COLORADO
Department of Health Care Policy & Financing

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Responses to Joint Budget Committee Questions for Fiscal Year 2026-27

January 2026

Common Questions (*Written Only*)

C1. Please provide a breakdown of your department's total advertising budget for the current
and prior fiscal year. Specifically:

a. What is the total amount budgeted and expended on advertising and media placement type?
b. How are those advertising dollars allocated across different media types (e.g., television (national/local/cable), radio (terrestrial vs streaming), SEM, digital (display, YouTube), connected TV, social media, print, outdoor, etc.)?
c. How much of that spending is directed to Colorado-based or local media outlets? How is the media currently purchased?
d. What performance metrics or evaluation tools does the department use to measure the effectiveness of these advertising campaigns? What are the goals of the campaigns, and what key performance indicators are measured for success?
e. If any portion of advertising is managed through third-party vendors (or 'partners') or media buying firms, please provide any available data or reporting from those companies on campaign performance and spending. How often do the departments discuss media placements with these vendors?
f. Monthly or quarterly reporting - how is reporting delivered?

RESPONSE:
HCPF does not have a dedicated advertising budget because Centers for Medicare and Medicaid Services (CMS) has strict rules around marketing and advertising and limits the use of funds to activities such as outreach. Any funds that are used for advertising purposes, either programmatic or otherwise come from HCPF's specific office operating funds. HCPF's use of advertising funds are primarily spent on recruitments for hard-to-fill positions, and stakeholder outreach on programmatic changes, such as public noticing.

Specifics on expenses for FY 2024-25 and FY 2025-26 to date are below:

a. In FY 2024-25 there was $0 budgeted and $4,655 spent on advertising. In FY 2025-26 there is $0 budgeted and $2,130 spent to date.
b. The advertising dollars are generally allocated to local print media, such as the Denver Post or Gazette, and online recruitment websites, such as ZipRecruiter.
c. Nearly all of HCPF's expenditure is paid to local media outlets with the exception of a small amount spent on online recruitment websites.
d. HCPF is not advertising for programmatic needs, but rather uses the advertisements for outreach (e.g. recruitments and public noticing), and therefore is not tracking metrics.
e. Not applicable.
f. Not applicable.

C2. Can you please outline a detailed plan for shifting 5.0 percent of General Fund salaries to cash and/or federal fund sources? Please include the following information:

a. A list of positions and associated funding that can be shifted to cash/federal fund sources without any action from the General Assembly.
b. A list of positions and associated funding that can be shifted to cash/federal fund sources but would require legislation to do so.
c. What other changes could be made – programmatic or otherwise – that would allow your department greater flexibility to use cash/federal fund sources in place of General Fund for employee salaries?

RESPONSE:

HCPF, in concert with OSPB, continuously evaluates all positions to look for ways to leverage other fund sources, where appropriate, to minimize the impact on the General Fund and has implemented any and all options available under current law.

- There are no additional positions HCPF can refinance from the General Fund to another fund source. We have and continue to utilize appropriate General Fund and Cash Fund sources for FTE where allowable.
- If the General Assembly authorizes the use of a new or existing cash fund to pay for positions, HCPF would utilize those sources for FTE. As mentioned above, HCPF is currently maximizing the allowable use of funds outside of the General Fund to pay for FTE.
- As mentioned above, HCPF has already taken all measures available under current law for personnel costs to fund sources outside of the General Fund.

In addition to funding positions with non-General Fund sources, where appropriate, HCPF also leverages additional federal match on systems-related FTE through Advanced Planning Documents (APDs).

C3. How many hires happened across the Department after the hiring freeze was implemented and why? (e.g., because the position was posted beforehand; an exemption, etc.) Please provide job classification, division, and fund source (General Fund vs. other funds) for each position hired.

RESPONSE:

From the start of the hiring freeze on August 27th, HCPF hired 51.0 FTE. All of the positions were hired because the position had been posted prior to the freeze date.

All positions are funded with a combination of General Fund, state funds, and federal funds.

Class Title	Division	Fund Source
Administrator IV	Clinical Operations Division	GF/CF/FF
Policy Advisor IV	Benefits & Services Management Division	GF/CF/FF
Statistical Analyst I	Special Financing Division	GF/CF/FF
Compliance Specialist III	Operations & Administration Division	GF/CF/FF
Budget Analyst I	Budget Division	GF/CF/FF
Mktg & Comm Specialist IV	Strategic Outcomes Division	GF/CF/FF
Program Management II	Eligibility Division	GF/CF/FF
Pharmacist I	Pharmacy Division - Deputy Director	GF/CF/FF
PROJECT MANAGER I	Project Management Section	GF/CF/FF
Rate/Financial Analyst IV	Managed Care Rates Division	GF/CF/FF
Project Manager I	Project Management Division	GF/FF
Project Manager II	Project Management Section	GF/FF
Mktg & Comm Specialist III	Special Financing Division	CF/FF
Training Specialist V	Eligibility Division	CF Only
Administrator I	Client Services Division	GF/CF/FF
Policy Advisor III	Eligibility Division	GF/CF/FF
Project Manager I	Project Management Section	GF/CF/FF
PROGRAM MANAGEMENT I	Medicaid Enterprise Integration, Data & Alignment Division	GF/FF
Program Coordinator	Special Financing Division	CF/FF

Training Specialist IV	Strategic Outcomes Division	GF/CF/FF
Project Manager I	Enterprise Project Management Office Division	GF/CF/FF
Rate/Financial Analyst I	Fee for Services Rates Division	GF/CF/FF
Rate/Financial Analyst I	Special Financing Division	CF/FF
Compliance Specialist II	Medicaid Operations Office Deputy Director	GF/CF/FF
Accountant III	Controller Division	GF/CF/FF
Administrator III	Compliance & Innovation Division	GF/CF/FF
Administrator III	Compliance & Innovation Division	GF/CF/FF
Policy Advisor IV	Benefits & Services Management Division	GF/CF/FF
Project Coordinator	Enterprise Project Management Office Division	GF/FF
Contract Administrator IV	Project Management Division	GF/FF
Project Coordinator	Enterprise Project Management Office Division	GF/FF
Liaison III	Children and Families Division	CF/FF
Statistical Analyst I	Special Financing Division	CF/FF
Analyst III	Eligibility Division	GF/CF/FF
Analyst III	Medicaid Operations Office	CF Only
Analyst III	Medicaid Operations Office	CF Only
Analyst III	Medicaid Operations Office	CF Only
Analyst III	Medicaid Operations Office	CF Only
Analyst III	Medicaid Operations Office	CF Only
Auditor III	Procurement & Audit Division	CF/FF
Statistical Analyst II	DAS - Analytics Division	GF/CF/FF
Contract Administrator IV	Project Management Division	GF/FF
Administrator III	Compliance & Innovation Division	GF/CF/FF
ANALYST IV	Contracts & Quality Assurance Division	GF/FF
ANALYST IV	Contracts & Quality Assurance Division	GF/FF

Administrator IV	Partner Relations & Administration Division	GF/CF/FF
Program Assistant I	Partner Relations & Administration Division	GF/CF/FF
Administrator IV	Case Management & Quality Performance Unit	FF Only
Administrator II	Legal Division	GF/CF/FF
Policy Advisor III	Behavioral Health Policy and Benefit Division	GF/CF/FF
Administrator III	Behavioral Health Systems Division	GF/CF/FF

GF - General Fund
CF - Cash Funds (HAS Fee)
FF - Federal Funds

Hearing Questions

Proposed Reductions Context

1. [Rep. Brown] For each service line where the Department proposes reductions, what are the recent utilization and expenditure trends? What is driving those trends? How will the proposed reduction bend the cost curve? Finally, please identify the current projected expenditures for that service by fund source to help put the magnitude of the reduction in context.

   RESPONSE:The Manatt presentation should have covered much of this, leveraging HCPF data.

   Further, many of these trends were included and described in our 2025 Annual Stakeholder webinar. You can review slides and listen to the recording on our website. We have also met with most of the JBC members to review these trends since this question was asked.

   In Appendix A, HCPF has provided a series of charts and graphs demonstrating utilization and expenditure information across the services categories affected by the reductions. Recent utilization trends have increased across most acute and long-term services following the conclusion of the Public Health Emergency and the end of associated enrollment lock-in policies. Coupled with steady provider rate increases, these factors have contributed to upward pressure on the overall expenditure trend. While HCPF does not project expenditure by service, the appendix also shows each projected reduction by fund source.

   Nationwide, health care expenditures have accelerated after the COVID-19 pandemic, with spending growth now being driven much more by utilization than by price. The Centers for Medicare and Medicaid Services' (CMS) latest National Health Expenditure

data show total U.S. health spending reached about $4.9 trillion in 2023, growing 7.5%—faster than both overall inflation and GDP—and largely reflecting higher consumption of hospital, outpatient, and prescription drug services amid historically high insurance coverage (about 92.5% insured).[1] Hospital spending alone grew more than 10% in 2023, the fastest rate in decades, mostly due to greater use of services rather than large price hikes. Meanwhile, retail drug spending increased more than 11%, driven in part by GLP-1 and other high-cost medications.

Across payer types—including Medicaid, Medicare, and commercial plans—plans and regulators are reporting "record high" utilization and rising medical loss ratios.[2] For Medicaid, the story is nuanced: aggregate spending growth has recently moderated as enrollment declines with the end of continuous coverage, but states are still seeing pressure from higher acuity, behavioral health demand, shifting care to outpatient and community settings, and the same drug-cost dynamics affecting other payers.[3]

While HCPF does not forecast utilization at the individual service-line level, the projected aggregate trend for acute care services in FY 2025-26 is 9.4%, and the projected aggregate trend for long-term services and supports is 14.7%. These figures mirror national trends that indicate rising health care utilization and spending. In response to recent growth in expenditure and budgetary pressures, HCPF has proposed a series of reductions via its November 1, 2025 R-6 decision item and its January 2, 2026 S-7 supplemental request. These reductions bend the cost curve by directly reducing expenditure via mechanisms like rate reductions and service utilization caps, which create a direct and immediate reduction in spending.

It is unclear whether these utilization trends will change in the near future. Although rate reductions and utilization restrictions will have a short-term effect to offset some spending increases, there are many factors which will continue to put pressure on the state budget. At the same time, economic factors may drive further expenditures; for example, if the state's economy enters a recession, Medicaid enrollment will grow. HCPF will continue to monitor expenditure and propose program changes in the future when necessary to help ensure that the state meets its constitutional balanced budget requirements.

2. [Rep. Gilchrist] Why is the Department proposing an across-the-board provider rate reduction, rather than more nuanced and targeted rate reductions?

RESPONSE:The across-the-board rate reduction is just one of many carefully considered reductions, including nuanced rate reductions, which HCPF put forward to target Medicaid trend drivers, reduce Medicaid spending, and help balance the state budget, while maintaining benefits and access to care for Medicaid members. This reduction is in alignment with HCPF's Medicaid Sustainability Framework. That framework, which includes six pillars, received 90% support from HCPF's August Annual Webinar poll of attendees, with 78% indicating it should be HCPF's #1 priority,

[1] https://www.cms.gov/files/document/highlights.pdf

[2] https://www.kff.org/medicaid/medicaid-enrollment-and-spending-growth-amid-the-unwinding-of-the-continuous-enrollment-provision-fy-2023-2024/

[3] https://medicaiddirectors.org/resource/top-five-medicaid-budget-pressures-for-fiscal-year-2025/

given mounting fiscal concerns. The Governor directed HCPF to enact budget reduction measures, including an across-the-board provider rate reduction.

3. [Sen. Bridges] When the state has one of the lowest fee-for-service Medicaid rates in the country, how will additional compression on Medicaid growth impact access to care for low-income people, children, and people with disabilities?

   RESPONSE: Colorado does not have one of the lowest fee-for-service (FFS) Medicaid rates in the country. According to KFF.org,[4] Colorado's FFS rates for all services indexed to Medicare rates is 0.83. Colorado's Medicaid FFS index is the same as that for Georgia and Virginia and is higher than 26 other states including California, Florida, Illinois, Louisiana, Ohio, Pennsylvania, Texas, and Washington.

   Because Medicaid cost trends are crowding out the rest of the state budget, the Polis Administration is proposing a Medicaid growth target proposal to assist the legislature in managing Medicaid expenditures in FY 2027-28 and beyond. Over the last 10 years, General Fund revenue has grown by 5.5% per fiscal year on average. At the same time, Medicaid costs have grown by 8.8% per fiscal year on average. A growth target would ensure that Medicaid expenditure growth returns to a sustainable rate versus the more recent double-digit average General Fund increases. A growth target would not put a hard cap on HCPF expenditures, nor would it remove or lessen HCPF's over-expenditure authority. The legislature would continue to appropriate funding for Medicaid in the Long Bill, which could be above or below the target. More detail on this in Question 156.

   A north star in our Medicaid Sustainability Framework is to maintain access to core services for the people who need them. By taking the actions we are proposing today, we are avoiding the need for more significant reductions down the road. As the legislature considers a Medicaid growth target, and through the annual budget process, HCPF will continue to work with the legislature to sustain services for our Medicaid members.

4. [Sen. Kirkmeyer] The safety net remains at risk in Colorado today. Health care providers prepare for potentially multiple years of downward pressure on Medicaid rates due to the state budget deficit. What is the Department's plan to monitor the structural impacts of the hundreds of millions in cuts that are being presented to the provider community and what this means for patient access to timely, high quality care (i.e. network adequacy, wait times, ER visits, uncompensated care burdens, PCP availability, mental health access)?

   RESPONSE: HCPF will pursue a host of existing, as well as new, mediums to monitor the impact of the changing landscape on providers.

   HCPF receives quarterly financial updates from hospitals, based on more recent legislation, which greatly assists in monitoring updated financials, especially for rural, independent and safety net hospitals. HCPF will also be setting up bi-monthly

[4] KFF Medicaid-to-Medicare Fee Index

meetings with the Colorado Rural Health Center to discuss both emerging rural hospital financials. Rural hospitals also reach out to HCPF as a standard when their days cash on hand or other concerns start to raise a red flag. We have helped several rural hospitals navigate their fiscal challenges in this way, with all of them successfully turning around their fiscal circumstances.

HCPF receives financials from nursing homes annually, meets with CCHN (the association for Federally Qualified Health Centers) annually, and does site visits throughout the year. We will make sure to add to the standing quarterly agenda a discussion point of FQs experiencing outlier fiscal risk.

The Colorado Health Institute, which conducts the bi-annual Colorado Health Access Survey (CHAS) is focused on conducting an uninsured rate-focused impact survey in 2026 in addition to their planned CHAS survey in 2027. We will partner with them, as always, on this work.

HCPF leadership also has a monthly standing meeting that reviews overall trends - like claim, membership, utilization, spending trends - with deeper dives into specific areas each month, such as ER or LTSS.

HCPF will continue to monitor the impact of reductions through appropriate existing processes. The fee-schedule rate reductions (e.g., waiver rates, DME, physician services, dental services, surgeries, transportation, etc.) will be monitored through the processes associated with the Medicaid Provider Rate Review Advisory Committee (MPRRAC). Hospital payment reductions will be monitored through the bi-monthly hospital engagement meetings, the CHASE model, and financial impacts monitored through robust hospital financial transparency reporting. Reductions to managed care services (e.g., behavioral health, Denver Health Medical Plan, and Rocky Mountain Health Plans) will be monitored through the annual rate setting process. HCPF also monitors its overall network by provider type and receives quarterly network adequacy reports from its contracted Regional Accountable Entities (RAEs) and Managed Care Organizations (MCOs) that detail each managed care entities' behavioral health and primary care network as well as their compliance with contractually required network adequacy standards. All network adequacy data is validated by an External Quality Review Organization.

In addition to these specifically defined processes, HCPF also has extensive and consistent contact with providers and members. HCPF researches, investigates and responds to raised concerns using all means available to us.

5. [Sen. Kirkmeyer] If the General Assembly rejects some of the reductions included in the Governor's executive orders and instead finds different ways to balance the

budget, how will the Department respond? Will the Department restore the relevant eligibility, benefits, and funding? What would it take to undo the Department's actions?

RESPONSE: Given the passage of SB 25B-001, Processes to Reduce Spending During a Shortfall, HCPF is following the Governor's executive order (D25-14). Continuation of the reductions are set forth for the JBC's consideration in R6. Executive orders are time-limited and would no longer be implemented moving forward upon the expiration of the executive order. The Governor has renewed the executive orders and can continue to do so while the General Assembly considers reductions for this fiscal year.

If the General Assembly passes legislation directing HCPF to pursue alternative reductions, or if the General Assembly provides funding via the Long Bill to maintain services or rates at different levels, those alternatives will be implemented by HCPF.

The process for reprocessing fee-for-service claims is fairly straightforward, though that doesn't mean the higher reimbursement will be paid out, as explained below. When claims have already been processed and a retroactive rate change occurs (for example, a rate increase from $100 to $105), the affected claims can be mass adjusted. The net result of that adjustment may be an additional $5 reimbursement to the provider. The ultimate adjustment may depend on how the claim was billed. Many claims are reimbursed using a "lower-of" pricing methodology, meaning the system pays the lesser of the provider's submitted charge or the allowed fee. In the example above, if the provider submitted a charge of $100, even if the allowed fee is increased to $105 and the claim is mass adjusted, the reimbursement would remain $100. We recommend that providers always submit their usual and customary charge, but that is not always the case.

Reductions for next fiscal year are part of the Long Bill process. Some of the reductions take more time to implement given updates to state rules and needed federal authorities, when applicable.

A full list of the executive order reductions, along with the expected timeframes for implementation, is available here.

6. [Sen. Bridges] Has the actual implementation timeline for reductions tracked with the projections in the November request? Are there any implementation delays that impact the projected savings?

RESPONSE: HCPF is on track with the implementation dates outlined in the R-6 request. HCPF has implemented rate changes that were effective in the Executive

Order prior to November 1, 2025 and has multiple initiatives that are expected to be implemented in spring 2026, pending federal approval and system changes.

7. [Sen. Kirkmeyer] For each element of R6, please provide an assessment of whether federal approval is necessary.

   RESPONSE: For ease of reference, the Department is using JBC staff analyst's numbering of the elements of R-06.

R6 Element	Does it require federal approval? Y/N
R6.01 Reduce the Accountable Care Collaborative Incentive Program	N
R6.02 Reduce the Behavioral Health Incentive Program	N
R6.03 Reductions to Access Stabilization Payments	N
R6.04 Ending Continuous Coverage	N
R6.05 Reduction in Immigrant Family Planning	N
R6.06 Reduction in SBIRT Training Grants	N
R6.07 Eliminate Outreach for Cover All Coloradans	N
R6.08 Definitive Drug Testing	Y
R6.09 Reinstate Medicaid Prior Authorization of Outpatient Psychotherapy	Y
R6.10 Implement Pre- and Post- Claim Review of All Pediatric Autism Behavioral Therapy	N
R6.11: Roll Back 1.6% Provider Rate Increase	Y
R6.12: Adjust Community Connector Rate (-15%)	Y
R6.13: Eliminate the Nursing Facility Minimum Wage Payment Supplemental Payment	Y
R6.14: Align IRSS Rates	N
R6.15 Reduce Pediatric Behavioral Therapy Rates to 95% of the Benchmark	Y
R6.16 Decrease Dental Reimbursement Rates	Y

R6.17 Change Auto Enrollment for DD Waiver Youth Transition	Y
R6.18 Reduce DD Waiver Churn Enrollments	Y
R6.19 Reduce Senior Dental Grants	N
R6.20 Delay implementation of Community Health Workers	N
R6.21 Realigning Children in Rocky Mountain Health PRIME	N
R6.22 Removing ACC credentialing component from FY 2026 R-6 Accountable Care Collaborative Phase III	N
R6.23 Reducing Certain Rates to 85% of Medicare Benchmark	Y
R6.24 Outpatient Drug Rate Reduction	Y
R6.25 Shifting Utilization to Cost-Effective Biosimilars and Other Agents	Y
R6.26 Third Party Liability Secondary Payer Shift for drugs	N
R6.27 Rate Reduction to Specialty Drug Carveout Program	Y
R6.28 Drug Dispensing Fee Reduction	Y
R6.29 LTSS Presumptive Eligibility Delay	Y
R6.30 Soft Cap on Certain HCBS/CFC Services	Y
R6.31 Cap Weekly Caregiving Hours	Y
R6.32 Cap Weekly Homemaker Hours for Legally Responsible Adults	Y
R6.33: Align Community Connector Rate with Supported Community Connections	Y
R6.34 Unit Limitations for Community Connector	Y
R6.35 Reduce Movement Therapy Rates: Note: HCPF is requesting to withdraw this proposal in S/BA-07	N/A
R6.36 Align Member Cost of Care Contribution (DD PETI)	Y

8. [Rep. Brown] A certain percentage of cost increases comes from rates, a certain percentage from utilization, etc. For R6 generally, please justify how each of these requested reductions aligns with the drivers of actual cost increases.
    a. If 50.0 percent of the cost increase is from utilization, then is 50.0 percent of the reduction from utilization?

b. Do the proposed reduction disproportionately impact certain communities and/or certain cost drivers?

RESPONSE:Over the past 18 months, HCPF has undertaken a comprehensive process to examine our cost trends, uncover key trend drivers, and propose specific reductions to address those trends. This process has been directed by HCPF's executive leadership through monitoring enrollment and forecast trends, researching other states' practices, and soliciting ideas and feedback from all HCPF staff. HCPF's R-06 request includes reductions to rates, delays in implementation, and other budget reduction proposals to achieve the state's budget balancing targets by addressing cost drivers while protecting coverage for as many Coloradans as possible.

HCPF has observed three key drivers of cost increases: utilization, rate increases, and enrollment/eligibility. HCPF's proposed sustainability actions directly address these cost drivers. The alignment is as follows:

Sustainability actions that address unsustainable utilization cost increases:

- R6.08: Definitive Drug Testing;
- R6.09: Reinstate Medicaid prior authorization of outpatient psychotherapy;
- R6.10: Implement pre- and post- claim review of all pediatric autism behavioral therapy;
- R6.20: Delay implementation of Community Health Workers;
- R6.30: Soft Cap on Certain HCBS/CFC Services;
- R6.31: Cap Weekly Caregiving Hours;
- R6.32: Cap Weekly Homemaker Hours for Legally Responsible Persons; and
- R6.34: Unit Limitations for Community Connector.

Sustainability actions that address unsustainable rate cost increases:

- R6.11: Roll back 1.6% rate increase;
- R6.12: Adjust Community Connector Rate (-15%);
- R6.13: Eliminate Nursing Facility Minimum Wage Supplemental Payment;
- R6.23: Reducing Certain Rates to 85% of Medicare Benchmark;
- R6.24: Outpatient Drug Rate Reduction; and
- R6.33: Align Community Connector Rate with Supported Community Connections(-23%).

Sustainability actions that address unsustainable enrollment/eligibility cost increases:

- R6.04: Ending Continuous Coverage;
- R6.05: Reduction in Immigrant Family Planning;
- R6.14: Align IRSS rates;

- R6.17: Change Auto Enrollment for DD Waiver Youth Transitions;
- R6.18: Reduce DD Waiver Churn Enrollments; and
- R6.29: LTSS presumptive eligibility (PE) delay.

In addition to developing measures to directly target our three key cost drivers, HCPF is proposing to implement sustainability actions that do not fit neatly into those three buckets: R6.01: Accountable care incentives, R6.02: Reduce the Behavioral Health Incentive Program, R6.03: Reductions to Access Stabilization Payments, R6.06: Reduction in SBIRT training grants, R6.21: Realigning Children in Rocky Mountain Health PRIME, R6.22: Removing ACC credentialing component from the Accountable Care Collaborative Phase III, and R6.36: Align Member Cost of Care Contribution (DD PETI). For specific impacts to populations please see responses to Questions 46, 47 (OCL) and 12 (Behavioral Health).

