost in itself. One home care provider counted 116 policy, operational and informational memos from the Department in 2025 and 66 so far this year. Small agencies said they cannot absorb that volume without something slipping – supervision, training, billing accuracy, or tracking a patient's change in condition – which is itself a program integrity risk. Others described policy issued by memo rather than through rulemaking, rule titles that make it hard to know when a change is coming, 23 separate newsletters, and webinars without questions. Several also described the fragmentation behind this – similar services run under different rules by different offices and departments, and good relationships at the program level that never reach the rest of the agency.

Specific examples recurred. A requirement that services delivered by interns carry their own provider number on claims from January 1, which providers say their billing systems cannot yet support. Code changes that closed intensive programs. A restriction on telehealth delivered in recovery residences. And Long Bill savings measures that participants said changed shape in implementation, with no check on whether the promised savings arrived – a blended private duty nursing rate pitched for children needing round-the-clock care and then applied far more broadly, and the end of the nurse assessor program without notice. The asks were consistent: a real stakeholder process before announcements, the evidence behind each change published with it, longer lead times, and a way for the legislature to check whether savings it approved materialized.

3. Rates – predictability over level

The most repeated rate ask was not a higher rate. Senior living, home care, a solo pediatric practice and a behavioral health association each said, separately, that what they need most is a rate they can plan against – fewer swings with each forecast and a regular inflation adjustment. Long-term care providers asked the Commission to stop across-the-board percentage cuts: two percent of an assisted living rate of about $145 a day takes far more from an operation than two percent of an inpatient stay. Home care raised local minimum wage increases as a cost driver the state absorbs after the fact – Denver's wage rising to about $20 against a $26 hourly rate – and asked how many budget requests have followed since local authority passed. Several asked why the rate review advisory committee's recommendations are not followed. One example given: the committee recommended raising the host home rate to the family caregiver rate, and the opposite was proposed. Providers also cautioned against cutting "overhead" before the cost reporting required by recent legislation arrives in 2027, arguing that indirect costs vary by setting, size and geography and that no single pass-through percentage fits all.

The workforce sits underneath all of this. Home care, private duty nursing and long-term care providers said they compete with food service and retail for the same workers, that federal immigration policy is shrinking the labor supply as demand grows, and that some recent policies assume agencies can find workers who do not exist, especially in rural areas. Two participants asked the state to enforce the federal requirement that family caregivers employed by home care agencies be W-2 employees rather than contractors, which they said would protect workers and undercut bad actors.

4. Long-term services, family caregiving and disability

This was the largest share of the conversations by volume.

The caregiver hour limit. In three separate sessions, unconnected people described the limit being applied to the member rather than the caregiver, and agencies giving conflicting guidance about it. People also

consistently described a 56-hour cap as already in force. The Department's packet sets a step-down – 84 hours since July 1, 70 from January 1, 56 from July 1, 2027 – so what families are describing today is the 84-hour limit. A caregiver organization argued that savings estimates model costs but not consequences: on the Department's own cost difference between nursing facility and community care, about 33 failed caregiving arrangements would erase the projected saving.

Post-eligibility treatment of income. Families of adults on the developmental disabilities waiver raised it in three sessions. Their points were that the savings estimate predates exemptions added since and has not been restated; that exempting anyone who works concentrates the contribution on adults who cannot; that the policy was tried on the waiver around 2008 and dropped; and that it reaches adults whose benefit rises when a parent retires. Their ask is to cap the contribution – for example at the $200 buy-in premium – rather than eliminate it.

The new assessment. Families and advocates in two sessions said the Colorado Single Assessment and the algorithm that will turn it into a budget have not been published. They also said the instrument appears to be yes or no with no "with assistance" option, and that the pilot stakeholders asked for is not happening. One pair cited litigation in another state where a similar tool cut support levels for about 900 people. Families are working from a January 1 or next-summer date; the Department's packet puts statewide implementation in FY 2027-28. The question advocates want asked is narrow: will the pilot results be published, showing whether support levels hold across the two instruments for the same people?

Case management. Families described assessments that set aside physicians' letters, findings overridden after the fact, no appeal route offered, and new exceptions not applied, along with case management that varies widely from one agency to the next.

Private duty nursing. Providers said unfilled hours keep medically complex children in hospital at $4,000 to $6,000 a day against about $1,500 at home, and that rates alone do not fill shifts. Their non-rate ideas were to require commercial plans to cover private duty nursing, as Minnesota does; to let family members certified as nursing aides provide trach and ventilator care alongside nurses, as Arizona and Oklahoma allow; to drop Medicare conditions of participation for this mostly pediatric service by Medical Services Board rule; and to publish fill rates. A related cost-shift point came from a family caregiver: rules that require providers to be in-network with a member's commercial plan push families to drop private coverage, leaving Medicaid as the only payer.