Finally, note that R6.35: Reduce Movement Therapy Rates, is not included above, as HCPF is requesting to withdraw that proposal in S/BA-07.

9. [Sen. Kirkmeyer] For each provider rate code the Department proposes reducing, what is the impact analysis? What are the long-term impacts of these reductions?

RESPONSE: HCPF will continue to monitor access to care and wait times to determine what effect, if any, occurs due to rate reductions. While HCPF has not performed impact analyses for each individual code, our proposals are informed by the access analysis within the recent work associated with the MPRRAC.

Further, HCPF's proposal to reduce rates is intended to preserve access to care, to the extent possible, by avoiding reductions to rates that are already below various thresholds using currently available metrics. This is in contrast to other possible actions which lower rates for services already at or below those thresholds and perpetuates existing rate disparities. For example, setting Medicaid rates at 85% of the Medicare benchmark aligns with the MPRRAC-supported understanding that rates between 80% and 100% of Medicare are generally sustainable and consistent with the ranges used in many other states for most fee-for-service services. For Long-Term Services and Supports (LTSS), we have chosen to take strategic action to avoid cutting already thin margins for the overwhelming majority of services.

Overall, our rate reduction philosophy helps us balance the required budget reductions with our commitment to supporting long-term access to care, by keeping rates within a range that has generally been workable in practice nationally, while acknowledging that some providers have expressed concerns about the impact of rate changes.

R-06: Managed Care Rates, ACC & Incentives

10. [Rep. Brown] How will the proposed rate reduction to 85% the Medicare benchmark impact managed care, such as PACE? Is the Department assuming a decrease in managed care rates? When would the policy impact managed care rates?

    RESPONSE:The proposed rate reduction would impact managed care capitation rates for Health Maintenance Organizations and PACE Organizations, as the rate-setting for those programs is in part based on the Medicaid Fee Schedule. If the Medicaid Fee Schedule rates are reduced, the affected managed care capitation rates would also be expected to decrease.

    Capitation rates for the Child Health Plan *Plus* (CHP+) and Behavioral Health Regional Accountable Entity providers would not be affected by a rate reduction due to Medicare benchmarking, as those capitations are not set in relation to the Medicaid Fee Schedule.

    The policy would have an effective date of 4/1/2026.

11. [Rep. Brown and Sen. Amabile] Are the costs different to insure people in managed care versus fee-for-service? What about the health outcomes and member experience? Does the Department prefer one approach over the other? If it varies based on the type of service, population, or region, then why? Should we increase the use of managed care or fee-for-service over the other to save money?

    RESPONSE:The costs can be different to insure people in full managed care versus Colorado's managed fee-for-service (FFS) model, in a variety of ways. There is not a compelling reason for the state to move to managed care: the administrative costs would be higher based on national norms under full managed care; the actions and factors that would drive savings through traditional managed care are the same actions and factors HCPF is either doing now or pursuing approvals to do; and, shifting people to capitated managed care programs would create a significant positive fiscal impact due to changing the timing of payments to providers.

    There is no clear difference in outcomes between managed fee-for-service and capitated or full managed care. Health outcomes and member experience can vary based on the region, the ability to contract an appropriate provider network, the services required under the managed care contract and more. At the same time, both types of delivery systems can work well. For example, Rocky PRIME incentivizes primary and specialty care to lower acute care costs on the Western Slope. Denver Health uses its robust hospital network to effectively coordinate care for members in the Denver Metro area. For managed fee-for-service members outside of those two

managed care entities, the Accountable Care Collaborative (ACC) incentivizes outcomes in a primary care model, and requires case management and care coordination. Within the Long-Term Supports and Services (LTSS) realm, HCPF leverages Home and Community-Based Services (HCBS) to provide targeted care to high needs populations. Under behavioral health, HCPF is able to leverage a 1915(b)(3) managed care waiver to allow community services, such as peer support services. These lower acuity services offer lower cost services while increasing access.

HCPF has contracted with a third party expert to review its Medicaid methodologies to identify opportunities for additional savings and efficiencies. That organization will also provide an independent perspective to answer this base question.

Irrespective of if a shift to additional managed care improves outcomes, moving additional members to existing managed care programs, such as the two Medicaid HMOs, would have a steep short-term cost unrelated to the cost of delivering care. Statutory requirements at 25.5-4-201, C.R.S., require HCPF to use the cash system of accounting for the financial administration for Medicaid. Under cash accounting, the movement from a post-service payment system in managed fee-for-service to a prospective payment system in full managed care would create a payment overlap. For the first several months, the state would be paying for incurred claims for the members' utilization in managed fee-for-service while simultaneously paying prospective rates for the managed care utilization. This cost, along with the increase in administration, creates a measurable barrier to a transition to full managed care.

12. [Rep. Brown] Please provide detail for the specific populations and services included in behavioral health capitation and behavioral health fee-for-service. What services do RAEs provide through capitation that are not eligible for reimbursement through fee-for-service? What determines whether a service is placed in behavioral health capitation, behavioral health fee-for-service, or elsewhere in the department?

    [Rep. Brown/Sen. Amabile] Please provide significant detail about how the per-member-per-month behavioral health capitation rates are set, including but not limited to:
    - How do previous years under- or over-expenditures factor into the next year's rates?
    - Are rates set by Department actuaries, RAE actuaries, or another entity? Are the Department's actuaries state FTE or contracted?
    - How large of a range for rates will the actuaries certify?
    - How sensitive are the rates to underlying assumptions for the rate setting?
    - What is the per-patient rate for each RAE?

- How do rate setting assumptions, including but not limited to MLRs, compare to federal requirements?
- What is the administration rate and margin for each RAE?

RESPONSE: All Colorado Medicaid members who have full Title XIX benefits, with the exception of those covered by the Program for All-Inclusive Care (PACE), are eligible to receive benefits under the capitated behavioral health program. The only other exception is in the case of retroactive eligibility, which would not be covered under a prospective capitation. Under retroactive eligibility, member's services would be covered under the fee-for-service (FFS) system.

Most behavioral health services are covered under the capitated program. This includes services only available under the capitation, such as those community-based services allowed under the section 1915(b)(3) waiver that are designed to treat individuals with a serious mental illness. The alternative services under the 1915(b)(3) waiver, referred to as "B3 services", include prevention, early intervention, clubhouses, drop-in centers, vocational services, assertive community treatment, residential mental health treatment, respite care, recovery services, and peer support.

Residential services for children in the care and custody of County Child Welfare or the Division of Youth Services (DYS) are only paid in FFS. Home and Community-Based Services (HCBS) Waiver specific services (services that are not part of the standard behavioral health benefit that all members have access to), such as those available under the Children's Habilitation Residential Program (CHRP) waiver, are also paid FFS.

HCPF sets behavioral health capitation rates in conjunction with contracted actuaries. As required in federal regulations at 42 CFR § 438, the capitations are set using historical line level claim data, enrollment data, financial information from the Regional Accountable Entities (RAEs), historical policy changes, utilization and unit cost trends, and current/future policy changes. HCPF's contracted actuaries align the rate-setting to the yearly rate-setting guidelines, which are published by CMS. The details of how the rate-setting aligns with the federal regulations and the CMS rate-setting guidelines are submitted yearly in the capitation rate certification letter.

To set the behavioral health capitations, historical claims data is matched to HCPF enrollment data to create a base of allowable claims for members. This data is broken into the different categories of people, known as Categories of Aid (COA), and service categories, known as Categories of Service (COS). The base data is then adjusted to account for claims runout and historic policy changes that may not be reflected in the original data.

To this adjusted base data, trends for utilization and unit cost are added to project forward into the new fiscal year based both on COA and COS. Once this is complete, adjustments are made for any new policy changes, such as new legislation and new federal requirements, being implemented by HCPF. Finally, the last step is to add in the administrative costs and any margin to the rates. The administration also has a range associated.

Trend factors and administrative costs are set prospectively; because they are not certain, HCPF and its actuaries use them to create a lower and upper bound. Trend and administrative costs at the higher end represent a less efficient program while costs at the lower end represent a more efficient program. Due to the range of values within the trend and administrative costs, the final rate range for Fiscal Year (FY) 2025-26 had a width of 4.5 percent.

After discussion with the RAEs, a rate within the range is agreed upon resulting in a final point estimate to which the actuaries certify. Each COA, or people group, has its own certified rate for each RAE. The aggregate average per member per month capitation rate for FY 2025-26 for each RAE is as follows:

- RAE 1: $113.28
- RAE 2: $111.23
- RAE 3: $98.08
- RAE 4: $119.50

Aside from program/policy changes, the rates are most sensitive to changes in the underlying base data. If the underlying base data has seen large jumps or drops, this can translate to the final rates. This could be tied to utilization differences like people using more or less services, or a shift to more or less costly services. It could also be tied to changes in the underlying population; for example, the rates changed significantly during the Public Health Emergency (PHE) and the PHE unwind while there was rapid caseload growth, then rapid caseload decline.

As part of the rate-setting, HCPF reviews and validates the previous year's medical loss ratio (MLR). The MLR measures how much of the revenue paid to the RAEs was spent specifically on medical services. Administrative costs include the costs to operate and administer the program, contracts, staff, provider support to build network capacity, technology, data and claims programs, overhead, and profit. Per federal regulations, RAEs must meet an effective 85% MLR floor, which limits the amount of administration costs that can be included in the capitations. A high medical loss ratio could imply unanticipated utilization/costs or could represent an inefficient managed care entity. A low medical loss ratio, below 85%, implies a low spend on

medical services and requires, per contract and federal regulations, a recoupment to get the RAE back to an effective 85% MLR.

For the administrative costs, HCPF and its actuaries evaluate certified financial information submitted by the RAEs. This information is then checked against submitted medical claims and is independently reviewed by HCPF's contracted auditors. The administrative costs are also weighed against future needs and anticipated efficiencies to produce an administrative adjustment as the final step of the rate-setting process. The administrative costs are broken into two components, those for fixed costs, and those that vary with the size of the population. To this administrative cost, a 1% margin is added for additional risk contingency. For the FY 2025-26 capitations, the four RAEs had the following administrative percentage added into the rates, inclusive of the 1% margin:

- RAE 1: 6.86%
- RAE 2: 10.84%
- RAE 3: 6.48%
- RAE 4: 9.92%

13. [Rep. Brown] Please describe the payments to the Regional Accountable Entities (RAEs) for administration, including the payments for the RAEs to manage the care for members and to incentivize providers but not the money that goes to providers for service costs. Where are the appropriations for these payments located in the budget? Please break apart the expenditures into the major components. For example, how much of the total administrative payments are for incentives?

RESPONSE: RAEs receive funding for administration from two sources: the capitation payment for behavioral health services and from the Care Management per-member-per-month (PMPM) payment. Funding for behavioral health services is located in HCPF's "Behavioral Health Community Programs" Long Bill group. Funding for care management services and quality incentive payments is located in HCPF's "Medical Services Premiums" Long Bill group.

The capitated behavioral health payment is a PMPM payment that HCPF pays to the RAEs to cover a defined set of services for enrolled members. This monthly payment includes the cost of both services and administration. Rather than paying for each service delivered and making a separate payment for administration, HCPF pays the RAE a predetermined rate, and the RAE assumes the financial risk of providing all required covered services within that amount. Capitation payments vary by eligibility category; for example, HCPF pays a different PMPM for children than it does adults. This payment allows each RAE to contract with a statewide network of behavioral

health providers that provide mental health and substance use disorder services for members. Rates can vary depending on historic utilization patterns and unique regional variations that affect pricing. RAEs accept financial risk under this arrangement; behavioral health providers submit claims for services to the RAEs, which process and pay those claims. Because the administrative payment is included in the total predetermined rate by HCPF, an estimated amount for behavioral health administration has been included in the table below.

For physical health care services, RAEs receive a flat Care Management PMPM for the full spectrum of care coordination and case management services, member engagement, practice support, network management, population health, community investments and any necessary administration. This PMPM varies by RAE and, unlike behavioral health, does not vary by eligibility type. The Care Management PMPM is not used to reimburse primary care claims; PCMPs bill HCPF directly under fee-for-service for physical health care claims.

RAEs must use the Care Management PMPM to establish and support a network of Primary Care Medical Providers (PCMPs) to serve as a member's focal point of care. RAEs must distribute a minimum of 33% of their Care Management PMPM to their PCMPs for this work, referred to as the medical home payment.

RAEs also use the Care Management PMPM for other activities including:

- Coordinating members' care themselves or working with their provider network to ensure care coordination is available to all members.
- Ensuring members receive appropriate and timely follow-up care after inpatient and residential care to reduce avoidable readmissions.
- Maintaining a network of community-based organizations that also support members within their region. This can include financial rearrangements.
- Collaborating with other entities that also serve members to reduce duplication of services and gaps in care for the member by ensuring there is a lead coordinator and care plan where applicable. This includes working with entities like the Case Management Agencies (CMAs), Dual-Eligible Special Needs (DSNP) plans for members dually-eligible for Medicare and Medicaid, and the Behavioral Health Administrative Service Organizations (BHASOs) for members that may lose or regain their Medicaid eligibility.
- Engaging in quality improvement work internally and with their network of PCMPs to support population health management and improve outcomes for members.

RAEs are eligible to receive quality incentive payments for meeting or exceeding performance towards physical health related quality and population health measures,

Performance Pool incentive measures, and Behavioral Health Incentive Program (BHIP) measures. **RAEs typically pass through the majority of their earned incentive funding to their contracted providers.**

The table below shows budgeted amounts by category for FY 2025-26.

Payment Category	FY 2025-26 Amount
Care management PMPM payments	$191,402,226
Behavioral health (approximate)*	$136,717,106
Physical health quality incentive payments	$43,806,868
Behavioral health quality incentive payments	$26,580,173

*This amount is calculated by multiplying the total FY 2025-26 projected behavioral health capitation expenditure with the statewide average administrative percentage added to the behavioral health capitation rates paid to the RAEs.

14. [Sen. Kirkmeyer] How much do the rates paid to providers differ by Regional Accountable Entity (RAE)? Where do the rates differ? What are the differences? What drives the differences?

RESPONSE: Each RAE has specific contracted rates with providers in their region. Historically, HCPF has seen large differences in rates for services including Outpatient Psychotherapy and certain Substance Use Disorder (SUD) services. Through HCPF's monitoring and robust conversations with the RAEs, these differences have been reduced. The launch of ACC 3.0 allowed the RAEs to rebalance provider rates across the new regions for FY 2025-26 and ensure the rates are comparable, though not identical, across the state. For certain providers, like Federally Qualified Health Centers (FQHCs) and Comprehensive Safety Net Providers (CSNPs), many service rates are standardized statewide.

For FY 2024-25, the following table represents some of the most commonly provided procedure codes. The table includes the lowest average rate and the highest average rate across the previous RAEs. This data represents averages of negotiated amounts paid to non-facility providers within the FY 2024-25 time period.

For the psychotherapy codes, the pricing spread has been reduced. For 90832, 90834, and 90837, and 90846 the top outlier averages were paid by Colorado Access, which has since modified its contracting. For 90847, the outlier average was for Rocky Mountain Health Plans, which has primarily rural areas.

For the Methadone administration code, previously an issue across providers, the rates have been leveled out across the state. Similarly, the SUD residential services, which are facility-based services, are showing relatively consistent rates across the state.

Select Behavioral Health Procedure Code Pricing FY 2024-25				
Procedure Code	Description	Fee for Service Rate (Effective October 1, 2025)	Average Rate for the RAE with the Lowest Reimbursement	Average Rate for the RAE with the Highest Reimbursement
90832	Psychotherapy - 30 min	$68.76	$46.36	$72.85
90834	Psychotherapy - 45 min	$91.09	$74.92	$118.00
90837	Psychotherapy - 60 min	$134.51	$98.01	$130.94
90846	Family Psychotherapy without member	$87.01	$83.68	$123.90
90847	Family Psychotherapy with member	$90.09	$81.45	$120.48
H0020	Methadone administration	$16.29	$16.27	$22.27
H2036 U1	SUD residential - ASAM level 3.1	$190.00	$246.56	$270.87
H2036 U5	SUD residential - ASAM level 3.5	$425.00	$476.82	$493.37

Provider rates across services may differ due to numerous factors, including prevailing provider rates, the number of available providers, and the general cost-of-living in the region. The RAEs then negotiate their rates based on these factors. Another major contributor to price differentiation is the network need for a particular provider type or service within a particular region. The contractual relationship between HCPF and RAEs allows each RAE to retain a degree of local control in establishing robust and region-specific networks that align with and target their local service needs and priorities.

R-06: Pharmacy

15. [Sen. Amabile] How will a Medicaid client with 3rd party insurance know that they need to go to an in-network pharmacy to get coverage? Will Medicaid members show up at out-of-network pharmacies and get a surprise bill? What education and outreach efforts is the Department providing?

    RESPONSE: Members are required under §25.5-4-301(1)(a)(III) to comply with the network rules of their primary insurance, including using in-network pharmacies. Medicaid may only pay as a secondary payer when the primary plan has been billed first and the pharmacy participates with both the member's primary insurer and Colorado Medicaid. The MMIS and PBMS conduct third-party liability (TPL) checks against member insurance data to ensure the primary plan is billed before Medicaid. If a member presents at a pharmacy that does not participate with either their commercial insurer or Medicaid, the pharmacy will direct them to locate a provider that accepts both coverages to help avoid any potential costs to the member. About 82% of Colorado-licensed pharmacies are enrolled as Medicaid providers.

    Education regarding commercial plan network requirements is provided by the primary insurer. Members may use the Health First Colorado (Colorado's Medicaid program) Find a Provider tool to locate Medicaid-enrolled pharmacies and can find additional information about coordinating benefits in the Medicaid Member Handbook. Members may also contact the Member Contact Center for assistance with questions about their other coverage.

16. [Rep. Sirota] Please provide the timeline for S.B. 25-084 (Medicaid Access to Parenteral Nutrition), submission of State Plan Amendments, and implementation of this request. If the Department has already submitted a State Plan Amendment, will the Department be required to submit another to implement the request? Will the request be implemented in FY 2026-27 if it requires the submission of a State Plan Amendment?

    RESPONSE: CMS has approved the State Plan Amendment (SPA), establishing a new total parenteral nutrition (TPN) rate of $73.21, effective January 1, 2026. HCPF will need to submit an additional SPA to implement the revised rate. Implementation could occur in Fiscal Year (FY) 2026–27, contingent upon timely CMS approval of that subsequent SPA.

17. [Rep. Brown] If we are cutting the specialty drug rates below the actual cost to the providers, where is the breaking point where the drugs are no longer available? What is the Department's confidence that the drugs will still be available? Which providers will see decreases in reimbursement and how does the projected decrease compare to costs?

RESPONSE: This carve out specialty drug reimbursement policy only impacts a very small number of specialty drugs (22), all of which are dispensed in the hospital setting. It was created to increase reimbursements for newer specialty drugs not fully accounted for in the Solventum model HCPF uses to establish such reimbursements. This drug reimbursement policy does not affect reimbursement to retail pharmacies, rural hospital pharmacies or independent hospitals that do not dispense these complex specialty drug therapies.

HCPF initially began carving out reimbursements for specialty drugs in August 2018 at 72% of cost. We increased reimbursement to 90% of cost in February 2022 and to 97% to 100% of cost began in January 2024. This level of Medicaid reimbursement is an extreme outlier compared to the overall 80% of costs Colorado hospitals receive on average under the Colorado Medicaid program. Reducing reimbursement back to 92% of hospital costs still reflects a level far above the 80% average.

Reimbursements have been lower than 92% of cost for the majority of the time this carveout reimbursement has existed, yet these drug therapies were still provided. Further, this reduction only applies to fee-for-service reimbursement; hospitals that provide these drugs will continue to see supplemental payments via CHASE payments, partially offsetting fee-for-service reductions.

Children's Hospital Colorado will bear the majority of the decrease in reimbursement, with University Hospital and HCA Presbyterian St. Luke's also seeing decreases. Since reimbursement is currently tied to costs, this will represent a 5-8% decrease in reimbursements for these specialty drugs, which will also see corresponding increases in CHASE payments.

HCPF believes that access will be maintained because reimbursement will remain above historic reimbursement levels and supplemental reimbursement is available to hospitals where costs are not fully covered in fee-for-service. HCPF will continue to monitor expenditure and utilization going forward under this carve out reimbursement approach.

18. [Sen. Amabile] The Department is requiring Medicaid members to use lower cost biosimilar drugs before paying for higher cost branded versions. Are there other places where we have a similar policy? Didn't we recently undo something similar for psychotropics? Why would we limit access to the drugs a doctor thinks are the best fit?

RESPONSE: Biosimilars are FDA-approved to be just as safe and effective as the original biologic drug. They are essentially the biologic version of generics - the same medication, made by a different manufacturer, at a lower cost.

Requiring the use of a lower-cost biosimilar first is consistent with long-standing industry standard as well as Medicaid policy to use the most cost-effective clinically appropriate option. We already apply this standard across most of our Preferred Drug List and have applied similar biosimilar-first-policies before, such as requiring a biosimilar for Remicade. These policies have not resulted in access issues; in fact, we have seen utilization increase for drugs subject to these policies.

This is very different from the psychotropic policy in SB 24-110. That bill sought to reduce the number of drugs a member must fail before receiving a non-preferred psychotropic drug. In contrast, with this initiative, providers still prescribe the medication they believe is best; the policy simply ensures the state pays for the most cost-effective version when products are clinically equivalent.

19. [Rep. Gilchrist] The Department says the biosimilars have no clinically meaningful differences in safety, purity, or effectiveness. Do the criteria address differences in quality of life?

RESPONSE: The language stating that biosimilars have no clinically meaningful differences in safety, purity, or effectiveness comes directly from the FDA, not from HCPF. Biosimilars enter the market only after the originator drug's patent expires, allowing other manufacturers to produce the same biologic drug. Despite the term "biosimilar," these products are the same medication, derived from a living organism, and reviewed by the FDA to ensure equivalent potency and safety.

While it would be unusual for a biosimilar to produce a different impact on quality of life, our existing processes allow providers to request the brand product if clinically necessary. As with all Medicaid drug classes, HCPF has policies in place to address the rare circumstance in which a member does not respond to a biosimilar in the same way they respond to the original product.

20. [Rep. Taggart] Does the biosimilars policy open the State to a potential lawsuit? Are we stepping over the line as an insurer and becoming doctors?

RESPONSE: Requiring a biosimilar before a higher-cost brand product poses no greater legal risk than our long-standing policy of requiring generics before brand-name drugs. Biosimilars are widely used, FDA-approved to be as safe and effective as the original product, and fall fully within HCPF's authority to prioritize the most cost-effective clinically appropriate option.

Biosimilars are not different therapies; they are the same drug made by a different manufacturer. If a member has a clinical reason they cannot use the biosimilar, our exception process allows access to the brand product. This is not HCPF "becoming

doctors"; it is ensuring the state pays for the most cost-effective version of the drug that the provider already believes is appropriate. Not following these industry standard policies would set the state up for an outlier trend increase for specialty drugs, which is not a tolerable position to take.

About 1.5% of prescriptions prescribed to Medicaid and Commercial members for the conditions they have are so expensive, they are consuming about 50% of total prescription drug spend. HCPF must continue to adhere to Medicaid policies that parallel the release of FDA-approved biosimilar drugs available at lower costs if we are to be sound stewards of taxpayer dollars. We must responsibly ensure Colorado Medicaid follows the same industry standard policies that battle the nation's #1 driver of rising health care costs - and that is the cost of specialty drugs. One of the best ways to do that is by prioritizing the dispensing of biosimilar drugs, which are the same specialty drug therapy but available at lower costs.

21. [Rep. Brown] What are the biosimilars the Department plans to require and what are their brand equivalents?

RESPONSE: HCPF plans to require two biosimilars: biosimilar ustekinumab in place of the brand Stelara, and biosimilar adalimumab in place of the brand Humira. These drugs represent some of our highest specialty drug spending, and using lower-cost biosimilars is the most effective way to address these cost trends. Both ustekinumab and adalimumab are primarily used to treat inflammatory conditions such as rheumatoid arthritis, plaque psoriasis, Crohn's disease, and ulcerative colitis.

We will continue monitoring additional opportunities as more biosimilars enter the market.

R-06: Specific Reduction Areas in R6

22. [Sen. Amabile and Rep. Gilchrist] Please discuss the combined impact of all the proposed changes to dental services. How do the individual initiatives interact with the others? What is the net impact on access to care? What is the net impact on providers?

RESPONSE: The net fiscal impact to dental providers for the proposed rate reduction and the two spending caps in the January amendment is estimated to be a reduction of $13.8 million total funds, including a reduction of $2.5 million General Fund in FY 2025-26 and $27.0 million total funds, including a reduction of $3.8 million General Fund, in FY 2026-27. The $3,000 cap on adult dental services is expected to begin July 1, 2026 and reflects $6.48 million total funds, including $42,000 General Fund, and $1.8 million cash funds of the total reduction. The remainder of this reduction is a result of the rate reduction.

In 2013, Colorado Medicaid introduced an adult dental cap of $1,000, raised it to $1,500 in 2019 and removed it effective July 1, 2023. Also effective July 1, 2024 was a significant rate increase for dental benefits. The current proposal would reinstate an annual adult cap of $3,000 alongside rate adjustments that have partially rolled back the 2024 rate increases.

The rate adjustment reduces those rates which received targeted increases, but was applied so that rates which had a significant disparity with commercial rates are not disproportionately affected. The reduction preserves the intent of the original rate action to correct significant rate disparities while still achieving the required savings.

In combination, a cap and lower reimbursement rates are expected to constrain total paid revenue per adult member and may change provider behavior, particularly for higher-cost, procedure-heavy cases. The initiatives interact in two main ways: the cap limits the maximum payable amount per member in a year, while rate reductions lower payment per service; together they reduce the financial return for complex treatment plans and increase the need for providers to sequence or defer care within the benefit year. In some cases, rate reductions mean that members can receive more services under a fixed-dollar cap.

Net impact on access to care may vary by geography and specialty: in areas with thin provider supply (e.g. rural communities, oral surgery/endodontics), some practices may reduce Medicaid appointment slots or focus on lower-intensity services, while other practices may maintain access but emphasize treatment planning to stay within the cap. For members, the cap introduces a hard annual limit that can affect continuity when comprehensive plans span multiple visits or benefit years; preventive and urgent care should continue, but some non-urgent restorative services may be staged.

23. [Rep. Sirota] The senior dental grants are the payer of last resort when a member has no other insurance, including Medicaid. How will seniors get needed services with the proposed reduction?

RESPONSE: Currently, the average Senior Dental Grant expenditure per senior is $860, and about 4,620 seniors in a fiscal year receive care through this program. With the reduction of $2 million proposed in this budget, there will be approximately $2 million in funding for the program, which will still allow for approximately 2,295 seniors to be served. Seniors who have unmet needs may need to pay out of pocket for services or be put on a waiting list for services.

24. [Sen. Bridges] What are the durable medical equipment codes that will be impacted by the reduction to 85 percent of Medicare?

RESPONSE: The affected DME codes are included in Appendix B. In total, 394 Durable Medical Equipment (DME) codes out of 1,141 (34.5%) will be impacted by the reduction to 85% of Medicare. The remaining 747 codes (65.5%) will not be affected, either because their current rates are already below 85% of Medicare, they do not have corresponding Medicare rates, they are manually priced, or for other technical reasons.

25. [Sen. Amabile] Why is the Department proposing delaying primary care stabilization funding for the smallest providers who most need it? Who does this reduction impact?

RESPONSE: Access Stabilization Payments are a new, additional payment for eligible Primary Care Medical Providers (PCMPs) that serve to supplement their primary care services revenue. As PCMPs have not yet received Access Stabilization Payments and the payments are on top of their FFS revenue, the implementation delay of six months does not represent a reduction of revenue for PCMPs.

There are 271 PCMPs eligible for an Access Stabilization Payment, comprising three categories of eligibility.

- Small: 87 PCMPs (5 or fewer rendering providers)
- Rural: 37 PCMPs (located in a county designated as "Rural" or "Counties with Extreme Access Considerations (CEAC)" by the Division of Insurance)
- Pediatric: 80 PCMPs (80% or more of patients with Medicaid under age 18)

A PCMP who meets multiple categories of eligibility does not receive any additional payment.

R-06: Drug Testing

26. [Rep. Brown and Sen. Amabile] Please elaborate on the request to limit tests for specific drugs. Why do we need this limit? What are the utilization trends and what is the problem the Department is trying to solve? Is fraud occurring?

RESPONSE:

Why the Limit Is Needed

HCPF has established a limit of 12 *definitive* drug tests per adult per state fiscal year to address significant overutilization and abusive billing practices that conflict with national clinical standards. This policy does not limit *presumptive* drug testing, the standard routine testing modality for monitoring substance use as part of standard treatment that is far less expensive ($12–$55 per test versus $98–$212 for definitive tests). Children and youth can exceed the limit through prior authorization, consistent with EPSDT requirements.

The limit is grounded in guidance from the American Society of Addiction Medicine (ASAM), which establishes that *presumptive* testing should be routine, while *definitive* testing should be reserved for specific clinical circumstances, such as when a patient disputes a result, when a specific drug or metabolite must be identified, or when results will drive a major clinical decision. ASAM explicitly warns against standing orders, automatic reflex testing of all presumptive positives, and routine use of definitive panels without individualized clinical justification. Colorado's Medical Services Board approved this policy limitation on December 12, 2025.

Utilization Trends

Since 2022, Colorado Medicaid has experienced substantial and concerning growth in *definitive* drug testing expenditures. Monthly fee-for-service spending rose from approximately $2.4 million in early 2022 to peaks exceeding $5.5 million by 2025. In the calendar year 2024, the program paid $54.9 million for definitive drug testing across 43,704 members, with an average of 7.06 tests per member among those receiving at least one test.

However, the statewide average obscures significant outliers. Certain laboratories bill at rates far exceeding what would be expected under clinically appropriate use. For example, one laboratory in particular averages 13.77 definitive tests per member (nearly double the statewide average) and billed $7.46 million in CY 2024. More than a dozen of their patients received more than 100 *definitive* drug tests each and the billing and reimbursement from HCPF totaled more than $13,000 in *definitive* drug testing payment *for each patient*. These patterns are driven by standing-order arrangements that either bypass lower-cost presumptive testing entirely or automatically reflex to expensive *definitive* testing on every *presumptive* positive, regardless of clinical context.

The Problem HCPF Is Solving

HCPF is addressing a pattern in which clinical laboratories routinely perform high-cost *definitive* testing on specimens that should receive only presumptive screening. This approach generates maximum reimbursement while providing no additional clinical value. The results do not change treatment decisions. It violates ASAM guidance, HCPF's medical necessity requirements under 10 CCR 2505-10 8.660.3.A.4 (which prohibits routine diagnostic tests without apparent relationship to treatment or diagnosis), and the standards applied by commercial payers and Medicare.

Is Fraud Occurring?

Yes. The billing patterns observed among certain laboratories are consistent with fraud, waste, and abuse as defined under federal and state program integrity standards. Repeated billing for medically unnecessary definitive tests, particularly under standing orders that lack individualized clinical rationale, may implicate the

False Claims Act, Anti-Kickback Statute, and the Eliminating Kickbacks in Recovery Act (EKRA).

This is not a theoretical concern. In October 2024, the U.S. Department of Justice announced a $27 million settlement with Precision Toxicology/Precision Diagnostics for medically unnecessary urine drug testing and kickbacks. The conduct at issue, lab-driven standing orders, bundled point-of-care and definitive testing, and lack of individualized ordering, closely mirrors what HCPF has identified in Colorado. Colorado Medicaid is among the states receiving restitution from that settlement, and the District of Colorado U.S. Attorney's Office participated in the case. Additional federal enforcement actions in addiction treatment settings (including Genco Lab, CleanSlate Centers, and others) confirm that routine or reflexive definitive testing in SUD populations is a recognized national enforcement priority.

The 12-test annual limit is a measured response that preserves access to clinically necessary *definitive* testing while curtailing billing practices that extract maximum reimbursement without corresponding patient benefit.

27. [Sen. Amabile] Will the limit on tests for specific drugs impact the ability of Medicaid clients to get coverage for court-ordered drug tests?

RESPONSE: Court-ordered drug tests are only covered by Colorado Medicaid's Laboratory Services benefit if they are medically necessary. Medicaid can reimburse medically necessary, covered services regardless of a court order for the services. However, when courts mandate a specific treatment intensity, length, or provider for an individual that is not covered by Medicaid or are not medically necessary, Medicaid is not allowed to reimburse for care. Under both federal Medicaid law and Colorado statute, HCPF can only use Medicaid dollars to pay for covered, medically necessary services, as defined in our rules and in accordance with Title XIX (C.R.S. 25.5-4-104, 25.5-4-105; 10 CCR 2505-10-8.076). A court can order that an individual receive a particular service, but it cannot expand what Medicaid is legally allowed to cover. Medicaid cannot make exceptions to coverage for an individual because a service is required by a judge.

This means the following requirements must be met:

- The test is ordered by a licensed healthcare professional, and
- The test is performed to diagnose conditions and illnesses with specific symptoms, and
- The test is not a routine diagnostic test performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint or injury.

The 12-test limit for drug tests specifically applies to *definitive* drug tests. *Presumptive* drug tests, which are the frontline method of urine analysis testing during drug and alcohol treatment, are not part of the yearly limit.

28. [Rep. Brown] What are the conditions when these types of tests are indicated?

RESPONSE: Guidance from the National Institute on Drug Abuse indicates that drug testing is never the sole determinant when making patient care decisions. Drug testing can be a useful tool, but it should not be the only tool for making decisions. Drug testing results should be considered alongside a patient's self-reports, treatment history, psychosocial assessment, physical examination, and a practitioner's clinical judgment. (NIDA)

It's important to clarify that HCPF's limit on drug testing only applies to *definitive* drug testing, and not *presumptive* drug testing.

Presumptive drug tests, which are the frontline method of urine analysis testing during drug and alcohol treatment, are unchanged and remain available for regular monitoring for substance use disorder treatment. The primary benefit of presumptive testing methods is a much faster turnaround time to receive results, which allows for a more rapid therapeutic response that can more meaningfully link substance use and behavior. *Presumptive* testing should be a routine part of initial and ongoing assessment of a member's use of substances.

Definitive tests are for targeted, treatment management-changing questions rather than routine monitoring. Definitive drug tests are considered medically necessary under criteria published by HCPF and based on guidance from the American Society of Addiction Medicine (ASAM). *Definitive* testing is a targeted tool used when greater analytical specificity is necessary. Colorado Medicaid uses the following criteria to evaluate medical necessity. These reflect the ASAM principle that definitive testing should be reserved for situations where the result will directly influence clinical decision-making, not used routinely, reflexively, or without individualized clinical justification.

- **Disputed Presumptive Result:** A member disputes a presumptive positive or negative result, and clarification will affect the treatment plan (e.g., level of care, medication adjustment, or contingency management incentives).
- **Need to Identify a Specific Drug or Metabolite:** The provider needs to distinguish between specific substances that presumptive testing cannot adequately differentiate (such as heroin versus other opioids within an opiate class screen) and the result will guide clinical management.

- **High-Impact Clinical Decisions:** The result will inform decisions with major clinical implications, such as initiation, discontinuation, or significant change in pharmacotherapy; transition between levels of care; or safety-critical determinations such as eligibility for take-home opioid agonist doses in an opioid treatment program.
- **Clinical Indicators of Use Despite Negative Presumptive Test:** The member demonstrates signs or symptoms strongly suggestive of recent substance use (such as intoxication or withdrawal) that conflict with a negative presumptive test, and definitive testing is needed to clarify the discrepancy.
- **Monitoring Complex Pharmacotherapy or Diversion Risk:** The test is used to monitor adherence to prescribed medications for addiction treatment (such as methadone, buprenorphine, or naltrexone) or to evaluate possible diversion when presumptive methods are insufficient.
- **Clarifying Unexpected Results With Significant Treatment Impact:** Definitive testing is needed to clarify unexplained or incongruent presumptive findings when results may lead to treatment intensification or additional safety measures.
- **Direct Ordering When Precision Is Required:** When substance use is already acknowledged by the member or otherwise expected, and the provider requires specific analyte identification and/or quantification (for example, to select an appropriate medication or evaluate relapse severity), it may be clinically appropriate to order a definitive test without a preceding presumptive test.

R-06: Cover all Coloradans

29. [Rep. Sirota and Sen. Amabile] What are the dental service trends for people eligible through Cover All Coloradans? Is the rationale for the lower cap on dental services based on low utilization?

RESPONSE: Since the launch of Cover All Coloradans on January 1, 2025, dental benefit data shows that this population is using dental services frequently, but primarily utilizing low-cost preventive services. Most participants are accessing preventive care. When additional claims run out, it is clear that more individuals may reach or exceed the $750 annual cap, though to-date the majority have received <$750 in services.

30. [Rep. Sirota and Sen. Amabile] How will the lower cap on dental services and the switch to fee-for-service for behavioral health services impact access to care for people eligible through Cover All Coloradans?

RESPONSE: People eligible through Cover All Coloradans will continue to have access to dental and behavioral health services. As noted in Question 29, most individuals in

Cover All Coloradans are utilizing low-cost, preventive services. However, higher-cost dental procedures like orthodontia will be subject to the proposed cap. Behavioral health services will move to fee-for-service.

The Cover All Coloradans population is mobile and has not used behavioral health services at a volume that makes it cost effective to serve this population under capitated managed care. The Fee-For-Service (FFS) Behavioral Health Benefit is a group of services designed to provide medically necessary behavioral health services that very closely mirror the managed care benefit. The FFS benefit includes outpatient and inpatient mental health services and substance use disorder (SUD) services. There are some benefits that are authorized through the Managed Care program that will be limited to those under 21 or over 65, such as stand alone case management and or residential care for those who do not have a serious mental illness or substance use disorder.

Even though members will no longer have general care coordination resources from our Regional Accountable Entities (RAEs), they may receive other wraparound support from community providers, including comprehensive safety net providers (CSNPs). Overall, the shift to fee-for-service for behavioral health services is expected to have a low impact on access to care for people eligible through Cover All Coloradans.

R-06: Pediatric Behavioral Therapy

31. [Sen. Amabile] How will the PBT audit generate savings? Will the Department implement changes that will decrease utilization? Please describe all changes the Department expects to implement, the associated cost savings, and estimated number of children impacted.

RESPONSE: Due to the growth of the Medicaid spend without a corresponding growth of members served, HCPF has contracted with an auditing firm to review claims for pediatric behavioral therapy (PBT). Based on claim and utilization trends, national industry studies already shared with the JBC, similar audits in other states, and the Office of the Inspector General (OIG) audit findings, HCPF is very confident that the implementation of preliminary audit findings, including pre- and post-payment reviews, will result in General Fund savings. These services involve complex billing requirements, rapidly growing utilization, and a demonstrated vulnerability to improper payments, making them well suited for a data-driven review approach.

Along with other state Medicaid programs, HCPF is currently being audited by the OIG on PBT services and is awaiting the final findings from its review. The initial findings have identified potentially improper payments largely related to missing documentation or documentation practices including copying multiple visits or documents from one child's EHR record to another's, lacking detail regarding

treatment, inadequate credentialing and oversight, and billing practices that do not meet requirements, such as billing for naps or meal times. Given the potential repayment of significant federal funds based on OIG audit findings, HCPF must in parallel expand pre and post payment efforts of PBT providers, as the OIG will not share findings at the provider level.

To accomplish this, HCPF will contract with vendors to conduct more robust and ongoing pre and post payment review to identify billing irregularities and identify noncompliant claims, clawback funds where appropriate, and stop inappropriate billing practices going forward, which is critical given the level of overbillings and inappropriate practices nationally across this industry, including here in Colorado.

Based on a data analysis of one year's PBT claims, the top five PBT providers have billed approximately $110 million. HCPF assumes that approximately $110 million in annual PBT payments would be subject to prepayment review. Of this total, we conservatively estimate that 25% of billing would be inappropriate. Other states that have similarly conducted pre and post payment efforts of PBT services have found improper payment error rates of 95-100%. Additionally, HCPF is launching postpayment audit efforts through its Recovery Audit Contractor (RAC). The RAC will be identifying key vulnerabilities, including services delivered without the required ordering provider and claims billed from disallowed places of service. Other states have used RACs to uncover similar issues, improving compliance and reducing improper payments. Audits are expected to be initiated no later than January 2026 with estimated recoveries in FY 2025-2026 of over $15.8 million total funds (~$7.7 million general funds). These targeted PBT risk areas in Colorado would enhance oversight, ensure provider qualifications and service appropriateness, and promote consistent, high-quality care for children and families.

HCPF will use these findings to strengthen rules and oversight— including rules for credentialing and background checks, clarifying allowable activities, improving documentation and EVV compliance, and tightening prior-authorization and postpayment review. These actions will not reduce medically necessary utilization but will prevent inappropriate billing such as naps, recreational activities, or services delivered by non certified staff. Additionally, the findings will be used to conduct post payment audits of claims potentially improperly paid to providers. Any recoveries generated from the postpayment claims audits will return the federal share and replenish state general fund. It should be noted that state law currently disallows HCPF from extrapolating audit findings across claim populations and instead HCPF has to review each claim individually and associated documentation. The inability to use extrapolation methodologies in audits leads to longer recovery timeframes and additional administrative costs.

32. [Rep. Taggart] Could the PBT audit result in federal or state funding claw backs? Who is required to pay back a federal or state clawback: the Department, RAEs, or providers? Does any portion of the Department's request assume savings from claw backs?

RESPONSE: The PBT benefit is fee-for-service, and RAEs do not have a role in administering or financing it.

The federal OIG audit of PBT services could result in the federal government clawing back the federal share of funding associated with alleged improper payments. The initial findings indicate amounts in the tens of millions of dollars. At this time, the OIG has not provided the underlying claim-level data used to generate its extrapolated repayment estimate. Without this information, HCPF cannot determine whether the sample was representative or whether the extrapolation was calculated appropriately. This concern is heightened by OIG's own footnotes indicating that some payments were classified as improper even though not all documentation was reviewed, and HCPF has no information on whether OIG may have improperly invalidated claims based solely on administrative or documentation issues where the underlying services were medically necessary and otherwise payable. Because this foundational data has not been provided, the state cannot verify the accuracy of the extrapolated amount. As required, HCPF will enter a negotiation period with the federal government to determine any amount the state must return, but that amount would be limited to federal funds only, not state dollars.

While HCPF is challenging both the methodology and the initial repayment amount indicated by the OIG, the audit does identify vulnerabilities in the PBT program, including overbilling, copy-and-paste documentation practices, and services provided by uncredentialed technicians. HCPF is clarifying expectations through regulation and intends to conduct both prepayment and post payment reviews of provider claims. Prepayment review means a claim is manually reviewed before payment; post payment review examines claims that have already been paid and may result in recovery of overpayments from providers.

If improper or potentially fraudulent billing is identified through HCPF's post-payment reviews, providers—not the state or the RAEs—would ultimately be responsible for repaying the state for those overpayments. However, because HCPF is not permitted to use extrapolation, recovery would require claim-by-claim review, which is resource-intensive and could significantly reduce net recoveries. In addition, recovery may not be possible in cases where providers have gone out of business or are otherwise insolvent and unable to repay the identified amounts.

33. [Sen. Amabile] Describe the net impact of the PBT requests on providers and children. The Department of Human Services submitted a request to license ABA facilities. The

Department of Regulatory Agencies has previously reviewed ABA providers and determined that professional licensing was not necessary. Please describe how the Department has or has not collaborated with other Departments to evaluate the net impact on PBT providers and children. Is there a cohesive plan to approach PBT utilization across the Executive Branch?

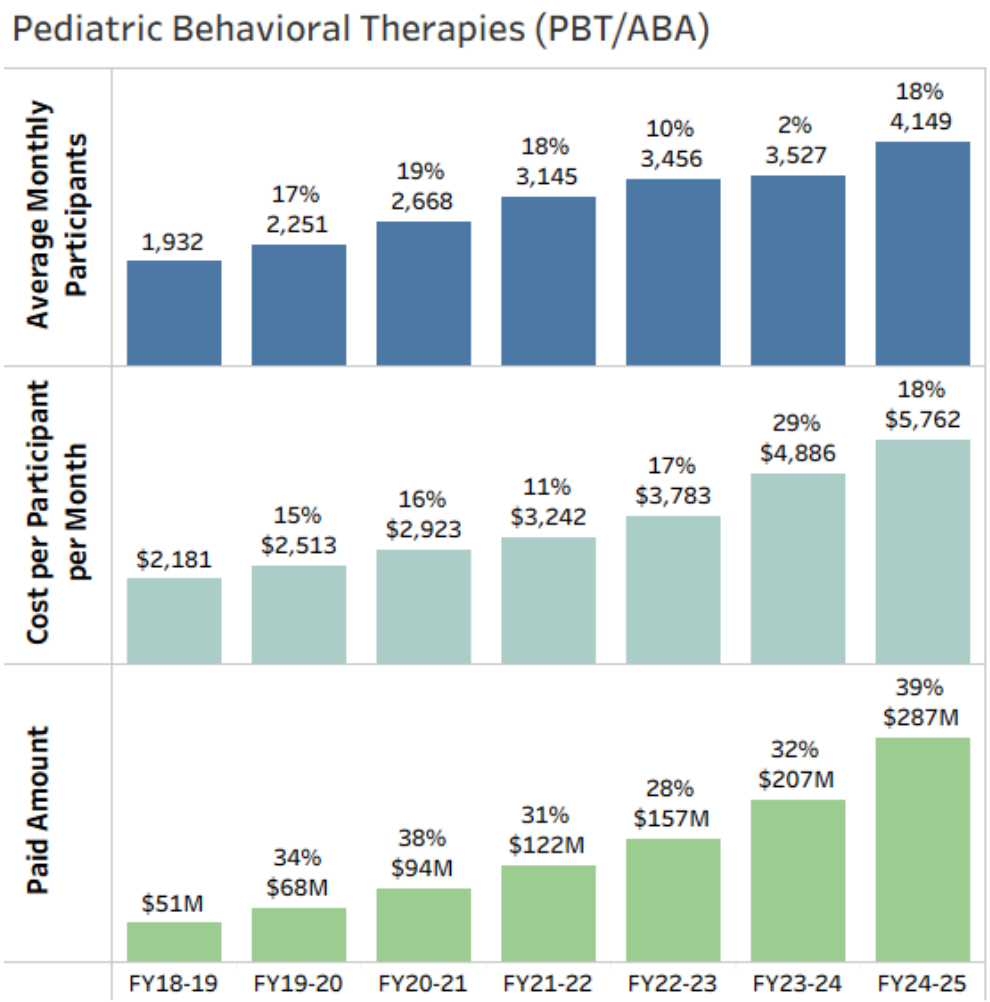
RESPONSE: The net impact of regulatory work across Colorado's state agencies is to strengthen safety and quality of care for children and increase access to needed care, while supporting providers who are already operating responsibly. As part of a cross-department work group with Colorado Department of Human Services (CDHS), Department of Regulatory Agencies, the Behavioral Health Administration (BHA), and others, we have discussed the urgent need for stronger oversights to keep children and youth safe, including the need for oversight through CDHS facility licensure. Both HCPF and the BHA have received serious complaints related to Applied Behavior Analysis (ABA)/Pediatric Behavioral Therapy (PBT) providers, including safety, supervision, and operational concerns, yet neither agency has authority to regulate, investigate or intervene because these facilities, and the providers who work within them, are not licensed by the state. As we have noted, there is currently no state entity to report health and safety concerns to, and families have nowhere to turn when issues arise.