Program design . Ideas included a return to self-direction – a stated budget, a menu of services and a support broker, roughly how supported living services worked twenty-five years ago; consumer-directed care for families on the developmental disabilities waiver in place of agencies that retain 20 to 50 percent; structured family caregiving, which its national provider estimates would save about $1.8 million in its first year and $6.8 million a year after; and, from disability advocates themselves, restoring per-person budget limits on waivers. Disability coalitions asked that Medicaid not be split into separate programs but that people with certified permanent conditions get low-friction rules: continuous authorization in place of annual redetermination, and clinical reviewers trained in pediatric and complex adult care. A cross-disability organization offered a boundary condition: protect the services that keep people alive and living in the community, and put everything else on the table.

5. Behavioral health and the regional entities

Behavioral health providers described the regional structure as the source of most of their operational problems. Members are reassigned between regions without knowing it, often mid-treatment. Providers learn after the fact, are told to refer out, are refused single case agreements, and either treat for free or interrupt care – one practice counted 50 such moves in a year. Networks are closed "at capacity" even where the only alternative does not offer the service. Recoupments reach back up to two years when other coverage is discovered. At least seven substance use clinics lost contracts recently with no explanation and no plan for their members. The same 60-minute therapy session pays about $143 in one region and $103 in another. Providers also raised an encounter benchmark of 2,100 a year per provider that reportedly led a community health center to close a psychiatric nurse practitioner fellowship serving about 2,000 patients. Others raised essential safety net designations that were earned but never funded, and providers paid by default through virtual credit cards.

Views on the fix divided. Some asked for regular public reporting of medical loss ratios with enforcement, required continuity-of-care agreements when a member's region changes, a single statewide entity, nonprofit-only entities, or fee-for-service behavioral health. An FQHC leader argued "mend it, don't end it" – strip out compliance work passed down to providers and move those dollars to care.

6. PRIME, primary care and value-based payment

PRIME was the one part of the program nobody criticized. Support came from a Western Slope clinically integrated network, an independent pediatric practice, a pediatric rural health clinic, an FQHC operating in and out of PRIME counties, a member-listening project and a tribal-serving organization. Their reasons were stable per-member payments that keep practices taking Medicaid where it is the dominant payer, a small set of measures tied directly to shared savings, and data the practices can use. They contrasted this with the reporting requirements in the statewide model, which one participant called an "administrative morass." The asks were to extend PRIME geographically and to children, to pay shared savings closer to real time rather than two years in arrears, and to recognize same-day access in pediatric measures.

Primary care leaders made related points. Community health centers cited the Department's own cost analysis showing their patients cost Medicaid about $900 to $950 less a year. Care coordination has grown into a full contract chapter, and patients receive duplicate follow-up calls. Measures change too often to show what works – "five outcomes and five years" was one proposal. Pediatric value is being designed on adult, Medicare-derived models, so up-front investment in children never pays back within a one-year window. Local public health agencies said they deliver Medicaid services they do not bill, with counties backfilling, and asked for a provider type, administrative claiming and keeping the 2028 community health worker benefit on schedule.

7. Rural access – transportation, emergency services and maternity

Rural transportation is the most acute failure raised. A tribal-serving provider in the southwest corner cannot bill because the new non-emergency transportation rollout covers nine metropolitan counties. Its county is not classified as rural, which limits a trip leg to 25 miles rather than 125, while it drives dialysis patients across state lines after the local center closed. On the Western Slope, providers report one broker left for the region. The region's only psychiatric hospital, which takes referrals from 24 emergency departments, says it holds Medicaid patients one to two extra days because they cannot get home and pays for taxis itself, and that the losses are not sustainable. It proposed a joint business plan with the regional

entity, which has offered vehicles. The rural classification question looks like something the Department could correct without legislation.

A rural ambulance chief said treatment in place pays about $67 against about $400 to transport, so agencies take patients to the emergency department instead. He described one patient whose home infusions avoided about $2.5 million in Medicare and Medicaid costs in a year, against a $430,000 program budget, and asked the state to plan now for the possible loss of federal ambulance supplemental payments.

On maternity, a perinatal quality collaborative reported that 40 percent of counties have no obstetric provider or labor and delivery unit and that two rural units closed in 2025. It added that the leading causes of maternal death here are overdose and suicide, and that risk now concentrates between 42 and 365 days postpartum. A Pueblo FQHC described southeastern Colorado as having no labor and delivery to the state line apart from one intermittently diverting unit, with the FQHC sending prenatal clinicians to La Junta and Walsenburg. The asks were to pay low-volume units for standby capacity rather than per birth, ideally across all payers; to give maternal health one owner inside the Department; and not to build a new maternity payment model ahead of the 2027 unbundling of the global payment.

8. Coverage and the federal changes

Participants expect the federal changes to reach people the public conversation overlooks. Many adults with intellectual and developmental disabilities are in the expansion group, not on a waiver, and there is no framework yet for documenting their community engagement hours. Job supports are thin, and county eligibility staff already struggle with annual renewals, let alone six-month ones. Older adults in affordable housing face medical frailty checks that may tighten after the first year, and an area agency on aging asked that older adults not get lost among the Commission's priorities. An immigrant health organization said about 16,000 lawfully present Coloradans lose coverage between October 1 and January 1, that the state affordability program most of them would move to is not sustainable, and that Cover All Coloradans took a 25 percent cut when providers took 2 percent. A pediatric practice expects families to withdraw from care out of fear. Local public health is already seeing more walk-ins. Families asked for help finding Medicaid in the first place – one grandparent learned of it only from a doctor – and for an end to the uncertainty at age 18 for conditions that will never change.