While DORA's prior sunrise reviews in 2016, 2018 and 2020 did not recommend licensure, we do not believe that the existing framework sufficiently protects children. HCPF plans to submit another sunrise request informed by new data, complaints, and safety findings. The number of providers who identify as ABA/PBT providers within the state has risen sharply since the last sunrise review, along with the number of children receiving services from them. These developments increase the possibility of bad actors commingling with reputable providers and amplifies their potential harm if left unregulated. In 2019, the number of billing and rendering providers on PBT claims submitted to HCPF was 687; this number has grown to 1,789 as of October 2025. Our collaboration across the Executive Branch has focused on building a cohesive approach to these services that maintains access to medically necessary autism services for children while addressing systemic issues contributing to both rapid growth in utilization—such as the 11.2% annual increase in hours per participant—and persistent safety and quality concerns. The goal is a coordinated, cross-agency strategy that ensures children receive safe, effective care and that providers operate within a structure that protects both families and the integrity of the benefit.

34. [Rep. Taggart] If there are bad actors over-billing for PBT services, why is the Department requesting a rate decrease that targets all PBT providers rather than developing a strategy to specifically identify and target bad actors directly?

RESPONSE: HCPF's rate review and its efforts to identify and address improper billing serve different purposes and operate through separate processes, although both can support cost control.

The proposed rate decrease is based on our analysis of major cost drivers and anomalous cost trends. Our analysis shows that costs in this benefit have grown over 450% since FY 2018-19. Data show that PBT utilization has grown at an extraordinary pace, **an 11.2% compound annual growth in hours per participant**, with today's members receiving **about double the hours per month** compared to FY 2018-19. This growth far exceeds what would be expected from changes in eligibility inflation, or the number of children being served. While we can see certain providers are driving trends, rate reductions are not a tool that can be distinct between providers of the same services. The following graph depicts the cost of paid claims for PBT treatment as an annual expenditure and on a per member/per month basis, as well as the average monthly participants participating in treatment from FY 2018-19 until FY 2024-25:



Separately, program-integrity work is specifically designed to identify and address inappropriate billing, which we discuss in our response to Question 31. A recent OIG audit found widespread documentation, credentialing, and billing deficiencies across the program, not issues isolated to a few bad actors. In response, HCPF is promulgating targeted regulations, including strengthened documentation requirements, enhanced credentialing oversight, and post payment review.

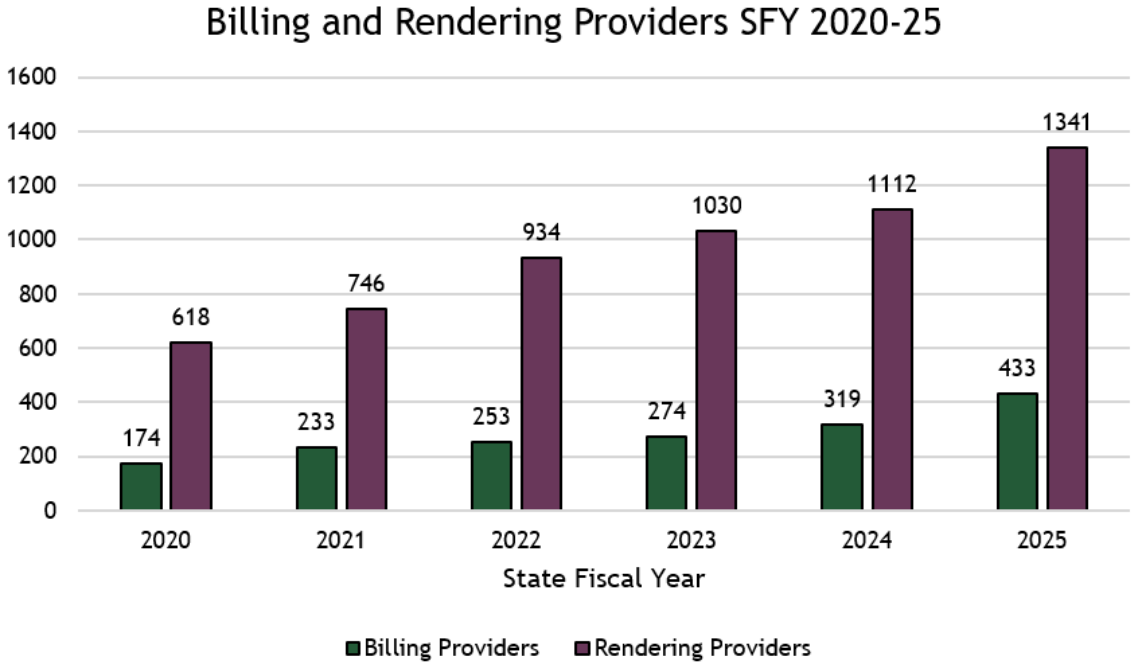
In short, the rate adjustment addresses unsustainable, system-wide cost growth, while program-integrity strategies directly target improper billing. Both approaches are necessary to protect member access and ensure responsible use of taxpayer funds.

35. [Rep. Brown] PBT services are essential to the families who need them. How does the Department plan to maintain access to coverage and services while policing misbehavior that may be occurring from certain providers?

RESPONSE: PBT services are incredibly important to families with children with Autism Spectrum Disorder (ASD) and similar diagnoses. We remain committed to maintaining access to medically necessary PBT. With that said, PBT is the single fastest growing benefit in Colorado Medicaid and across the country. Medicaid programs and commercial health insurers are struggling to control costs and maintain integrity in the benefit. HCPF believes that the actions we are taking to bring about greater program integrity are important for the sustainability of the benefit, to improve care access, and to protect the safety and well-being of our members.

One area where we are receiving a great deal of provider pushback is in our efforts to require that behavioral technicians be credentialed prior to being able to serve our vulnerable Medicaid children and youth. HCPF believes it is a reasonable expectation and critical to the safety and well-being of our members that these technicians be credentialed prior to providing services to Medicaid members. Technicians generally are required to have a high school diploma and 40 hours of classroom training prior to certification. However, some providers have told families they will lose services immediately if PBT providers cannot bill Colorado Medicaid for activities like paid training time for technicians prior to credentialing. Many providers also cite high technician turnover as a reason they cannot meet basic certification requirements. At the same time, these providers insist that long-term therapeutic relationships with technicians are essential—an internal contradiction, because high turnover makes stable relationships unlikely. High turnover also means that the technicians they are billing for prior to credentialing may, in fact, never be credentialed. These operational decisions, including whether a provider stops services, are business choices made by the provider, not mandates from HCPF.

A 2025 U.S. Department of Health and Human Services Office of the Inspector General (OIG) audit identified system wide issues in documentation, child safety, credentialing, and billing. Our responsibility is to correct those issues to protect children and ensure high-quality care — not to reduce access. Our program-integrity actions target provider misbehavior, while families continue to receive the essential services they rely on. The graphic below illustrates the stability of our network, with significant provider growth, as we prepare for needed integrity improvements.



Office of Community Living

Overview of OCL, Long-Term Services and Supports (LTSS), and Home and Community Based Services

36. [Rep. Brown] Please discuss the interaction between HCBS waivers and EPSDT (Early Prevention, Screening, Diagnosis, and Treatment) requirements. What services are being provided through the waivers that are not in EPSDT?

RESPONSE: EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) is a mandatory preventive and comprehensive health benefit for Medicaid-eligible individuals under the age of 21, including children on Home and Community-Based Services (HCBS) waiver programs. EPSDT generally covers state plan services that are often more clinical in nature while the HCBS waivers cover the long-term supports that allow children to remain safely at home as an alternative to institutional care. HCBS and state plan services cannot be duplicated. If a service is available to a child under the state plan or could be provided under EPSDT, it cannot be covered as a waiver service for the children population.

Under EPSDT, states must cover any medically necessary services that are mandatory and/or optional under section 1905(a) of the Social Security Act (SSA). Even though EPSDT requires states to provide all medically necessary services for children under 21, EPSDT applies only to services that fall within existing Medicaid State Plan benefit categories. EPSDT does not authorize coverage of services that are not medical in nature or not otherwise part of the Medicaid benefit structure. CMS ultimately determines what benefits fall under the service categories described in §1905(a) of the Social Security Act, and thus directs states through interpretive guidance as to when services require a waiver application in order to be covered. States may choose to offer home and community-based state plan services or benefit programs, such as Colorado has with the 1915(k) Community First Choice benefit, but these services are not subject to EPSDT coverage provisions, and instead available to supplement EPSDT services.

Because of this regulatory and subregulatory guidance, states must use Medicaid waiver authority to cover non-medical supports—such as home modifications and vehicle modifications. Therefore, states must cover any medically necessary services that could be part of its Medicaid state plan package, irrespective of whether the state explicitly includes such benefits in their state plan.

37. [Sen. Kirkmeyer] Please provide a list and description of all acronyms used by the Office of Community Living.

RESPONSE: The Office of Community Living maintains a public webpage listing common acronyms and identifying their meaning. This can be found at Office Of Community Living Acronym Glossary | Department of Health Care Policy and Financing. It is also printed in Appendix C.

LTSS Cost Growth

38. [Rep. Taggart] With so little population growth in recent years, why have the application numbers for disability increased so dramatically?

RESPONSE: In practice, Medicaid Long-Term Services and Supports (LTSS) tends to grow materially faster than a state's overall population because LTSS spending is driven less by "how many people live here" and more by (1) how many people need LTSS and (2) the cost per LTSS user (workforce wages, acuity, service intensity, rates).

Across the U.S., and in Colorado, LTSS growth typically outpaces population growth because the aging population share is increasing — the U.S. share of adults 65+ is projected to continue rising substantially through 2060, and more people live longer with serious disabilities due to medical advances, meaning they may require LTSS for longer periods.

Colorado's older population is growing rapidly relative to other states. Colorado had

the second-fastest growth in the 65+ population in the U.S. from 2010–2020, behind only Alaska, and the share of Colorado residents 65+ is projected to climb toward ~19–20% by 2030–2040. Advances in medical and supportive care are allowing disability populations to live longer lives, lengthening the period over which they may need LTSS.

As outlined in HCPF's annual reporting to the General Assembly, Colorado continues to see sustained increases among older adults, transition-age youth with significant functional needs, and individuals with intellectual and developmental disabilities who require intensive community-based supports.

HCPF's most recent projections show that Home and Community-Based Services (HCBS) participation across all waivers is expected to increase by approximately 9–10% between FY 2023-24 and FY 2026-27, with higher-acuity programs—such as Developmental Disabilities (DD), Children's Habilitation Residential Program (CHRP), and Brain Injury (BI) waivers—making up a disproportionate share of that growth. This means that more Coloradans are aging into, or developing, disabilities requiring formal assessment and eligibility determinations, regardless of overall population trends.

Second, Colorado and the General Assembly have made intentional policy choices that expand access to disability-related services. Over the last several years, the state has:

- Expanded accessibility and options within multiple HCBS benefits such as Remote Supports and Respite;
- Created Community First Choice (CFC) with an enhanced federal match;
- Funded additional enrollment authorizations across high-acuity waivers;
- Expanded the Working Adults with Disabilities (WAwD) program to individuals aged 65+; and
- Invested heavily in the direct care workforce to stabilize service delivery.

These improvements make community-based supports more available, more stable, and more visible to families. As access strengthens, a larger share of Coloradans pursue disability determinations in order to qualify for services that did not previously exist or were more difficult to obtain.

While we do not have concrete data to support this assertion, it has been reported that the aftermath of the COVID-19 Public Health Emergency (PHE) continues to contribute to higher disability-related application volume. During the PHE unwind, many individuals experienced new or worsening chronic conditions, declines in

functional status, or complex health needs that required evaluation for disability-based eligibility. HCPF also implemented a centralized escalation process to prevent individuals with LTSS or disability needs from losing coverage. These mechanisms improve accuracy but also mean that more cases appropriately enter the formal disability-determination pathway rather than remaining unaddressed.

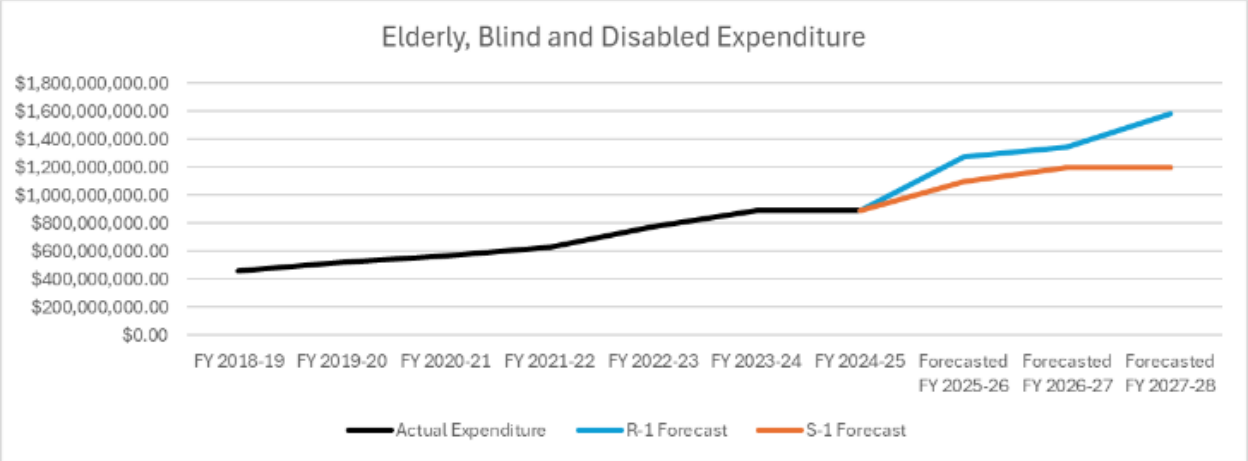
Finally, Eligibility Sites and Case Management Agencies (CMA) have increased their capacity to match the increased incoming workloads relative to application processes which has strengthened their capacity to assist with complex disability and LTSS eligibility processes—the most time-intensive category of Medicaid applications. As outreach and technical support improve, individuals who previously would not have applied, or who struggled to navigate the disability pathway, are now completing applications that more accurately reflect their functional and medical circumstances.

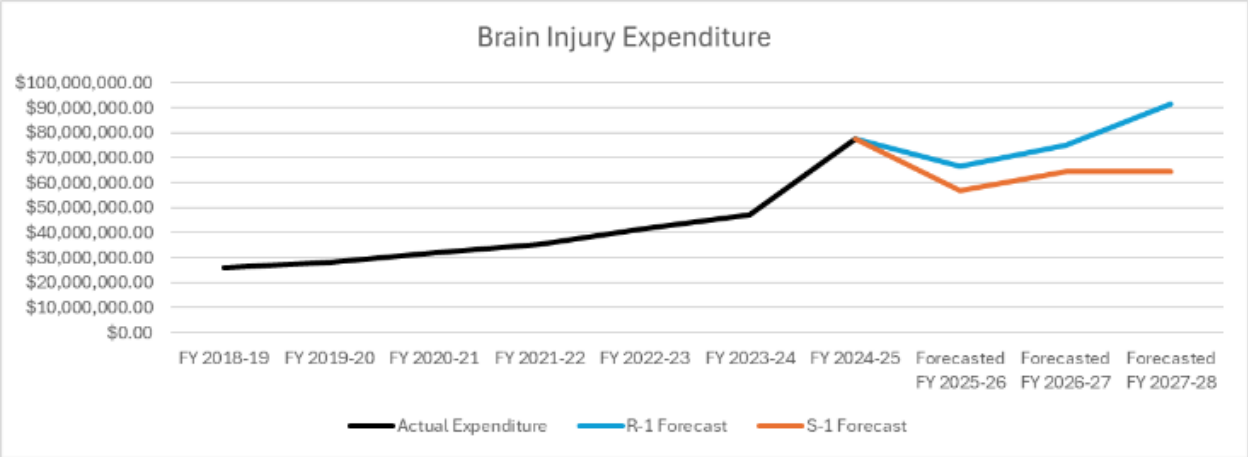
Taken together, these factors show that disability-related application growth reflects demographic shifts, rising acuity, post-PHE complexity, and deliberate state policy and program investments—not overall population growth.

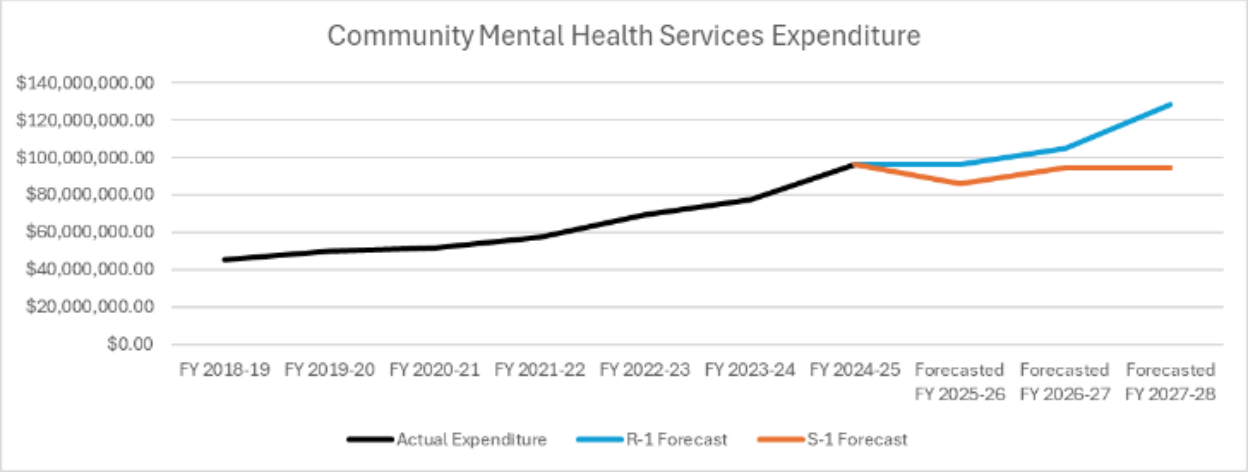
39. [Rep. Brown] For each of the five non-IDD HCBS waivers (i.e., Brain Injury; Community Mental Health Supports; Complimentary and Integrative Health; Elderly, Blind, and Disabled; and Children with Complex Health Needs), please provide a chart showing total expenditures and full program equivalent from FY 2019-20 through FY 2027-28 (forecasted). Charts should be similar to those on pages 8 and 9 of the JBC staff briefing document from December 15, 2025.

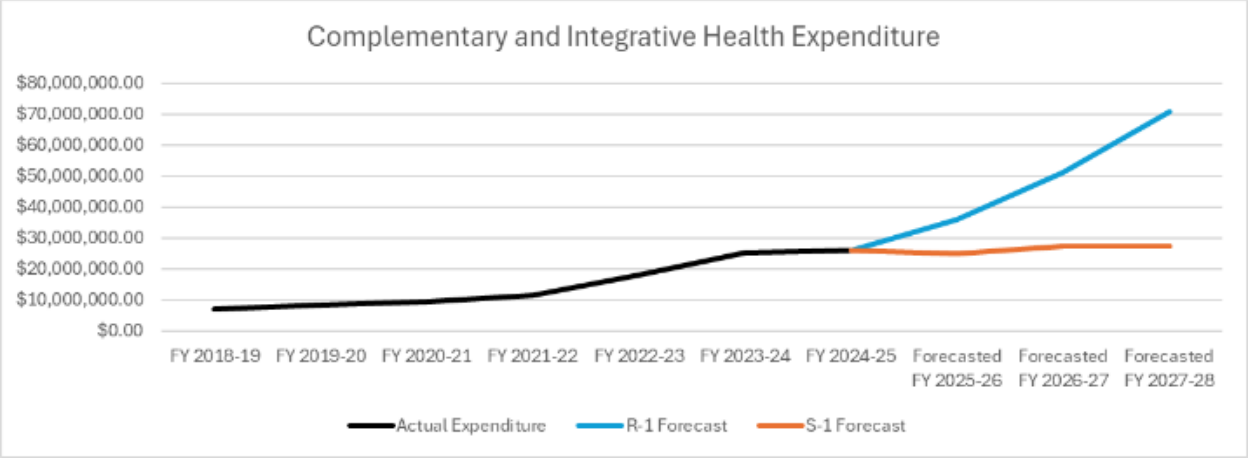
RESPONSE: The below chart reflects the cost for all of the waivers from FY 2019-20 through FY 2024-25 actual expenditures and from FY 2025-26 through FY 2027-28 from the October 31, 2025 forecast. (HCPF will submit a revised forecast in mid-February 2026.) HCPF combined the Children's Life Limiting Illness (CLLI) Waiver and the Children's Home and Community-Based Services (CHCBS) Waivers in the actual expenditures as the waivers were combined on July 1, 2025. All these figures can be found publicly on our webpage under the Medical Services Premium Forecast.

Fiscal Year	Elderly, Blind and Disabled	Community Mental Health Supports	Brain Injury	Complementary and Integrative Health	Children with Complex Health Needs
FY 2018-19	$460,036,072	$45,292,226	$26,179,750	$6,814,633	$38,462,235
FY 2019-20	$524,508,159	$50,043,198	$28,048,466	$8,441,234	$53,010,487
FY 2020-21	$570,076,575	$51,795,158	$31,990,425	$9,365,269	$72,251,604
FY 2021-22	$629,852,388	$57,477,877	$35,169,013	$11,314,696	$102,615,035
FY 2022-23	$773,665,219	$69,347,396	$41,819,077	$18,079,592	$143,463,607
FY 2023-24	$895,388,876	$74,692,783	$47,155,499	$18,602,825	$190,352,482
FY 2024-25	$1,173,207,637	$90,798,207	$58,481,718	$25,940,783	$230,495,227
Estimated FY 2025-26	$1,277,576,042	$96,318,018	$66,708,349	$35,870,531	$267,858,569
Estimated FY 2026-27	$1,354,006,784	$105,097,478	$75,228,352	$51,441,464	$286,031,320
Estimated FY 2027-28	$1,581,735,718	$128,393,504	$91,360,031	$70,773,025	$299,463,153




Brain Injury Expenditure
$100,000,000.00
$90,000,000.00
$80,000,000.00
$70,000,000.00
$60,000,000.00
$50,000,000.00
$40,000,000.00
$30,000,000.00
$20,000,000.00
$10,000,000.00
$0.00
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
FY 2023-24
FY 2024-25
Forecasted FY 2025-26
Forecasted FY 2026-27
Forecasted FY 2027-28
Actual Expenditure
R-1 Forecast
S-1 Forecast


Community Mental Health Services Expenditure
$140,000,000.00
$120,000,000.00
$100,000,000.00
$80,000,000.00
$60,000,000.00
$40,000,000.00
$20,000,000.00
$0.00
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
FY 2023-24
FY 2024-25
Forecasted FY 2025-26
Forecasted FY 2026-27
Forecasted FY 2027-28
Actual Expenditure
R-1 Forecast
S-1 Forecast


Complementary and Integrative Health Expenditure
$80,000,000.00
$70,000,000.00
$60,000,000.00
$50,000,000.00
$40,000,000.00
$30,000,000.00
$20,000,000.00
$10,000,000.00
$0.00
FY 2018-19
FY 2019-20
FY 2020-21
FY 2021-22
FY 2022-23
FY 2023-24
FY 2024-25
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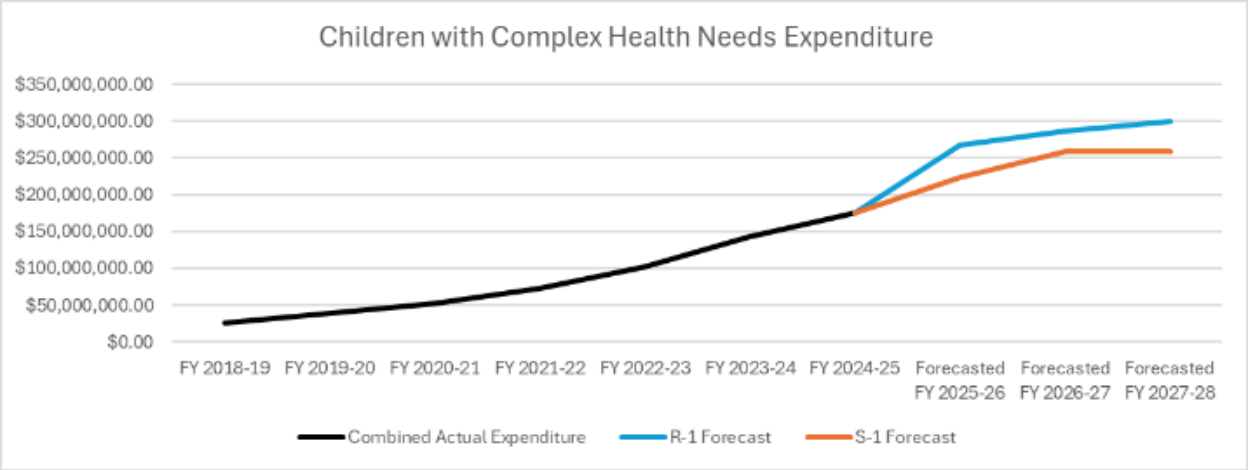
Forecasted FY 2026-27
Forecasted FY 2027-28
Actual Expenditure
R-1 Forecast
S-1 Forecast



40. [Sen. Kirkmeyer] How much of the recent growth in the long-term care budget can be attributed to wage-related policy changes versus caseload, acuity, or other factors?