9. Where participants would look for money

Before cuts to services, participants pointed to the Department's administration, contracts and intermediaries. An immigrant health organization pointed to two Long Bill lines – about $57 million in professional services and special projects and $81 million in personal services – for which it has never had a breakdown. The dental association said the Department's administrative cost now exceeds total dental spending. A safety net coalition proposed documenting how the Department's staffing and spending have shifted since 2016. Intermediary agencies were said to retain anywhere from about 5 to 50 percent of family caregiver payments. One parent asked that the Department and its contractors be audited and take a reduction alongside everyone else.

The state health information exchange offered the clearest evidence that some administrative spending buys time back. On its account, supplying its data to the disability determination contractor cut processing from eight months to 38 days and halved manual records requests. It also described contracting as duplicative, with renewals arriving on a month's notice and then sitting unsigned.

Ideas outside the usual cut list included alcohol and soda taxes dedicated to health care, revisiting the state's hospital facility fee report, the cost of hospital infusion of biologics, commercial coverage of private duty nursing, and keeping private insurance primary for children who have it. The dental association will submit least-harm options and administrative fixes by early November.

10. The Commission's own process

Three points came up repeatedly. First, the consumer voice is thin on the panels. Consumer groups asked for a consumer panel or a consumer seat on an existing panel, and families said the earlier family panel felt like testimony rather than a place to offer solutions. Second, waiting six or seven hours for two minutes of comment is not access for people with intellectual and developmental disabilities. Advocates asked for a time-capped slot earlier in the day, and raised the accessibility of the room for wheelchair users. Third, participants asked how a report due December 11 can matter when the Governor's budget request lands November 2, and some said their emails feel as if they disappear. The channel stakeholders now believe carries their input is the list of suggested questions I give members at the start of each meeting. That is a thin channel to be carrying this much.

Contrasting views

Not everyone pulled in the same direction. One participant – a strong supporter of long-term services – suggested a residency preference for waiver services, and a provider described families moving to Colorado for its paid family caregiving. This is anecdotal, and any preference would likely conflict with federal rules. Disability advocates themselves proposed restoring per-person waiver budget limits, though they said not everyone in their community agrees. A home care provider proposed minimum size limits for home care agencies to raise efficiency and compliance. Behavioral health participants split on whether the regional entities should be repaired, restructured or replaced. And one provider argued that peer support billing, rather than clinical care, is where behavioral health spending has grown fastest and deserves scrutiny.

Questions members may want to consider

1. What program data does the Department hold, what does it publish, and what would a standing public dashboard of a few coverage, access and performance measures take?
2. What would a multi-year rate path for long-term services look like, and if a reduction is recommended, on what basis should it be distributed rather than across the board?
3. How does the Department confirm that corrected guidance on the caregiver hour limit reaches the member rather than stopping at the agency, and what is a member's remedy when a determination with no appeal route is simply wrong?
4. Will the Colorado Single Assessment algorithm and pilot results be published before rollout, showing whether support levels hold across the two instruments for the same people?
5. What is the restated savings figure for post-eligibility treatment of income, and how many members are expected actually to contribute?
6. When a member's region changes mid-treatment, what protects continuity of care, and what reporting would show whether each regional entity meets its medical loss ratio?

7. Why is Montezuma County not classified as rural for transportation trip limits, when does the rollout reach beyond the nine metropolitan counties, and what does a psychiatric bed held for lack of a ride cost compared with the ride?
8. Given broad support for PRIME, what would it take to extend it geographically and to children, and what would the Department need to see first?

Items Not Verified But Raised During Office Hours

Figures participants cited that should be checked first. The 25 and 125 mile trip-leg limits and Montezuma County's classification, which come from one provider's reading of the manual. The treatment-in-place rate and the bill that created it. The 2,100-encounter benchmark and its $3 per-encounter consequence, which are second-hand. The $143 and $103 regional therapy rates. The 116 and 66 memo counts. Parent CNA growth from about 8,000 to 11,000 recipients between 2023 and 2025. The $57 million and $81 million Long Bill lines. The claim that Department administration exceeds dental spending of about $583 million. The eight-months-to-38-days determination figure. The $900 to $950 community health center savings. The 16,000 immigrants losing coverage. The towns where labor and delivery units have closed in southeastern Colorado, which come from a garbled transcript. The 40 percent of counties without obstetric care. The 900 people affected by an assessment in another state. And the statements that post-eligibility treatment of income was tried and dropped around 2008, and that federal Community First Choice rules bar limiting services once eligibility is set. Allegations of fraud or misconduct raised in several sessions, including figures from a privately assembled federal dataset, have not been reviewed and are not repeated here.