RESPONSE: Growth in Colorado's long-term services and support (LTSS) budget over the past several years is driven by multiple factors, including caseload, member acuity, utilization, and rate changes, including wage-related adjustments. While supporting fair compensation for the workforce is important, wage growth alone does not account for overall cost increases. People with complex needs, including adults with I/DD aged 60 and older, are living longer. Older populations are more likely to require LTSS, with an estimated 70% of those over age 65 needing some form of support. As of 2024, about 16.4% of Colorado's population was age 65 or older, and projections indicate this share will continue rising toward nearly 19% by 2030, contributing to increased demand for LTSS and mirroring national aging trends. Many LTSS recipients have low incomes and rely on Medicaid, which covers a disproportionate share of these costs—nationally accounting for 61% of LTSS spending.

A breakdown of LTSS cost growth (FY 2020–21 to FY 2024–25) shows:

- 42.7% due to rate changes, including base wage adjustments, across-the-board provider increases, targeted rate changes, and statutorily required updates
- 45.9% due to utilization, primarily LTHH and in-home services and supports (homemaker, personal care, and health maintenance activities)
- 11.4% due to enrollment growth, skewed toward higher-cost populations (e.g., Developmental Disabilities (DD) waiver at approximately $100,000 per member vs. approximately $37,000 for a member on the Elderly, Blind, and Disabled waiver program)

The cost growth attributed to rate changes to support the direct care workforce base wage was critical to ensure a robust workforce to serve the needs of LTSS members. Over the last several years, wage compression with other frontline workforces had threatened the viability of the workforce- with recruitment lagging to meet the demand and turnover rates ranging from around 40–50% on average to as high as 81% for some providers. These increases were required to keep pace and maintain services for Coloradans with the most acute needs. While rising cost of living and inflation continue to affect recruitment and retention, workforce initiatives appear to be having a positive impact. In 2024, 60% of HCBS providers reported having no open positions, increasing to 72% in 2025, indicating improved staffing stability. However, 13.8% of providers reported turning away new referrals due to staff shortages. These findings suggest that efforts such as recruitment support, training, and wage adjustments are helping stabilize the workforce, though continued action is needed to address ongoing staffing challenges. These efforts remain a high priority for HCPF.

41. [Sen. Kirkmeyer] Please quantify how much additional state funding has been required over the last several fiscal years to adjust long-term care provider rates specifically due to local minimum wage ordinances and the state's base-wage policy for direct care workers? Please break this out by major long-term care programs so we can see where the pressures are greatest.

RESPONSE: Over the last several fiscal years, the General Assembly has invested additional funding to increase long-term care provider rates in response to local minimum wage ordinances and the statewide base-wage policy for direct care workers, along with other factors that are affecting the supply of the long-term care provider workforce. These investments were intended to better support the long-term care industry and reflect broader pressures on the system, including growing demand for services, workforce shortages, rising recruitment and retention costs, and increasingly complex care needs. Based on available data, the total state funding directly appropriated for these wage-related adjustments is approximately $309 million across 4 fiscal years.

- FY 2021-22 S-10 HCBS ARPA Spending Authority - $121 million
- FY 2023-24 R-07 Rate Adjustments - $62 million
- FY 2024-25 R-06 Provider Rate Adjustments - $126 million

These figures represent the components of rate increases directly tied to wage-related requirements, as identifiable through the rate-setting process. The actual total is considerably higher due to the compounding effects and growth in utilization over time.

While wage policy plays an important role, it is only one part of a much broader

workforce picture. Providers have faced high turnover, recruitment challenges, training needs, rural workforce shortages, and rising member acuity. These pressures affect provider stability and member access just as much—and in some cases more—than wage changes alone. In response, HCPF has been working to address the many challenges affecting the direct care workforce, supporting recruitment and workforce connection efforts for long-term care providers, offering free training to support workforce entry and upskilling, and helping stabilize the workforce in the face of high turnover while reducing hiring costs and promoting consistent training for better member outcomes. We also take steps to support rural providers, including analyzing service gaps, identifying best practices, and facilitating collaboration to address workforce challenges.

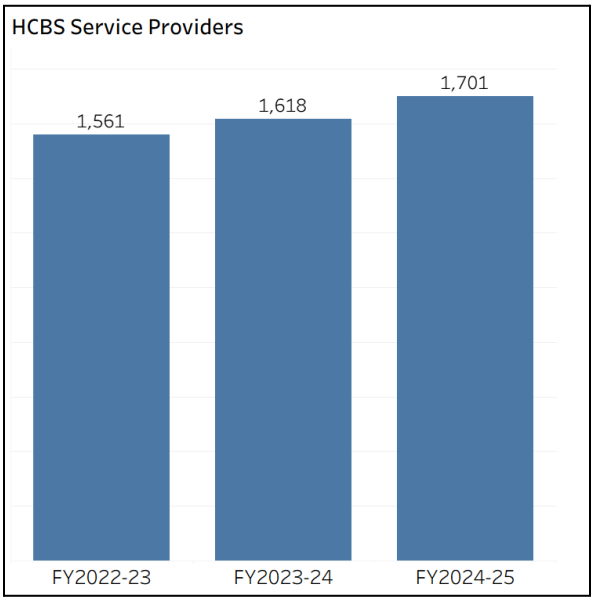
The cost pressures created by local wage ordinances and the state's base-wage policy need to be understood within this larger effort of keeping the long-term care system sustainable. Colorado is seeing steady growth in the number of older adults and people with disabilities who rely on services, with demand increasing significantly in recent years, and this is expected to continue into the future. Meeting this growing need requires a workforce that is robust and stable enough to support members in every part of the state.

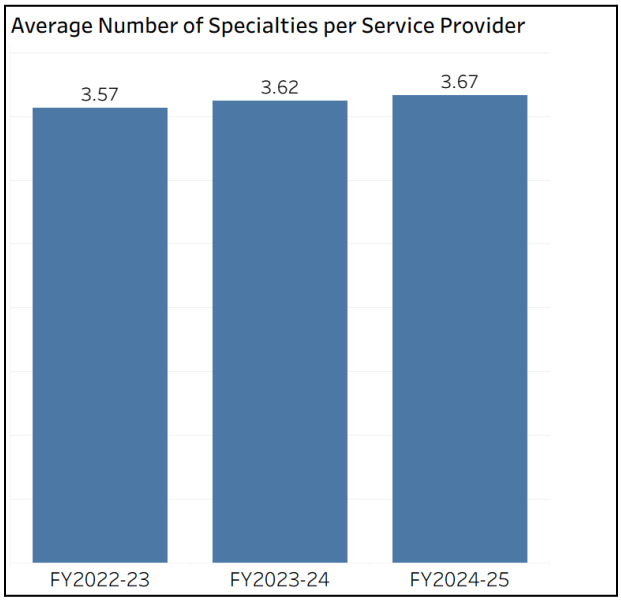
To address these broader challenges, the state has made several significant non-wage investments that help providers recruit, train, and retain staff. These include no-cost recruitment and job-matching tools focused specifically on Medicaid providers; free training supports to ease onboarding and reduce provider burden; foundational training for new direct care workers; and guidance to providers on state resources available to support their employees. These investments strengthen the system in ways that go beyond rate adjustments.

Maintaining a strong in-home workforce is also key to avoiding more expensive institutional care. Community-based services typically cost the state significantly less than providing care in an institutional setting, making workforce stabilization a cost-effective strategy over the long term.

42. [Sen. Kirkmeyer] Has the department evaluated any system-wide effects—such as provider stability, network adequacy, or shifts to higher-cost settings—that may be connected to wage mandates?

RESPONSE: HCPF continuously evaluates provider capacity and continues to see increases in the overall provider network across providers, as well as the total number of specialties offered by individual providers. Specialties allow providers to bill for specific services based on qualifications and certifications. The tables below show the year-over-year growth for the last three years.





While these trends suggest growing capacity and service diversity, multiple factors influence system-wide outcomes. Wage mandates are one contributing factor, but changes in these broader system measures cannot be attributed solely to wage policy.

Overall, while wage mandates support workforce stability and provider capacity, system-wide outcomes are influenced by multiple factors. HCPF continues to monitor trends and gather data to ensure that policies effectively support access, network adequacy, and quality of care across the long-term services and supports system.

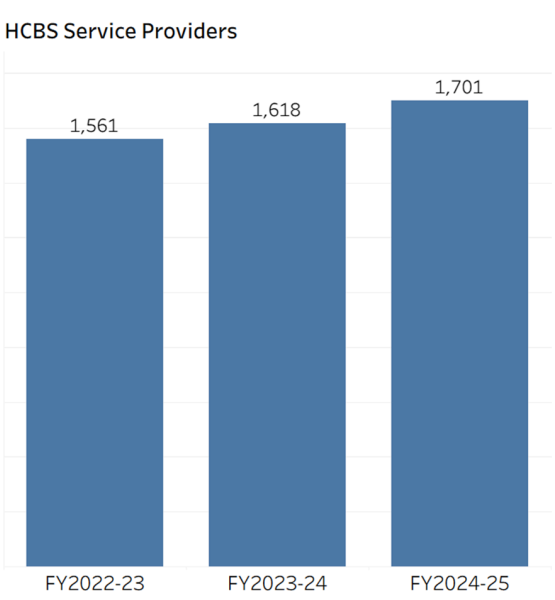
43. [Sen. Kirkmeyer] Why isn't the Department requesting funding this year to keep pace with minimum wage increases? How does the Department expect providers of home-and community-based services and nursing homes to absorb the minimum wage increases without increased Medicaid funding? How many years in a row does the Department think it can go without asking for a rate increase in response to minimum wage increases?

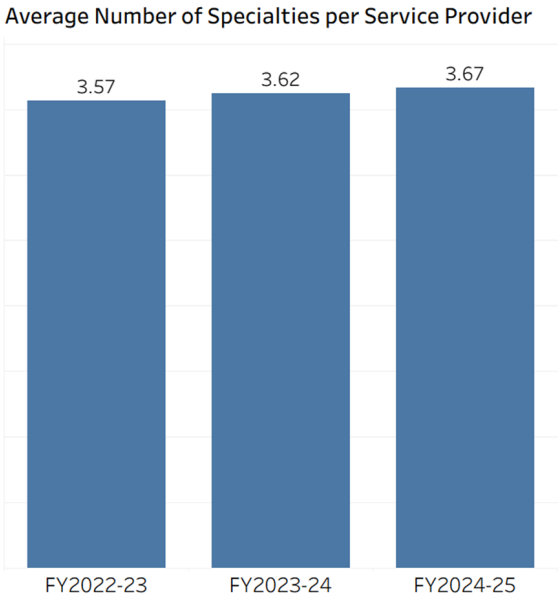
RESPONSE: Over the last several years, the General Assembly and HCPF have made substantial investments, over $600 million, in home and community-based services and nursing facility rates, including targeted wage increases and ARPA-funded workforce initiatives that moved average direct care worker wages from $12.41(2021) an hour to $19.11(2024) an hour. In the current budget environment, our focus has been on maintaining wages for workers and strategically making reductions to dampen concerning trends while keeping individuals in the community.

This year, HCPF is not requesting additional funding specifically to keep pace with minimum wage increases due to the structural budget deficit and the need to prioritize preserving core Medicaid eligibility, benefits, and existing provider rates.

We fully recognize that continued increases in the state and local minimum wage create pressure for HCBS providers and nursing facilities. To be clear, the expectation is not that providers simply absorb these costs without support. Rather, in the near term, we are relying on the significant investments made in recent years, combined with ongoing efforts to strengthen the direct care workforce and reduce administrative burden.

We are closely monitoring access-to-care indicators, including network adequacy, provider closures, and member wait times, to understand how wage pressures are impacting the system. Please see the tables below showing increases in provider capacity across individual provider locations, and across provider specialties. Specialties allow providers to bill for specific services based on qualifications and certifications.





Looking ahead, HCPF anticipates the need for future rate increases to respond to minimum wage changes. HCPF reassesses rates annually based on available revenue, federal and state requirements, and data on access and quality. In some years, that will mean bringing forward targeted or across-the-board rate requests; in years like this one, with an extraordinary budget gap, it means focusing on sustainability and protecting the services people rely on. We are committed to working with the legislature in future budget cycles to align rates, workforce stability, and minimum wage policy as fiscal conditions allow.

44. [Sen. Kirkmeyer] Looking forward, what is the projected ongoing fiscal impact to the state if all current local minimum wage ordinances remain in place?

RESPONSE: The fiscal impact to the state depends on appropriations by the General

Assembly; HCPF does not raise rates until and unless the General Assembly provides funding. There is no statutory mandate that the state increase rates by a certain amount due to minimum wage increases.

HCPF recognizes that local minimum wage ordinances were put in place to help stabilize workers and families who keep their communities running, especially as many face rising costs of living and high inflation. These local decisions reflect municipalities' efforts to support their residents and maintain a viable workforce. In addition, wages in many other industries have increased to attract and retain employees, showing that rising wages are part of broader market trends and not solely driven by local minimum wage ordinances.

It is not possible at this time to provide a reliable projection of the ongoing fiscal impact of these ordinances. The timing, calculation methods, and underlying economic assumptions used by municipalities vary, which makes forecasting difficult before their final wage levels are published. To prepare for these developments, we continually monitor announced municipal wage actions, review year-over-year base wage data, and identify where current rates may fall above or below expected trends. We also coordinate closely with the Governor's Office and the Joint Budget Committee as new information becomes available. When funding is available, HCPF would use the regular budget process to request funding for any proposed increase.

R-06 Executive Order and Other Spending Reductions: High Level

45. [Sen. Amabile and Rep. Gilchrist] For the nurse assessor program and each of the proposed reductions in long-term services and supports, how many people will end up in institutional settings rather than community settings and at what cost? How much are we actually saving from these initiatives?

RESPONSE: For both the nurse assessor program and the LTSS sustainability proposals, HCPF's actions are intended to create sustainable programs that continue to provide services to individuals. These actions are explicitly designed to keep people safely supported in the community while slowing unsustainable cost growth and utilization, and not to change eligibility or push members into higher levels of care. The Nurse Assessor program, unlike the sustainability proposals, was not designed as a cost-saving measure but rather to ensure members receive the appropriate skilled services to meet their needs. HCPF never assumed savings with this program.

The LTSS sustainability actions — such as the 56-hour weekly cap per individual caregiver (R6.31), limits on certain HCBS hours (R6.30), and refinements to Community Connector (R6.34 and R17) — are targeted guardrails on how services are authorized and delivered, not removals of the underlying benefits. Authorizations

remain tied to assessed need and existing policy. The proposed limits are set above the average levels used by most members and paired with exception processes to allow members with higher needs to receive additional hours when justified. The intent is to correct outlier patterns, reduce over-reliance on a single caregiver, and align policy while preserving a comprehensive package of home and community-based services (HCBS).

For actions related to enrollment changes, such as to the Developmental Disabilities Waiver (R6.17 and R6.18), the intent is to slow the growth in the state's most expensive waiver. At the same time, members continue to receive services in the community through other waiver and state plan services. HCPF has asked to maintain emergency enrollments for individuals who require urgent access, which will prevent unnecessary institutionalization.

Across these initiatives, the projected savings are "real" in the sense that they represent lower LTSS spending than the trend would otherwise produce, primarily by moderating growth in hours and rates in HCBS, while slowing enrollment growth in the most costly waiver (see table below for anticipated savings by fiscal year). We have not built in offsetting increases in nursing facility or hospital costs because we do not anticipate shifts to institutional care if these guardrails are implemented with exceptions and supported by our ongoing investments in the direct care workforce and case management. At the same time, we will be monitoring nursing facility utilization, hospitalizations, critical incidents, and transitions to higher-level care as part of our Quality Improvement Strategy to ensure these savings are achieved without unintended harm to members or increased costs elsewhere in the system.

Action	FY 2025-26 Impact		FY 2026-27 Impact		FY 2027-28 Impact	
	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
Community Connector Rate Decrease (R6.12)	($6,026,470)	($3,013,235)	($12,052,939)	($6,026,469)	($12,052,940)	($6,026,470)
Eliminate the nursing facility minimum wage payment supplemental payment (R6.13)	($8,719,922)	($4,359,961)	($8,719,922)	($4,359,961)	($8,719,922)	($4,359,961)

Reduce Individual Residential Services and Supports (R6.14)	($2,900,558)	($1,450,279)	($5,801,116)	($2,284,479)	($5,801,116)	($2,284,479)
Auto Enrollment Changes for Certain Youth Transitions in DD Waiver (R6.17)	$72,922	$36,461	($15,261,376)	($7,630,688)	($18,742,602)	($9,371,301)
Reduce DD Waiver Churn Enrollments (R6.18)	$72,922	$36,461	($6,497,170)	($3,248,585)	($43,686,880)	($21,843,440)
Delaying Long Term Services and Supports Presumptive Eligibility (R6.29)	($1,303,093)	($690,802)	($2,775,871)	($1,471,558)	($1,387,936)	($735,779)
Implement a Soft Cap on Certain HCBS Services (R6.30)	($2,321,008)	($1,160,504)	($13,891,297)	($6,945,648)	($13,886,452)	($6,943,226)
Implement a Soft Cap on Weekly Caregiving Hours (R6.31)	($335,604)	($167,802)	($2,266,749)	($1,133,374)	($2,265,134)	($1,132,567)
Implement a Soft Cap on Weekly Homemaker Hours for Legally Responsible Persons (R6.32)	($74,350)	($37,175)	($446,102)	($223,051)	($446,102)	($223,051)
Align Community Connector Rate with Supported Community	($3,055,311)	($1,527,656)	($18,331,864)	($9,165,932)	($18,331,864)	($9,165,932)

Connections (R6.33)						
Implement New Service Unit Limitations for Community Connector (R6.34)	($2,473,183)	($1,236,592)	($15,092,223)	($7,546,112)	($15,092,223)	($7,546,112)
Reduce Movement Therapy Services to Align with Rate Methodology (R6.35)	($119,412)	($59,706)	($716,467)	($358,234)	($716,467)	($358,234)
Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services (R6.36)	$0	$0	($12,641,817)	($6,320,909)	($26,267,767)	($13,133,884)

46. [Sens. Amabile and Kirkmeyer/Rep. Taggart] Given the many different but overlapping proposals within R6, please provide a summary and visual aid of these changes by patient type. How many different reductions would a single member be subject to?

RESPONSE: Because R6 combines enrollment policies, benefit limits, cost-sharing alignment, and provider payment changes across the entire Medicaid program, the number of "reductions" any one member experiences depends entirely on their situation. This response focuses on the reductions that have a direct impact on LTSS member enrollment or benefit amounts, not other actions that impact provider payment, for example. Further, this response does not include any caps on weekly caregiver hours as those actions do not have a direct impact on enrollment or service authorization for members.

The budget reduction items included in this response are:

- **R6.17: Change Auto Enrollment for Developmental Disabilities (DD) Waiver Youth Transition**
  - Ends automatic youth-to-adult DD waiver transitions for members aging out of CES or CHRP waivers, unless enrolled in child welfare services.

- **R6.18: Reduce DD Waiver Churn Enrollments**
  - Reduces churn enrollments in the DD waiver by 50%.
- **R6.30: Soft Cap (Unit Limitations) on Certain HCBS/CFC Services**
  - Places a cap on Personal Care, Homemaker, and Health Maintenance Activities (HMA) that will limit annual utilization at approximately 19,000 units for HMA (about 13 hours per day), 10,000 units for Personal Care (about 6.8 hours per day), and 4,500 units for Homemakers (about 3 hours per day).
- **R6.34: Unit Limitations for Community Connector**
  - Reduces the annual cap on Community Connector services by 50%, lowering the maximum allowable units from 2,080 to 1,040 per year under the CES and CHRP waivers.
- **R17: Community Connector Age Limit**
  - Removes access to Community Connector services for members who are not school-aged (not included in R6, but only other LTSS-related requested action that has direct impact on enrollment or service authorization).

Data from FY 2024-25 for the HCBS/CFC service (R6.30) and Community Connector service (R6.34) caps, and R17 Community Connector age limit shows that:

- 92% of all HCBS members will experience no change to the programs they are currently enrolled in or the services they receive.
- 12% of members receiving the affected services (Personal Care, Homemaker, Health Maintenance Activities, and/or Community Connector) will only be impacted by one of these budget reduction items.
  - A very small subset of high-intensity members (<1%) are affected by two budget reduction items, however the soft caps/unit limitations will all have exceptions processes which will allow members to receive services above the new service limits should they have a demonstrated need.

Member Category	Member Count	Percent of All HCBS	Percent of Members with Services Impacted by Caps
All Members Served in HCBS FY 2024-25	59,193	100%	N/A
Members with Proposed Caps Services FY 2024-25	38,779	66%	100%
Members with at Least One Service Over a Cap FY 2024-25	4,595	8%	12%
Members with Two Services Over Cap FY 2024-25	101	0.2%	0.3%

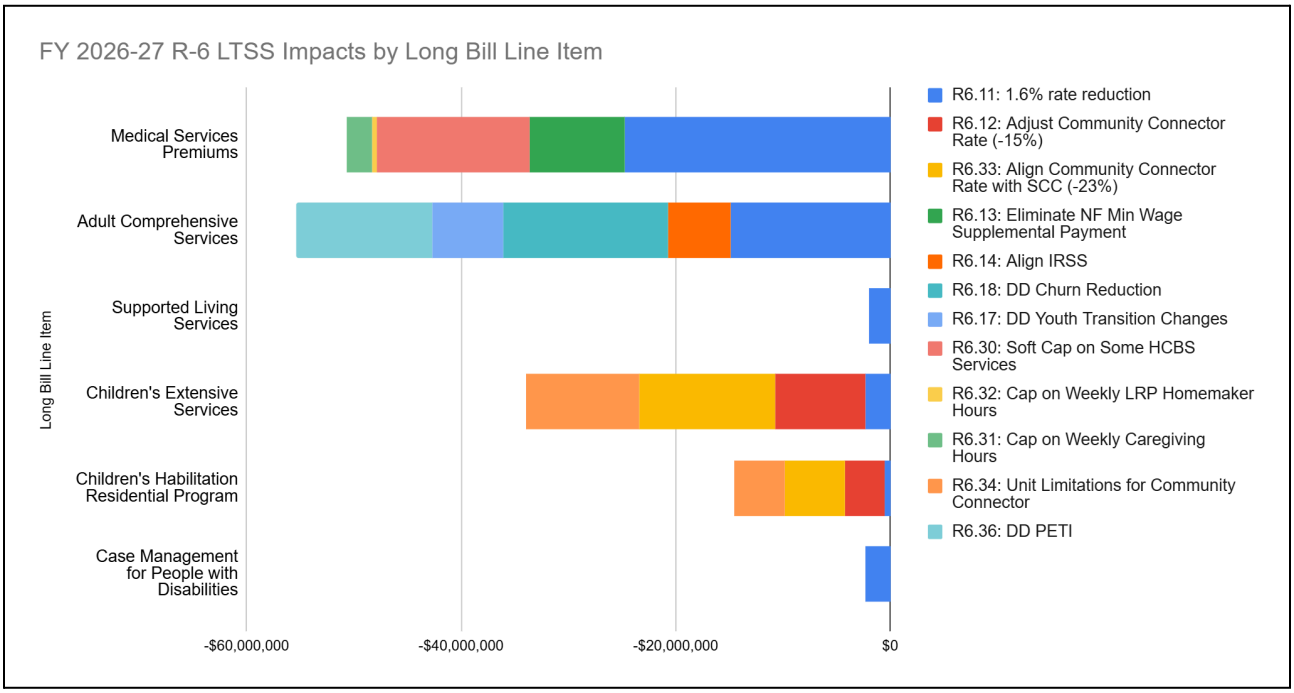
The visual below shows the main groups that will experience a direct impact due to the R6 and R17 actions, the primary drivers of the changes, and the ways HCPF will continue to support members.

- First are adults and children who currently have high utilization of select services. Targeting those services that have been experiencing the greatest utilizations trend growth, the changes will institute new limits with exceptions when a member's needs require hours beyond what the caps would allow.
- Second are children currently on the CES and CHRP waivers. There has been very high growth in enrollment and utilization costs for these populations, in particular for the Community Connector service, and the budget actions reflect strategies to rein in that service growth while maintaining the service option and aligning appropriate utilization with parental duties. Additionally, as these youth transition to adult waivers, they will experience a shift: only those with urgent needs will move into the DD waiver; others will access services through other adult waivers and/or state plan services.
- Third are adults currently on the waitlist for the DD waiver, who may experience longer wait times.

Taken together, HCPF's intent is to introduce consistent and proactive guardrails in a few places where costs are growing fastest, with exceptions, processes and monitoring to prevent harm. For some members, that will translate into up to two visible changes, rather than a stacking of independent reductions, while allowing the state to avoid more severe reductions to eligibility or the core LTSS benefit package in the future.

47. [Sen. Kirkmeyer] For the R6 elements that impact Home and Community-Based Services (HCBS), please provide a visual aid showing each proposal's impact on the Medical Services Premium line item and the various IDD waiver line items. How are line item determinations made?

RESPONSE: The below chart, and accompanying table, illustrate each of the R-6 proposals impacting the Long-Term Services and Supports (LTSS) programs by Long Bill line item.



Summary of FY 2026-27 R-6 Components by Line Item*	
Line Item	**Request Components**
Medical Services Premiums	R6.11: 1.6% rate reduction, R6.13: Eliminate NF Min Wage Supplemental Payment, R6.30: Soft Cap on Some HCBS Services, R6.32: Cap on Weekly LRP Homemaker Hours, R6.31: Cap on Weekly Caregiving Hours,
Adult Comprehensive Services	R6.11: 1.6% rate reduction, R6.14: Align IRSS, R6.18: DD Churn Reduction, R6.17: DD Youth Transition Changes, R6.36: DD PETI
Supported Living Services	R6.11: 1.6% rate reduction
Children's Extensive Services	R6.11: 1.6% rate reduction, R6.12: Adjust Community Connector Rate (-15%), R6.33: Align Community Connector Rate with SCC (-23%), R6.34: Unit Limitations for Community Connector
Children's Habilitation Residential Program	R6.11: 1.6% rate reduction R6.12: Adjust Community Connector Rate (-15%), R6.33: Align Community Connector Rate with SCC (-23%), R6.34: Unit Limitations for Community Connector
Case Management for People with Disabilities	R6.11: 1.6% rate reduction

*Please note HCPF is not moving forward with R6.35, Alignment of Movement Therapy rates. That would have impacted members on the Supported Living Services, Children's Extensive Services and Children's Habilitation Residential Program waivers.

Line items are determined through legislation or are proposed by departments to align with programmatic structures. Medical Services Premiums has historically been the main service line item for Medicaid services. This line includes the LTSS waivers such as the Elderly, Blind, and Disabled (EBD) or Brain Injury (BI) waivers, as well as nursing facility costs, hospitals, primary care, etc. As the Medicaid program has grown over time, the size of the Medical Services Premiums line item continues to grow.

With the passage of HB 13-1314, the programs for individuals with Intellectual and Developmental Disabilities (IDD) were moved from the Colorado Department of Human Services to HCPF. The Long Bill structure with that transfer was designed to align with the previous structure and the requirement under the bill to designate a Division for IDD programs.

HCPF understands that the large line items in the Long Bill are not conducive to transparency, and we are committed to providing detailed information about expenditure and forecasts via a wide variety of mechanisms. In response to a long-standing request for information from the Joint Budget Committee, HCPF provides a monthly report that details caseload and expenditure information for all of its programs. In addition to providing this information to the Joint Budget Committee, this information is posted publicly on the HCPF website.[5]

In its budget requests, HCPF provides detailed forecasts for individual components of Medicaid. In total, HCPF's budget requests for Medicaid, CHP+, and other state programs include hundreds of pages of tables and text that include detailed information about its forecasts and projections, calculations of fund splits and allocations to cash funds, and other information. Further, HCPF collaborates with Joint Budget Committee staff before these briefings and before Figure Setting to provide any additional analysis that staff believes would be helpful to the Committee in setting the budget.

HCPF is strongly committed to transparency in the reporting and budgeting for Medicaid expenditure. If the Joint Budget Committee needs additional reporting, or reporting done in a different way, HCPF will make every effort to meet the Committee's needs.

[5] HCPF's responses to RFI 1 can be found on our website: https://hcpf.colorado.gov/budget/FY-Premiums-Expenditures-Caseload-Reports

48. [Sen. Bridges] With the many cuts planned for home healthcare, how will this affect the state's ability to comply with the DOJ v. Colorado settlement about involuntarily institutionalized?

RESPONSE: The target population of the voluntary DOJ Settlement Agreement is limited to adults with physical disabilities living in nursing facilities or at risk of institutionalization in a nursing facility. The reductions that may impact this population of adults allow for exceptions if the need is demonstrated. Because of the safeguards associated with the implementation of the changes, HCPF does not anticipate they will create a barrier to our ability to meet the requirements of the voluntary agreement. If monitoring shows that a particular change is creating barriers that increase nursing facility admissions or slow transitions, HCPF will adjust implementation to remain in compliance.

R-06 Rates Related Changes

49. [Sen. Amabile] What are the qualifications to be a provider of community connector services? What services are they providing? Please provide specifics for the services and the qualifications.

RESPONSE: Community Connector is a one-to-one, community-based service on the Children's Extensive Support (CES) and Children's Habilitation Residential Program (CHRP) waivers. By rule, it is used to help a child or youth build the skills and relationships needed to participate in typical community life, using real community settings as the learning environment and tying the work to measurable goals in the support plan. Examples of Community Connector activities can include volunteer opportunities, visiting the museum, or a community enrichment class. It must be delivered in integrated community settings, not as segregated activities, center-based day care or general supervision, passive community presence, or performing typical parental responsibilities. It also does not pay for tickets, food, or other entertainment costs.

Community Connector services are provided by agency-based, program approved service agencies (PASAs), who hire staff to deliver the service. The following requirements must be met to be a provider:

- Must be enrolled as a Medicaid provider of Home and Community-Based Services.
- The individual providing the services must be 18 or older, able to communicate effectively and complete documentation, able to provide services according to the service plan, have completed state-required training, and have the skills and interpersonal abilities needed to work with people with developmental disabilities.

- When parents are also the provider, they must still follow the same Community Connector service definition—working in inclusive community settings on skill-building and connection, not simply providing routine parental care.

These qualifications align with the Supported Community Connections (SCC) benefit which is the comparable service in the adult waivers. As such, the services should not be reimbursed at different rates.

50. [Rep. Sirota] The request indicates that the reduction is a result of identified irregularities in the rate setting methodologies for movement therapy. What irregularities were identified? What does the Department see as comparable therapies, and what are the rates for those therapies?

RESPONSE: HCPF has carefully reconsidered its initial proposal to reduce reimbursement rates for Movement Therapy services, including Music Therapy, following the receipt of additional information from stakeholders and professional organizations. This new material outlined the extensive education, training, and credentialing required of Movement Therapy, specifically Music Therapy practitioners. It also demonstrated the strong alignment of these requirements with those of other allied health professions—such as occupational therapy and physical therapy—that offer similarly specialized, clinically grounded therapeutic interventions.

In light of this more comprehensive perspective, HCPF recognizes that the methodology originally used to support a potential rate reduction does not adequately reflect the level of professional preparation or the clinical value inherent in Movement Therapy services. HCPF greatly appreciates the time and effort invested by partners in supplying this clarifying information, which has significantly improved our understanding of the profession and its role within the continuum of care.

Accordingly, as reflected in Supplemental/Budget Amendment-07, HCPF is requesting the withdrawal of the rate reduction specific to Movement Therapy, including Music Therapy. We no longer find sufficient methodological justification to support such a change and believe it would not appropriately reflect the professional standards or service needs associated with these therapies.

51. [Sen. Amabile] The request provides rates of $16.11 for movement therapy. What is the billing period for this rate? Is this the anticipated hourly rate for services?

RESPONSE: As stated in Question 50, through Supplemental/Budget Amendment-07, HCPF is withdrawing this request. However, to clarify on the second part of Rep. Amabile's question, each unit is 15 minutes.

52. [Rep. Sirota] The Committee has received significant pushback on the movement therapy rate reduction, including providers indicating that the rate reduction will put them out of business. How has the Department assessed the impact to services for

this reduction?

RESPONSE: As stated in Question 50, through Supplemental/Budget Amendment-07, HCPF is withdrawing this request.

R-06 Utilization Related Changes

53. [Rep. Brown] Please clarify if this policy change allows a client to rotate among multiple caregivers. Could the cap be avoided by having multiple caregivers per member? Could this request unintentionally increase costs elsewhere (e.g., hospitalizations, other types of care, etc.)? How is the Department accounting for that kind of external effect?

RESPONSE: This proposal would establish a cap of 56 paid hours per week for a single caregiver providing services to one member. The limit applies to Home Health Aide, Personal Care, Homemaker, Health Maintenance Activities, and Nursing services. The underlying benefit package needed to meet the member's assessed need remains unchanged.

Members will continue to be able to receive services from more than one caregiver, including a mix of family and non-family caregivers or multiple agency staff. The 56-hour cap applies per individual caregiver, not as a cap on the member's total hours. In practice, this means that a member with higher authorized hours can rotate among multiple caregivers, as they do today. The intent is to place reasonable guardrails on extremely high weekly hours for one caregiver, which can create safety, quality, and program integrity concerns, while preserving person-centered care plans and choice of caregivers.

The total number of hours a member may receive will continue to be based on the standardized assessment, existing service limits, and case management review. R6.31 is designed to distribute those hours more safely and sustainably, reducing over-reliance on a single caregiver rather than reducing access to medically necessary care. We believe this will generate savings by addressing extreme outlier situations and bringing Colorado back in line with long-standing program parameters and federal HCBS rules. Historically, CDASS and IHSS have had limits on paid family caregiver hours, and federal guidance expects plans of care to include both paid services and unpaid natural supports, with spouses and parents paid only for extraordinary care. Over time, we have moved away from those guardrails, and in some cases there appear to be incentives for providers to encourage families to ask for more paid hours than necessary. The projected savings from this proposal are modest relative to the overall LTSS budget, but they contribute to the broader package of LTSS sustainability actions needed in the current revenue environment.

With respect to potential cost shifts, HCPF has not assumed offsetting increases in nursing facility, hospital, or other institutional costs in the fiscal estimates for R6.31 or the related LTSS sustainability actions. These proposals are explicitly designed as guardrails on utilization and delivery, with limits set above typical patterns of use and

paired with exception processes, so that members remain safely supported in the community. At the same time, both the Manatt Landscape Analysis and the literature on family caregiving underscore that poorly supported or over-extended caregivers can be associated with higher emergency department use and hospitalizations, while better-balanced caregiving arrangements can help prevent those outcomes.

To guard against unintended consequences, HCPF will monitor nursing facility utilization, hospitalizations, emergency department visits, critical incidents, and transitions to higher levels of care as part of our Quality Improvement Strategy for LTSS.

54. [Sen. Kirkmeyer] How much was expended in each fiscal year for homemaker services since FY 2018-19?

RESPONSE: The total expenditures for waiver homemaker services per fiscal year can be found in the table below:

Fiscal Year	Total Homemaker Expenditures	Year over Year Percent Change
FY 2018-19	$45,765,407.18	19.00%
FY 2019-20	$53,790,859.59	17.54%
FY 2020-21	$62,911,598.98	16.96%
FY 2021-22	$71,544,224.11	13.72%
FY 2022-23	$89,114,542.94	24.56%
FY 2023-24	$117,054,785.29	31.35%
FY 2024-25	$174,099,143.89	48.73%

Note: Does not include Homemaker provided through CDASS. Services for CDASS Homemaker, Personal Care, and Health Maintenance Activities are consolidated within a single budget for individuals using that form of participant direction. This prevents the disaggregation of utilization trends and precludes inclusion of these services in the same dataset as other service models. In addition, providers do not submit claims for a specific CDASS service.

R-06 Enrollment Related Changes

55. [Sen. Kirkmeyer/Rep. Taggart] Please discuss the dynamics driving caseload for each waiver. What is causing the significant caseload increases in the two children's waivers? What are the income requirements for each of the IDD waivers? What impact did the COVID-19 public health emergency have on waiver caseloads? Where eligibility

requirements changed due to the public health emergency? What are the societal factors affecting caseload?

RESPONSE: For the four Intellectual and Developmental Disability (IDD) waivers, caseload is driven by four main factors:

- How many people meet level-of-care and targeting criteria and want to enroll in the programs,
- How many funded enrollment slots are available in the Developmental Disabilities (DD) waiver, which has a waitlist
- Provider capacity, and
- Reimbursement rates.

The two children's waivers that serve children and youth with intellectual and developmental disabilities (IDD) are where we have seen the most rapid caseload growth.

- Children's Extensive Services (CES) waiver enrollment has grown every year for at least six years, with a sharp increase in enrollments since early 2024, especially among very young children whose families are seeking services like Homemaker and Community Connector.
- Children's Habilitation Residential Program (CHRP) waiver serves children and youth with very high behavioral and residential needs, often involved in child welfare. CHRP's caseload has been the fastest-growing of the four IDD waivers as it is increasingly used as a community-based alternative to institutional care as eligibility has been expanded. HB 18-1328 expanded CHRP eligibility for children not involved in child welfare (effective July 2019). HB 24-1038 further expanded eligibility to include youth with serious emotional disturbance, effective January 1, 2025.

For the adult IDD waivers:

- DD waiver caseload and costs are steadily increasing as more youth in CES and CHRP waivers transition to adult services and as emergency and institutional transitions are approved. Additionally, the legislature approved 129 additional DD waitlist enrollments in FY 2024-2025.
- SLS caseload has been relatively flat or slightly declining, but expenditures are rising as members' needs and provider rates increase.

Further, the General Assembly has funded enough enrollment to avoid waitlists in Supported Living Services (SLS), CES, and CHRP, so underlying need is reflected directly in caseload.

Financially, the IDD waivers all use the standard HCBS rule that income must be below 300% of the SSI benefit rate with limited assets. For the adult DD and SLS waivers, the individual's income and resources are both considered in the eligibility process. For CES and CHRP, only the child's income and resources are counted; parent income is not considered.

In some cases, select income may be disregarded and not counted towards a member's Medicaid eligibility. For example, if a member/applicant is also a live-in caregiver for a member receiving HCBS waiver or CFC services, the wages they earn for providing some of those services are considered Difficulty of Care payments and will be excluded from their gross income when applying for MAGI Medical Assistance. This circumstance would likely only apply to members on the SLS waiver, since children are not eligible to be a paid caregiver and members on the DD waiver have 24-hour care needs, making it difficult to be a caregiver for someone else.

During the COVID-19 Public Health Emergency (PHE), the federal continuous coverage requirement reduced terminations from Medicaid, which had only a small impact on waivers, especially IDD waivers, as most people enrolled in waivers remain eligible due to having a long-term disability. HCPF also implemented temporary flexibilities in how HCBS services were delivered and how assessments were conducted, but did not permanently change core financial or functional eligibility standards for the IDD waivers. As the PHE ended, standard redeterminations resumed; while that has moderated overall Medicaid enrollment, IDD waiver caseloads, particularly CES and CHRP, continue to grow based on underlying need and expansions.

The biggest change following the PHE was that CMS changed longstanding guidance around when and how Legally Responsible People (parents, legal guardians of children, and spouses) may be paid to provide select services. Following the change in federal guidance, HCPF opted to allow Legally Responsible People to continue to receive payment for this service. HCPF does have the option to discontinue this allowance. This change in policy resulted in a significant increase in utilization and cost (for example, a 510% growth in monthly participants and a 1,178% increase in costs for the Community Connector service), even with caps and training in place. Because of this dramatic growth in utilization and cost, many of the reductions proposed are aimed at ensuring these services can be provided in a fiscally sustainable manner.

Finally, societal factors are putting sustained pressure on IDD caseloads: population growth, earlier and more accurate diagnosis of IDD and autism, more children with complex medical needs surviving into childhood and adulthood, housing and caregiver stresses, and a policy preference for keeping people in the community rather than in institutions. These pressures, combined with rising costs per person, are a major

driver of HCPF's budget growth for the Office of Community Living in the current revenue-constrained environment.

56. [Sen. Amabile] With respect to the Level 7 rate negotiations, does a more accurate reimbursement strategy result in families receiving a lower daily rate? Please explain.

RESPONSE: Support Level 7 and Level 6 "negotiated rates" are used in the DD and CHRP waivers when a member's needs exceed the highest standard Residential Habilitation Support Level rate. In these situations, HCPF works with the Case Management Agency and the provider agency (such as a Host Home, Foster Home, Group Home, or Residential Child Care Facility) to set an individualized daily rate **paid to the service provider agency**, not directly to the family.

Through R-15, HCPF is proposing to replace the current ad hoc tools with a standardized, data-driven methodology for **new** Level 7 and Level 6 negotiated rates. This methodology would apply prospectively to members who newly seek a negotiated rate above the highest Support Level; **it would not change existing negotiated rates** that are already in place, but the new standardized tool would be used at their next scheduled review.

The negotiations of these rates rely on tools created in 2007 and on average require approximately fifty-five hours per month across five department FTE to review each request, reconcile different documentation, and arrive at a rate. This process is subjective and has contributed to rapid growth in the cost of negotiated rates. Recent data illustrates why a more accurate and standardized approach is needed. Between FY 2018 and FY 2024, the average daily rate for negotiated Support Level 7s for individuals served on the DD waiver increased roughly 66%, from approximately $374 per day to $623 per day. From calendar year 2023 to 2024, the average negotiated daily rate in CHRP group homes increased by nearly 11% and in CHRP Residential Child Care Facilities (RCCF) by nearly 21%.

The new approach would use a standardized tool and national benchmarks to tie reimbursement more closely to a member's assessed needs and the staffing pattern required to safely support them, with the goal of creating more equity across providers who receive these negotiated rates.

Over time, a more accurate reimbursement strategy will not have a uniform effect on all new cases. For some members, including some family-based settings, the standardized tool may support a similar or higher negotiated provider rate because it better documents the intensive staffing or behavioral/medical needs involved. For others, especially where a requested rate is significantly higher than what the standardized staffing model supports, the negotiated provider rate may be lower than under today's more subjective process. The goal is to ensure that all providers,

including family caregivers serving as paid providers, are reimbursed consistently and equitably based on the member's assessed needs and reasonable staffing assumptions, rather than on the strength of individual negotiations.

57. [Rep. Taggart] Trying to negotiate each level 7 rate individually seems like a monumental task.

RESPONSE: We agree that negotiating every Support Level 7 rate, one case at a time, is not sustainable, and that is in large part what HCPF is trying to fix with R-15 (not R6.31). Today, members with the most intensive needs on the Developmental Disabilities (DD) and Children's Habilitation Residential Program (CHRP) waivers receive individually negotiated rates when their needs exceed the highest established Support Level rate. R-15 does not create a new requirement to negotiate, rather requests funding for a contractor to analyze current negotiated rates, review representative member cases, and identify the key cost drivers that differentiate these highest-need members. That analysis will be used to develop a standardized, data-driven methodology and ultimately an internal consistent rate-setting tool.

These members represent a very small subset of the larger Intellectual and Developmental Disability (IDD) population (307 out of 8,332 HCBS-DD Waiver members) whose providers are approved to receive the negotiated Support Level 7 rate in FY 2024-2025. However, the negotiations of these rates rely on tools created in 2007 and on average require approximately 55 hours per month to review each request, reconcile different documentation, and authorize a rate. This process is subjective and has contributed to rapid growth in the cost of negotiated rates.

Between FY 2018 and FY 2024, the average daily rate for negotiated Support Level 7s for individuals served on the DD waiver increased roughly 66 percent, from approximately $374 per day to $623 per day. Based on the trends identified in recent years, HCPF finds it necessary to improve the existing process and develop an objective, efficient, and effective rate negotiation mechanism.

The new methodology will be used for members newly seeking a Level 7 negotiated rate for Residential Habilitation services in the DD waiver beginning in winter 2026, with CHRP to follow on a later timeline, if funding is approved for the additional analysis.

58. [Sen. Amabile] How do our services compare to other states? Does the Department believe our services are attracting people to move to the state?

RESPONSE: The Adult Comprehensive waiver, formally titled the Developmental Disabilities (DD) waiver in Colorado, looks very similar to what other states offer in their "comprehensive" Intellectual and Developmental Disabilities (IDD) waivers: 24-hour residential habilitation, day and employment services, behavioral supports, transportation, assistive technology, and home modifications so people can live in the community instead of institutions. National surveys and research on IDD waivers show

that Colorado's benefit package is aligned with common practice, and Colorado's broader Long Term Services and Supports (LTSS) system generally scores well on measures like choice of setting and support for family caregivers compared to other states.

We do not have strong quantitative evidence that the DD waiver is driving people to move to Colorado. Our eligibility systems do not track whether someone relocated specifically to access IDD services, and federal rules do not allow the state to require a minimum length of residency for Medicaid eligibility. In addition, the DD waiver is the only Home and Community-Based Services (HCBS) waiver in Colorado with a waitlist, so individuals who move here still face the same funding and availability constraints as existing residents. The DD waiver is designed to meet the needs of eligible Colorado residents and provide a community alternative to institutional care, rather than to encourage in-migration, and we are continually balancing that mission with the state's current revenue limitations.

59. [Sen. Amabile] Are there residential treatment options provided through Medicaid that do not involve waivers?

RESPONSE: Yes. Under the Medicaid state plan, individuals may reside in nursing facilities (NFs) as well as intermediate care facilities for individuals with intellectual or developmental disabilities (ICF/IID). In these settings, residents receive both medical treatment and other services and supports. JBC members may be familiar with the Regional Centers, which operate both ICF/IID group homes (relatively institutional settings funded through the Medicaid state plan) as well as Home and Community-Based Setting (HCBS) group homes funded through the Developmental Disabilities (DD) waiver.

Additionally, the only non-institutional behavioral health residential service under Medicaid that does not require a waiver is for children and youth. Medicaid covers Qualified Residential Treatment Programs (QRTP) as a residential level of care without a waiver. A QRTP provides residential trauma-informed treatment that is designed to address the needs, including clinical needs, of children with serious emotional or behavioral disorders or disturbances.

A Psychiatric Residential Treatment Facility (PRTF) is a higher level of care than a QRTP and is more akin to an institutional level of care and is more medically intensive than residential services and includes 24-hour nurse monitoring. PRTFs operate primarily from a medical approach for higher acuity mental health conditions that may require stabilization efforts, medication management, and care for physical risk factors. Unlike residential services, where room and board payment is excluded, PRTF reimbursement includes room and board.

60. [Sen. Kirkmeyer] How are the individual residential services and supports (IRSS) daily rates set?

RESPONSE: IRSS is a bundled residential habilitation service on the DD waiver that is paid as a daily per-diem. HCPF establishes IRSS daily rates through the standard fee-for-service rate-setting process and publishes them on the rate schedule. Daily rates are tiered by the member's Support Level, with higher acuity levels receiving higher per-diem payments. Separate rate lines exist for the setting in which the service is delivered—IRSS in host homes and other IRSS settings—with distinctions between Denver and non-Denver areas.

Historically, when IRSS is provided by a family caregiver in the family home, those services have often been reimbursed under a distinct IRSS rate series that is higher than the standard host home IRSS rate for the same Support Level. This occurred despite the IRSS rate methodology being designed to support higher reimbursement for only staffed settings, which are more expensive to operate due to the use of rotating agency staff and associated higher administrative staffing costs.

The IRSS rate alignment will bring family-home arrangements in line with host-home arrangements so that services are paid consistently, regardless of whether the live-in caregiver is a host-home provider or a family caregiver, while ensuring that services delivered in settings that are truly staffed, including family homes where agency staff provide more than 50 percent of the care, may continue to be billed under the staffed home rate structure. Members with a Support Level 7 negotiated rate will not be impacted by this change and those rates will continue to be individualized and member-specific. Overall, this alignment is intended to promote fairness, consistency, and sustainability in the administration of these essential programs.

HCPF estimated savings using a conservative assumption about the volume of family caregivers delivering IRSS. Current data does not identify caregiver type at the claim-level—and EVV data cannot be used because this service is exempt—this information gap is being addressed through revised regulations. These draft regulations, which have been shared with stakeholders, clarify the settings associated with each rate series, and providers will be instructed to bill according to the updated guidance. The impact of the change will vary by provider and depend on previous billing practices and how the revised rules apply to their service models.

61. [Sen. Kirkmeyer] What was the public process for the proposal? How much feedback and public comment did the Governor's Office and the Department solicit and receive regarding this proposal? How will the Department implement the proposed change?

RESPONSE:
Stakeholder Engagement

HCPF hosted two meetings for stakeholders held in October and November of this year that focused on clarifying IRSS residential setting definitions in regulations, while reviewing upcoming rate and billing changes required under Executive Order D

2025-014, and presenting revised language to stakeholders based on prior feedback. Each meeting drew roughly 200-300 participants and was focused on receiving public comment from members, their families and providers. Stakeholders also provided over 215 written responses on the proposed definition and related implementation considerations, which informed the refinement and finalization of the IRSS language. The Office of Community Living Leadership also met with families in person in late October to hear their concerns and receive feedback. HCPF collated and reviewed all oral and written feedback which directly influenced the regulation language that is moving forward through the regular Medical Services Board review process.

Implementation of the proposed change

The IRSS rate alignment will be implemented through a combination of rule changes, billing guidance, and provider and case manager education, with an anticipated effective date after Medical Services Board approval and completion of operational changes, currently targeted for April 2026. Implementation steps will include:

1. Regulatory changes and formal guidance
    a. HCPF will amend regulations to clearly define IRSS setting types—Staffed Homes and Shared Living Environments - and specify that only Staffed Homes, defined as provider-managed homes with rotating agency staff where primary caregivers do not reside, qualify for the higher IRSS rate. Shared Living Environments, in which a primary caregiver lives in the home (including host homes) and provides at least 51% of care, will bill at the lower rate.
    b. Billing manuals will be updated and an Operational Memo published, summarizing the new definitions, rate alignment, and billing expectations for providers and case management agencies.
2. System and operational updates
    a. HCPF will update claims processing systems and provider rate tables so that IRSS claims for staffed homes are reimbursed under the staffed home rate structure, while claims for settings where a family member or other live-in caregiver are reimbursed at the shared living environment rate structure.
    b. HCPF will coordinate with case management agencies to ensure member support plans and authorizations accurately reflect the correct IRSS setting type for each member.
3. Stakeholder communication and training
    a. Targeted outreach to providers, case management agencies, and advocacy organizations will be completed to walk through the new

definitions, examples of when the higher rate is appropriate, and how to avoid billing errors.

b. Member-facing materials will be developed and distributed to explain that the change is intended to clarify billing and support sustainability and is not expected to reduce access or cause members to lose services.

4. Monitoring and ongoing engagement
    a. HCPF will monitor claims and utilization patterns after implementation to ensure that the higher rate is being used only for staffed home models, that billing is accurate, and that members remain stable in their homes.
    b. The existing stakeholder feedback mechanisms will remain open, such as the Sustainability stakeholder comment form, so that HCPF can continue to hear feedback on how the change is working in practice, including any unintended impacts on members or providers.

Within the broader context of the state's significant revenue shortfall, this change is designed to address areas where conflicting guidance has led to overuse of the higher IRSS rate, while maintaining access to DD waiver residential services. By reserving the higher rate for higher-cost staffed homes and aligning live-in caregiver arrangements with the lower rate, the proposal is expected to generate approximately $1.45 million General Fund savings in FY 2025-26, which supports sustaining waiver services for all DD members.

62. [Sen. Kirkmeyer] What are the reasons (e.g., funding, provider capacity, etc.) for having a waitlist for the DD waiver?

RESPONSE: The Home and Community-Based Services (HCBS) for Persons with Developmental Disabilities (HCBS-DD) waiver is Colorado's only waiver with a waitlist and it provides access to 24-hour, seven-days-a-week supervision and residential habilitation for adults with intellectual and developmental disabilities. Because HCBS waivers are optional under federal Medicaid rules, the state may cap enrollment based on a predetermined number in accordance with funding, which is why a waitlist exists for the DD waiver. HCPF cannot exceed the number of slots authorized by the General Assembly or go beyond the federally approved capacity. A waitlist is maintained to manage the resources approved by the General Assembly in accordance with the federally approved waiver. Even with the significant investments the state has made, budget limits, growing demand, and provider capacity concerns continue to make it infeasible to open the DD waiver to everyone at once. More people are seeking these services than can be served with current funding, and eliminating the waitlist would require a major increase in the General Fund. To eliminate the waitlist, it would require $37,712,196 GF and $75,424,388 TF in FY 2026-27 and grow exponentially from there, with estimates for FY 2031-32 reaching $146,928,556 GF and $293,857,107 TF.

In the meantime, 90% of people on the DD waitlist are receiving Colorado Medicaid services and 79% are receiving other HCBS waiver services — such as Supported Living Services (SLS), Elderly, Blind, Disabled (EBD), and Community First Choice (CFC).

63. [Sen. Amabile] What is the average length of time a person eligible for the DD waiver stays on the waitlist? Please provide information and context regarding the calculation of the average.

RESPONSE: On average, individuals currently wait seven years on the HCBS-DD waiver waitlist before receiving an enrollment authorization.

The calculation is based on two points in time:

1. The individual's DD waitlist placement date, which is the date they were first determined to have a developmental disability—or their 14th birthday if the determination occurred earlier; and
2. The date they are offered an enrollment authorization.

HCPF includes only the years after age 18 when calculating the average wait, as a person isn't eligible for the DD waiver until they are 18. Time spent on the list before age 18 establishes a person's future place in line but is not counted in the "seven-year" waiting time measure.

This seven-year figure is a systemwide mean and does not reflect a single uniform experience. Individuals approved through Reserved Capacity—emergency, child welfare system, or deinstitutionalization—may enroll immediately. Others may choose to intentionally defer adult services for many years, which affects the length of time they remain on the waitlist but not the calculation of the average. Currently available data indicates that the declination rate for FY 2024-25 churn authorizations was 16% (41 of 254). Declination data for the 129 one-time appropriations that were approved in FY 2024-25 was 68% (88 of 129). This declination data suggests that people continue to indicate they would enroll as soon as available, if offered an enrollment, but often are able choose to receive services outside of the DD waiver.

How long someone waits also depends on how many DD waiver enrollments the state can fund each year and how often openings become available. When a spot opens up, it is offered to the next person in line. This is referred to as "next by date" churn. Because the number of DD waiver slots is limited, not everyone who is eligible can enroll right away, which is why a waitlist exists.

64. [Sen. Kirkmeyer/Rep. Taggart] Please describe the circumstances, processes, and criteria for an individual to skip the waitlist and be immediately enrolled in the DD waiver. Do these types of enrollments affect individuals currently receiving services

through the DD waiver? In the last three fiscal years, how many individuals were able to skip the waitlist? What effects do immediate enrollments have on the waitlist?

RESPONSE: HCPF enrolls members into the DD waiver through two mechanisms working together:

- Routine "next-by-date" enrollments (churn) from the As Soon As Available (ASAA) list- When a member leaves the DD waiver, the next person on the statewide waitlist in order of their placement date is authorized to take their place. The process of filling vacant enrollments with new enrollments is sometimes referred to as "churn." Churn enrollment may be considered more of a traditional waitlist process; and
- Reserved Capacity, which is currently limited to three defined circumstances:
    - **Emergency:** The individual meets DD waiver criteria, is experiencing an emergency that threatens health or safety, such as imminent homelessness, abuse or neglect, danger to self or others, or loss or incapacitation of a primary caregiver, and the situation cannot be resolved with any other supports.
    - **Youth Transition:** The individual meets DD criteria and is aging out of the Children's Habilitation Residential Program Waiver (CHRP), Children's Extensive Support Waiver (CES), or child welfare. *As of July 1, 2026, R6.17 would limit this to children in child welfare who meet DD waiver eligibility*.
    - **Deinstitutionalization:** The individual meets DD criteria, is leaving a skilled nursing facility, mental health institute, Intermediate Care Facility, or Regional Center, and needs DD services to support a safe discharge to the community.

These pathways share the same statewide appropriated capacity and operate in parallel, not in competition. Importantly, even during years with significant Reserved Capacity utilization, the average wait time has remained stable or decreased, because many individuals on the waitlist are effectively served through other programs.

Across the last three fiscal years, HCPF approved the following Reserved Capacity enrollments:

- **FY 2022-23:** 182 Emergency, 102 Youth Transition (less than 30[6] Child Welfare and 92 CES/CHRP transitions), and 20 Deinstitutionalization enrollments.

[6] Safe Harbor requirements dictate that any number less than 30 be reported as less than 30.

- **FY 2023-24:** 182 Emergency, 103 Youth Transition (less than 30 Child Welfare and 93 CES/CHRP transitions), and 21 Deinstitutionalization enrollments.
- **FY 2024-25:** 164 Emergency, 116 Youth Transition (less than 30 Child Welfare, 84 CES, and 25 CHRP transitions), and 33 Deinstitutionalization enrollments.

For Reserved Capacity enrollments, the Case Management Agency (CMA) must document all the eligibility requirements necessary for DD waiver enrollment. Including the need for 24-hour support, completion of the level-of-care assessment, demonstration that other HCBS waivers or Community First Choice (CFC) cannot meet the person's needs, and finally submission of a detailed Reserved Capacity request to HCPF. HCPF is the only entity that can authorize DD waiver enrollment. HCPF reviews the documentation and, if approved, authorizes enrollment without waiting. These immediate enrollments do not remove services from anyone already on the DD waiver.

Reserved Capacity enrollments are a long-standing essential component of Colorado's waitlist management structure and are built into the DD waiver's caseload modeling, annual appropriations, and federally approved waiver capacity.

65. [Sen. Amabile] What happens to individuals on the waitlist who need the services and care provided through the DD waiver?

RESPONSE: Most individuals on the "As Soon As Available" DD waiver waitlist receive other Medicaid and waiver services. As stated in a previous response:

- 90% of individuals on the Developmental Disabilities (DD) waitlist are receiving other Medicaid services.
- 79% are enrolled in other Home and Community Based-Services (HCBS) waivers.

Individuals on the DD waitlist have access to a broad array of Long-Term Services and Supports (LTSS) services, including access to the following waiver and services:

- Community First Choice (CFC), which includes core services like personal care, homemaker, and health maintenance activities and can be used alongside enrollment on an HCBS waiver. Many of these services are offered through participant-directed options like In-Home Support Services (IHSS) and Consumer-Directed Attendant Support Services (CDASS). We anticipate those who choose this option to only grow, as this benefit was just made available on July 1, 2025.
- Supported Living Services (SLS): Services include Day Habilitation, Supported Employment, Prevocational Services, Peer Mentorship, Life Skills Training, Remote Supports, home and/or vehicle modifications and more.

- Elderly, Blind, and Disabled (EBD): Services include Adult Day Services, Peer Mentorship, Respite, Alternative Care Facilities, home and/or vehicle modifications and more.
- State-funded supports such as the Family Support Services Program (FSSP) and State Supported Living Services (State-SLS).
- Regional Accountable Entity (RAE) care coordination for medical and behavioral health.
- Case Management for LTSS navigation and monitoring.

Used together, these services often meet the needs of individuals and families who are waiting on the DD waitlist while allowing them to remain safely in the community.

Individuals experiencing emergencies, youth in child welfare, and individuals leaving institutional settings can request to be enrolled in the DD waiver immediately through Reserved Capacity enrollment. This ensures that the DD waiver is used to mitigate crises, which is critical given the fixed capacity based on funding appropriations set by the General Assembly.

66. [Sen. Amabile] With the waivers being an optional set of services provided through Medicaid and the existence of a waitlist for DD services, what would happen if individuals are left out of services?

RESPONSE: While Home and Community-Based Services (HCBS) waivers are optional under Medicaid, these programs are an important part of the Colorado Medicaid ecosystem and are critical to comply with the Olmstead decision and serve people in the least restrictive setting possible. Colorado's Long-Term Services and Supports System (LTSS) is set up in a way to intentionally avoid these adverse outcomes.

If a member is on the DD waitlist, case managers are required to provide ongoing, person-centered options counseling and to make sure the member has access to available services that meet their needs. All Colorado Medicaid members also receive coordination through their Regional Accountable Entity (RAE). This care coordination connects members to physical health, behavioral health, and community supports.

HCPF's data demonstrates that 90% of members on the waitlist with ASAA status are actively receiving Colorado Medicaid services and 79% of those members are receiving other Home And Community-Based Services (HCBS) waiver services. HCPF also maintains Reserved Capacity enrollments for the DD waiver for individuals whose needs cannot be met through other programs so there is a safety net in the event of an emergent need.

67. [Sen. Kirkmeyer] The General Assembly has had a policy of reducing the DD waitlist when capable. What are the Department's justifications for this proposal, which reduces service provisions to some of the most acute cases of individuals with

intellectual and developmental disabilities while increasing the waitlist?

RESPONSE: HCPF fully recognizes and shares the General Assembly's long-standing goal of reducing the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver waitlist. Over the past decade, with the Joint Budget Committee's support, enrollment into HCBS Intellectual and Developmental Disabilities (I/DD) waivers and programs has increased by 112%, and the HCBS-DD waitlist has been reduced by 61%, reflecting a sustained, bipartisan commitment to expanding access to comprehensive services for adults with intellectual and developmental disabilities.

Even if Colorado's state budget were to improve, it is unlikely the state could afford the current estimated $13,121,836 General Funds ($26,243,669 total funds) and $293,857,107 ongoing funds to eliminate the waitlist. Because of this, HCPF has focused on bolstering other, more sustainable, service options for adults with IDD. The HCBS-DD waiver is Colorado's most costly waiver, with enrollment growing by more than 43% since FY 2018-19 and associated costs for the waiver have increased by 112%, rising faster than overall Medicaid spending. Without targeted action in this area, HCPF would face the prospect of broader and more disruptive cuts across Long-Term Services and Supports (LTSS) and other Medicaid services.

HCPF's proposals are therefore designed to slow the rate of future enrollment growth and better align financing, while preserving services for people already enrolled and maintaining access for those with the most urgent needs. The DD waiver enrollment changes (R6.17 and R6.18) would reduce churn enrollments from the waitlist by half and end automatic youth-to-adult transitions for certain groups, but they do not remove any current member from the DD waiver or change the underlying benefit package. Case Management Agencies will be expected to continue to provide options counseling to assist members to understand what services and programs may best meet their needs through their annual waitlist contact requirement.

HCPF will continue to authorize prioritized Reserved Capacity enrollments for individuals experiencing emergencies, transitioning from institutions, or exiting child welfare services, so that people with the most acute and immediate needs may still access comprehensive DD services without going through the standard waitlist. Additionally, those on the waitlist will continue to receive meaningful services and supports through the many other robust waiver and state plan programs.

HCPF believes this targeted approach best balances several important goals: preserving services for individuals already on the DD waiver, protecting access for those with the most acute and urgent needs through Reserved Capacity enrollment, and leveraging other waiver and state plan options to support people while they wait, to avoid more severe budget cuts to eligibility or benefits.

68. [Sen. Bridges/Rep. Brown] Please provide projects on the impact of this policy change on enrollments in and the waitlist for the DD waiver. How will this change the total enrollments in the DD waiver? How will this change the number of individuals on the DD waiver waitlist? How will this change the average length of time an individual is on the DD waiver waitlist?

RESPONSE: These changes to the Developmental Disabilities (DD) waiver will slow enrollment growth and bring long-term stability to the disability fiscal landscape. Following this policy change, available enrollments each year will be used to support Reserved Capacity, which is available to individuals who truly require 24-hour residential habilitation and Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care including in emergencies, institutional discharges, and youth in the child welfare system. Approximately 50% of the previously available enrollments will still be available to individuals from the As Soon As Available (ASAA) list.

HCPF has adjusted its projected Reserve Capacity enrollments authorizations within FY 2025-26 estimates to account for a higher proportion of emergency enrollment requests, understanding the reality that some youth that would have been authorized through automatic youth transition enrollments will still need enrollment authorization at the time that they age out of their current HCBS waiver. Despite an expected increase in Reserved Capacity enrollments, HCPF anticipates that total DD enrollment and caseload will grow more slowly because a portion of members who would have filled DD slots will be served through other waivers and Community First Choice (CFC). Over time, it is likely that the DD waiver caseload will be more highly concentrated among individuals with the most intensive needs.

It is difficult to estimate how the two policy changes will impact total enrollments on the DD waiver, the number of people who will be on the waitlist, or the change in the waitlist length because of the many factors that play into people's decisions to add their name to, and stay on, the waitlist, and the likely impact on Reserved Capacity enrollments. For example:

1. Individuals may determine their needs can be met by another waiver and/or CFC services and that they no longer need to be on the DD waitlist.
    - By using Supported Living Services (SLS), other adult waivers, and CFC for individuals, we expect fewer people to move into a status where they are actively seeking DD enrollment as the only way to maintain stability.
    - Stronger options counseling and transition planning mean families are more likely to pursue the waiver or program that may better fit their needs, rather than automatically targeting DD.

2. More accurate tracking of those who truly do want and need DD-level supports.
    - When HCPF offers monthly authorizations from the ASAA waitlist, we see a high declination rate, with the primary reason being that people report they are already getting their needs met through other services.
    - Under the new policy, we expect the waitlist to reflect fewer individuals who are stable and not actually seeking DD-level residential services, and more individuals for whom DD truly is the appropriate next step.

It is likely that in the near term, the number of members on the waitlist may grow modestly as the system transitions and as people continue to be added to the list, while the approval rates are decreased. Over time, it is likely that the demand for the DD waiver will lessen as individuals determine their needs can be met with other Medicaid and waiver services.

The average wait time may also be impacted by these same factors. Today, the average wait for individuals with an ASAA status is about seven years; however, it is important to note 90% of members on the waitlist with ASAA status are actively receiving Colorado Medicaid services and 79% of those members are receiving other Home And Community-Based Services (HCBS) waiver services. Without any policy change, HCPF's long-term projections show that continued demographic pressure and historic auto-enrollment patterns would push average wait times higher over the coming years. With the new policies we expect the wait time to hold close to the current levels as individuals find services in other waivers that serve their needs and the waitlist narrows to include only those who most need the unique set of DD waiver services.

Our intent is not to lengthen the wait for people in crisis or with intensive 24-hour needs, but to align DD enrollment with those needs and to rely on the broader disability ecosystem to support people safely in the meantime.

69. [Sen. Amabile] How does this policy change affect the costs of the Supported Living Services waiver? What are the impacts on other HCBS waivers?

RESPONSE: Under the following policy changes, reducing the Developmental Disabilities (DD) waiver churn by half and ending automatic Children's Extensive Services (CES)/Children's Habilitation Residential Program (CHRP) transitions for youth not in child welfare services, HCPF anticipates seeing total savings of $21.8 million in FY 2026-27 and $62.4 million in FY 2027-28. HCPF expects many individuals who would have enrolled in the DD waiver will enroll or remain in other programs—in particular the Supported Living Services (SLS) waiver and the new Community First Choice (CFC) option. These assumptions were built into the savings projections (blunting the expected savings).

This has three important budget and operational implications:

Costs will shift from the DD waiver to SLS and CFC rather than be eliminated. When youth move from children's waivers, they will still need services; most will enroll in SLS (projected to be about 80%) and use CFC for personal care, homemaker and skill-building. Because SLS provides a package of services and supports that allows individuals with intellectual and developmental disabilities to remain in their own homes and communities and CFC provides basic attendant services statewide, these programs will see higher enrollment and service utilization. However, SLS and CFC have lower per-member costs than the 24-hour residential habilitation covered by the DD waiver, so shifting individuals into SLS and CFC slows the growth of overall spending even as those programs' budgets increase.

HCPF notes that 90% of members on the waitlist with ASAA status are actively receiving Colorado Medicaid services and 79% of those members are receiving other Home And Community-Based Services (HCBS) waiver services. This change does not leave individuals without services. Individuals waiting for the DD waiver may enroll in one of the other Home and Community-Based Services (HCBS) waivers—including SLS, the Elderly Blind and Disabled waiver (EBD), or the Community Mental Health Supports (CMHS)—and can access State Supported Living Services (State-SLS) and the Family Support Services Program (FSSP). Maintaining individuals in other programs while they wait for DD means the cost pressure shifts across waivers but does not represent a new burden.

In addition to SLS, we expect modest increases in enrollment and service utilization in EBD, CMHS, Complementary and Integrative Health (CIH), and other adult waivers as case managers match each person to the waiver that best meets their current needs. Because none of the other waivers have waitlists, this shift will ensure services continue without interruption while the DD waiver is reserved for those most in need. Over time this should make the DD waitlist more accurate by removing individuals whose needs are already being met elsewhere, while also slowing the growth of DD waiver expenditures.

70. [Sen. Kirkmeyer] Why does this proposal drive increases in administrative costs? Why are more FTE required?

RESPONSE: The two proposed changes to DD waiver enrollment will significantly impact the workload management of the DD waitlist. Central to the operational implementation structure is the proposed full-time equivalent (FTE) who will support:

- Policy, waiver amendments, and regulation promulgation
- Public comment and stakeholder engagement
- Policy and operational guidance to Case Management Agencies to implement Enhanced Transition Coordination, and
- Appeals oversight, training, and technical assistance.

The changes to managing the waitlist will result in a small increase in administrative costs and additional FTE and the anticipated savings cannot be achieved without additional FTE. HCPF is prioritizing development and implementation of Enhanced Transition Coordination and the Reserved Capacity enrollments as members in these circumstances are in need of immediate enrollment. With the proposed changes, we anticipate the volume of these requests to increase. HCPF reviews 100% of these requests—and no other entity may approve DD enrollment. Each request requires detailed clinical, regulatory, and document review, often across multiple systems (children's services, schools, behavioral health, hospitals, child welfare).

At the same time, HCPF expects an increase in appeals for individuals enrolling into or on the DD waiver. This is not because families are losing services but because more decisions must now be made case by case, and each of those decisions is appealable under Medicaid requirements. This increased administrative load must be managed to ensure statewide consistency, accuracy, and timely decisions.

71. [Rep. Taggart] When a client moves from the child waiver to the adult DD waiver, do the caregivers remain the same? What is a typical scenario? How often does the caregiver change at that transition point?

RESPONSE: The majority of children on Home and Community-Based Services (HCBS) waivers live at home, and their primary caregivers are often their parents or other family members. Youth transitioning into the Developmental Disabilities (DD) waiver often retain a family caregiver, when they require 24-hour continual support and meet all DD waiver enrollment criteria. Many provider agencies are enrolled to serve both children's and adult HCBS waivers, so families are often able to remain with the same provider organization, and often the same direct support professionals, as the youth moves into adulthood. If a member does not transition to the DD waiver and instead transitions to the Supportive Living Services (SLS) waiver, a family member can continue to be the caregiver and provide personal care, homemaker and Health Maintenance Activities (HMA) services, while maintaining relationships with existing provider agencies where that is the family's choice.

Since July 1, 2025, youth aging out of children's waivers have new, streamlined pathways to maintain caregiver continuity through Community First Choice (CFC) and the accompanying participant-directed options such as In-Home Services and Supports (IHSS) and Consumer-Directed Attendant Support Services (CDASS). These models allow caregivers to continue as the paid providers seamlessly from youth to adulthood. Because many agencies serve both children's and adult programs, they can also continue to provide services under CFC and adult waivers, supporting continuity not only of the individual caregiver but also of the broader provider team. As a result, the person providing hands-on care typically remains exactly the same when the youth reaches adulthood.

With the implementation of CFC, a common scenario now would be a youth with an intellectual or developmental disability on the Children's Extensive Support (CES) waiver who lives at home with their family. As they approach adulthood, the Case Management Agency (CMA) works with the family to develop a transition plan that often includes:

- Maintaining personal care, homemaker, and health maintenance services through CFC, using a participant-directed model (IHSS or CDASS) that allows caregivers to remain paid attendants.
- Enrolling into an adult waiver without a waitlist, most often the Supported Living Services (SLS) waiver, where the young adult's needs can be met while they remain in the family home.
    - Many service types available on children's waivers have comparable adult offerings, such as Community Connector services transitioning to Supported Community Connections in the SLS waiver, which helps keep the nature of supports consistent even when the waiver changes.

For the relatively small number of children in out-of-home placements through child welfare, such as those in the Children's Habilitation Residential Program (CHRP) waiver, HCPF also prioritizes continuity. When these youth transition to adult services, they typically remain with the same residential provider agency—and often the same direct support staff—with only back-end billing and waiver authority changing.

Most changes in caregivers during transition stem from family choice (such as a young adult moving out of the home), provider staffing changes, or normal life circumstances.

72. [Sen. Amabile] With the changes proposed in R6.17, how will the system of automatic enrollment change?

RESPONSE: Beginning July 1, 2026, Colorado will end the practice of automatically enrolling youth from the Children's Extensive Support (CES) and Children's Habilitation Residential Program (CHRP) waivers into the adult Developmental Disabilities (DD) waiver, unless the youth is involved with child welfare. Under R6.17:

- Immediate access to the DD waiver is reserved only for youth experiencing emergencies, discharging from institutions, or leaving child welfare. These members will continue to receive priority DD enrollment through Reserved Capacity requests.
- Case managers will evaluate what waivers and service delivery options a young adult may be eligible for, such as the Supported Living Services (SLS), the Elderly Blind and Disabled (EBD) waiver, or other adult Home and Community-Based Services (HCBS) waivers. These waivers cover day

habilitation, employment supports, respite, home modifications, and more. Personal-care, homemaker and health maintenance services will be provided under Community First Choice (CFC) regardless of waiver, often through participant-directed options like In-Home Services and Supports (IHSS) and Consumer-Directed Attendant Support Services (CDASS).

- Individuals retain their place on the DD waitlist. If they later need 24-hour residential support, they can transition to the DD waiver with their original placement date.

73. [Sens. Amabile and Kirkmeyer] Does the Department have a transition plan to assist those families and individuals affected by this change who were expecting to transition to the DD waiver in the next two fiscal years? If so, please provide a detailed description of the plan and the communications to-date with those affected.

RESPONSE: Yes, HCPF has a transition plan to support families, case managers, and our system partners as HCPF moves away from automatic transitions from the Children's Extensive Support (CES) waiver and Children's Habilitation Residential Program (CHRP) waiver to the Developmental Disabilities (DD) waiver. This change is proposed to take effect July 1, 2026, after federal approval, case manager training, and Care and Case Management (CCM) system updates.

Last year, almost 80%, or 433 members, transitioned from CES and CHRP into the DD waiver; 20%, or 93 members, transitioned to other HCBS waiver or State Plan services. After July 1, 2026, most youth who would have automatically transitioned to the DD waiver will instead transition into other adult Home and Community-Based Services (HCBS) waiver programs —most often the Supported Living Services (SLS) or Elderly, Blind, and Disabled (EBD) waivers—while retaining the ability to access the DD waiver through Reserved Capacity in the event of an emergency, child welfare transition, and institutional-to-community transition.

HCPF will provide a member list to each Case Management Agency along with a member communication for those who are impacted. Each member transitioning out of CES or CHRP will receive enhanced transition support, with a focus on ensuring youth receive the right services at the right time. From a member and family perspective, the transition from a children's waiver to adult services is planned and supported. Case managers will begin structured conversations well before a youth ages out of their current waiver, focusing on adult goals, daily supports, health and safety needs, living arrangements, and caregiver capacity. Rather than a single default pathway, case managers will walk families through all available adult supports, focusing on how these services work together to meet current needs.

Caregiver continuity is prioritized. Transition planning explicitly addresses how caregiving arrangements may continue into adulthood, often through participant-directed options. DD waiver access remains available when truly needed. If needed, case managers will work with families to submit Reserved Capacity requests through emergency, child welfare, or institutional transition pathways. These requests are individually reviewed by HCPF to ensure timely access when DD-level services are necessary.

Additionally, families will receive written communication explaining the transition, services moving forward, and their appeal rights, reinforcing transparency and consistency statewide. No family navigates the transition alone. Case Management, RAE Care Coordination, and HCPF remain engaged throughout the process to support stability, address complex needs, and resolve issues if circumstances change.

74. [Sen. Amabile] How much of the CHRP waiver caseload receives child welfare services? What happens to those individuals who age out of CHRP but are not receiving child welfare services?

RESPONSE: The Children's Habilitative Residential Program (CHRP) was built as a cross-system waiver that sits at the intersection of Intellectual and Developmental Disabilities (IDD), behavioral health, and child welfare. Many of the children served are in foster or kinship care or have active child welfare involvement, and CHRP is often used as a community-based alternative to higher-level residential placements. Currently, 88 members, or 13% of members enrolled on the CHRP waiver, are in child welfare.

For children who age out of CHRP and are not in child welfare, the transition is managed through person-centered planning led by the Case Management Agency (CMA). If they meet adult IDD waiver criteria and need 24-hour support, they can move into the Adult Comprehensive/Developmental Disabilities (DD) waiver through the youth transition Reserved Capacity process. If they need less intensive support, they may transition into the Supported Living Services (SLS) waiver or other adult Home and Community-Based Services (HCBS) programs. Youth who do not qualify for adult IDD waivers are connected to other Medicaid community-based services for adults, including behavioral health and housing resources, so that when they transition off of the CHRP waiver it does not mean an abrupt loss of support solely because they are not in child welfare custody.

75. [Rep. Taggart/Sen. Amabile] Please discuss how the Department calculated the assumed savings from this change. Given the individuals affected by this policy change are currently receiving services, and would presumably require the same level of services going forward, how does this change save money? With an implementation date of July 1, 2026, why is the FY 2027-28 savings nearly three times that of the FY 2026-27 savings?

RESPONSE: The cost savings from R6.17 come from shifting youth into lower-cost programs, not from denying services. To build its estimate, HCPF:

1. Projected the number of youth who would have transitioned into the Developmental Disabilities (DD) waiver under current policy and assumed that roughly 80% will instead enroll in Supported Living Services (SLS) and the remainder in the Elderly, Blind, Disabled (EBD) waiver.
2. Compared per-member costs between the waivers. The DD waiver is the state's most expensive program because it includes 24-hour residential habilitation. SLS and EBD, combined with Community First Choice (CFC) and State Plan services, offer necessary support at a lower per-member cost.
3. Applied the cost difference to the projected transition cohorts. Small implementation costs exist in FY 2025-26, followed by savings of about $15 million (total funds) in FY 2026-27 and $44 million in FY 2027-28. Savings grow in FY 2027-28 because R6.17 is fully phased in, so additional cohorts of youth spend the entire fiscal year on the lower-cost path.

This calculation does not assume that youth stop needing services. It assumes their needs are met through SLS, EBD and CFC rather than stepping immediately into the DD waiver. Emergencies, institutional discharges and child-welfare transitions still qualify for immediate DD enrollment, which were accounted for in the calculated savings calculations.

76. [Sen. Kirkmeyer] Why does this proposal drive increases in administrative costs? Why are more FTE required?

RESPONSE: To implement this change, HCPF is creating a clear operational structure to support families and case managers. Central to this structure is the proposed full time equivalent (FTE) who will support HCPF's review of all DD waiver enrollment and appeals activity during the transition to include:

- Reviewing every Reserved Capacity request (Emergency, Youth Transition, and Deinstitutionalization) across the state;
- Providing technical assistance and training to Case Management Agencies (CMA) to ensure consistent statewide interpretation of DD waiver enrollment criteria;
- Managing and tracking an expected increase in appeals, which will arise because determinations previously made "automatically" will now require individualized, appealable decisions;
- Ensuring that HCPF-level decisions are accurate, timely, and compliant with federal waiver requirements;
- Coordinating with internal teams to update workflows, guidance, and training for case managers;

- Supporting sustained stakeholder and family communication throughout the transition and
- Providing oversight of CCM system updates to ensure accurate routing, tracking, and documentation of youth transition pathways

The end of "automatic" transitions fundamentally changes HCPF's workload, and the savings can not be achieved without FTE. Under the new structure every youth aging out of CES or CHRP will undergo an individualized and comprehensive transition coordination review by HCPF. This change requires HCPF to review and approve 100% of DD waiver enrollment requests. The volume of Reserved Capacity submissions is expected to increase dramatically. Each request requires detailed clinical, regulatory, and documentary review, often across multiple systems (children's services, schools, behavioral health, hospitals, child welfare).

At the same time, HCPF expects a substantial increase in appeals. This is not because families are losing services—SLS, EBD, Community First Choice (CFC), State Plan benefits, Care Coordination, and Case Management all remain available—but because the denial into the DD waiver must now be made case-by-case, and is appealable under Medicaid law.

77. [Sen. Amabile] Please provide a detailed description of post-eligibility treatment of income (PETI) and how it will be applied to the Developmental Disabilities (DD) waiver. Who pays for the room and board at this point? How will individuals on the DD waiver be able to pay for the additional cost with this change?

RESPONSE: Post-Eligibility Treatment of Income (PETI) is the process used within the Home and Community-Based Services waivers, after an individual has been determined eligible for Medicaid, to calculate the portion of that individual's income that must be applied toward the cost of long-term care services delivered in residential settings. This is a standard process within the HCBS waiver applications used by many states. As part of this calculation, a personal needs allowance and other required deductions are protected first. Any remaining income is then considered the member's monthly "cost of care" contribution, and Medicaid covers the balance. This approach is already standard in other residential Long-Term Services and Supports (LTSS) programs in Colorado.

Under the current Developmental Disabilities (DD) waiver, members receiving residential habilitation services pay only a standard room and board amount, while Medicaid pays the full daily service rate. In contrast, members in other residential waiver services, such as individuals residing in an Alternative Care Facility (i.e. Assisted Living), already contribute a portion of their income toward service costs through the PETI process. This is currently a requirement for members in all residential settings within LTSS programs. R6.36 would apply the same PETI framework to residential habilitation under the DD waiver, aligning the DD waiver with other residential waiver programs. The application of PETI to the DD waiver is not

new; prior to 2008 the PETI was used within the DD waiver, but a shift in internal policy paused the requirement. This is a resumption of the PETI policy to all adult residential benefits.

Members will continue to pay room and board from their own income, as federal rules prohibit the use of HCBS waiver funds for room and board expenses. The PETI calculation will only consider income remaining after room and board and the personal needs allowance are set aside.

For individuals on the DD waiver, the additional contribution is intentionally structured to come only from income left after basic living needs are met. Members with very limited income will have little or no PETI obligation, and all members will retain the full personal needs allowance to support everyday expenses. To ensure that incentives to work remain intact for Members on the DD waiver, individuals enrolled in the Working Adults with Disabilities (WAwD) program will be exempt from the PETI process. Members with higher incomes will contribute more, consistent with the PETI approach already used in other residential waivers. This policy is one of HCPF's tools to support the long-term sustainability of the DD waiver, manage cost growth, and preserve access to comprehensive 24-hour services in the context of a statewide budget shortfall.

78. [Rep. Brown] How will individuals on the DD waiver afford the cost sharing policy? What assets are subject to this policy? Does this policy cover current and/or future income and assets?

RESPONSE: HCPF is requesting to apply the same Post-Eligibility Treatment of Income (PETI) rules that already apply in other residential Long-Term Services and Supports (LTSS) settings to members served on the DD waiver. Today, DD waiver members pay room and board, and Medicaid pays the full residential habilitation rate. Under PETI, after a member has already qualified for Medicaid, a standard calculation is used to determine how much of their monthly income is available to contribute toward the cost of their residential services, while preserving a personal needs allowance and other allowable deductions. HCPF is proposing to begin using PETI for DD waiver residential services effective in July 2026, pending federal approval, consistent with other Home and Community-Based Services (HCBS) residential waivers and nursing facility residents who already contribute a portion of their income toward their care.

With respect to affordability, the proposal is designed so that members continue to pay room and board as they do today and keep a personal needs allowance (PNA) for their own expenses. Only income above room and board and the PNA would be applied toward the residential habilitation rate. For example, a member with $1,500 in monthly income in 2025 would keep $797 for room and board and $421.46 as a personal needs allowance, with the remaining $281.54 per month going toward the cost of services that Medicaid currently pays in full. This approach maintains a protected amount for clothing, transportation, and other basic personal items, while

asking DD waiver members to contribute toward services in the same way as members in other residential programs. HCPF will use the existing PETI rules and personal needs allowance protections; members will not be required to contribute more than their income above room and board and the PNA.

Regarding assets, this policy does not create a new asset or resource test. PETI is a post-eligibility income calculation that is applied only after a member has already qualified for Medicaid under existing financial eligibility rules. It determines how much of a member's ongoing monthly income (for example, Social Security, pensions, or wages that are counted as income under current rules) is available to contribute toward long-term care costs, while preserving the personal needs allowance and other deductions recognized in regulation. The request does not change which assets are countable or exempt for Medicaid eligibility, and it does not extend PETI to "future" assets beyond the standard ongoing eligibility reviews that already occur. Once implemented, the PETI calculation would apply prospectively to members' monthly income at and after the effective date, consistent with how PETI is used in other residential settings.

Finally, aligning DD waiver cost-of-care contributions with other residential waivers helps address the state's significant budget shortfall while preserving access to 24/7 community-based services for adults with intellectual and developmental disabilities. The request is projected to generate savings of approximately $6.3 million General Fund in FY 2026–27 and $13.1 million General Fund in FY 2027–28, helping sustain the DD waiver and the broader LTSS system over time.

79. [Rep. Taggart] Please discuss how the Department calculated the assumed savings from this change. With an implementation date of July 1, 2026, why is the FY 2027-28 savings more than the FY 2026-27 savings?

RESPONSE: To estimate savings, HCPF applied the existing PETI framework, which is already in place for other residential waivers, to the DD waiver residential population:

HCPF started from current and projected DD waiver caseload using 24-hour residential habilitation (IRSS and GRSS) and associated per-diem expenditures.

Using the same PETI methodology that applies in assisted living and other Home and Community-Based Services (HCBS) residential settings, staff modeled how much of each member's income, above room and board and the personal needs allowance, would be redirected to the cost of services instead of being paid entirely by Medicaid.

Members whose incomes are already fully absorbed by room and board and personal needs allowances were assumed to have no additional contribution; members with higher income generate a larger contribution.

The model compared this PETI-based contribution to the current policy, where members in the DD waiver generally pay only room and board. The difference is the gross savings to the Medicaid program.

Finally, HCPF applied the standard federal match rate and financing mix for the DD waiver to convert gross program savings into total funds and General Fund savings. The resulting estimates are:

- $12.6 million total funds / $6.3 million General Fund in FY 2026-27
- $26.3 million total funds / $13.1 million General Fund in FY 2027-28

Why FY 2027-28 savings are larger than FY 2026-27

This new policy will become effective on July 1, 2026, with a rolling implementation structure. Meaning that members will not be impacted by the new policy until their annual recertification. That is why the budget estimates demonstrate FY 2026-27 as a transition year rather than a full year of mature savings. There are two main reasons the savings grow in FY 2027-28:

1. Partial-year and phased implementation in FY 2026-27
    a. The change requires federal approval, rulemaking, system changes, and updates to case management and provider billing.
    b. PETI is typically implemented at the individual level through financial and eligibility redeterminations, not all at once for every member. The FY 2026-27 estimate therefore reflects a ramp-up period, with savings accruing as members cycle through recertifications and as operational changes are fully implemented.

2. Full-year effect plus underlying DD waiver growth in FY 2027-28
    a. By FY 2027-28, HCPF assumes that all eligible DD waiver residential members are subject to PETI, so the savings reflect a full year of the policy in place across the caseload.
    b. In addition, DD waiver expenditures and enrollment are growing, driven by higher-acuity needs and the underlying LTSS cost trend. IDD waiver spending increased by more than 20% between SFY 2024 and SFY 2025 and is a major LTSS cost driver.
    c. As residential costs grow, applying member contributions consistently to that larger base produces higher dollar savings in the second year.

Together, these factors mean that FY 2026-27 reflects only a partial-year and partial-caseload impact from aligning DD waiver cost share with other residential waivers, while FY 2027-28 reflects a full year of implementation on a larger DD waiver

expenditure base, which is why the savings nearly double between those years. HCPF will refine these estimates as federal approvals, rules, and implementation timelines are finalized, and will continue to ensure that members retain their personal needs allowances and access to residential supports consistent with assessed need.

80. [Rep. Taggart] As compared to some of the other proposals for soft caps on annual utilization of some services, why does the Department not require additional staffing to manage the PETI process?

RESPONSE: R6.36, Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services, applies the same cost of care contribution expectations to members in the DD waiver's 24-hour residential services that already apply in other Long-Term Services and Supports (LTSS) residential settings. This is done through the long-standing Post-Eligibility Treatment of Income (PETI) process, which is a standard Medicaid mechanism to determine a member's monthly cost share based on income after required federal disregards and allowances. This is a policy alignment within an existing process, not the creation of a new benefit, eligibility pathway, or manual review function.

Because PETI is already in place for other Medicaid LTSS populations, HCPF is not building a new infrastructure to implement R6.36. PETI calculations currently occur within existing eligibility and billing systems and are supported by established procedures for members in nursing facilities and other residential waivers. Staff within HCPF, case management agencies, and providers are already familiar with cost of care contribution requirements and the associated member communications, billing, and reconciliation workflows. Thus, this is not a new or novel process; the system is already functioning today for other members and HCPF already collects these contributions.

In contrast, the LTSS soft-cap proposals on annual or weekly utilization for certain services create new exception and appeal pathways that require subject matter expert review, coordination with case managers, and ongoing monitoring to ensure that members with higher needs can access additional units when appropriate. Those initiatives therefore include targeted requests for additional (FTE) to operate centralized exception reviews, track outcomes, and support case management agencies. For PETI, the work is largely rules-based and automated, relies on income information already collected through financial eligibility, and does not require individualized exception determinations in the same way that a soft cap on service units does.

HCPF has evaluated the expected volume of DD members who will become newly subject to PETI under R6.36 and determined that this additional workload can be absorbed within current staffing levels. The primary impacts will be one-time updates to business rules and systems and additional training and technical assistance for case management agencies, which can be managed by existing policy and operations staff. Given the state's significant revenue shortfall and the need to prioritize General Fund

for direct services, HCPF is limiting new administrative FTE requests to those initiatives where new manual processes are unavoidable. For R6.36, leveraging the existing PETI infrastructure allows HCPF to advance equity across residential programs and support long-term LTSS sustainability without adding new ongoing administrative positions.

Other Requests: R-8, R-12, R-15

81. [Rep. Sirota] Please explain the cost increases starting in FY 2027-28?

RESPONSE: In FY 2026-27, R-8 shows a net reduction because it is a transition year: HCPF is phasing in the Colorado Single Assessment (CSA) with a smaller cohort (or grouping) of case managers using a soft launch approach that will start in the fall of 2026, while at the same time backing out one-time SB 16-192 funding, discontinuing the Interim Support Level Assessment (ISLA) and other legacy assessment costs. Those offsets are large enough that the net effect in that first year is a decrease of about $11.7 million total funds.

The cost increase in FY 2027-28 reflects the first full year in which HCPF anticipates that case managers at all 15 Case Management Agencies (CMA) will be using the CSA and Person-Centered Support Plan (PCSP) statewide. Case managers will be conducting the CSA and PCSP for all members at higher per-assessment rates, which are based on a time study. The ongoing cost of that work is only partially offset by eliminating the Interim Support Level Assessment (ISLA). In addition, FY 2027-28 carries the full-year cost of three term-limited full-time equivalent (FTE) and contractor support for CSA stabilization, Care and Case Management (CCM) system enhancements, quality review, and training.

The savings in FY 2026-27, followed by higher costs in FY 2027-28, are driven by timing and annualization of the rollout planned in accordance with stakeholders. In the first year, HCPF realizes one-time savings as we retire older tools and funding and utilize a gradual implementation of the CSA and PCSP by phasing it in with a smaller cohort of case managers. By FY 2027-28, HCPF is paying the ongoing, fully annualized cost of implementing a more robust, objective, statewide assessment and planning process, which will include 100% of members being assessed for their initial enrollment or annual reassessment.

82. [Rep. Sirota] Why has it taken 10 years to get to the point of deploying the single assessment tool?

RESPONSE: HCPF acknowledges that it has been a long journey from the original legislative direction in 2016 to being ready to implement the single assessment tool. The primary reasons are:

- The scale and complexity of the change;

- The decision to build a Colorado-specific assessment and person-centered support plan with extensive stakeholder input rather than purchase an off-the-shelf product;
- The impact of the COVID-19 pandemic and Public Health Emergency (PHE) unwind; and
- The need to sequence multiple major Long-Term Services and Supports (LTSS) and Information Technology (IT) reforms so that the ecosystem and workforce can absorb and integrate the new assessment instrument.

In 2016, Senate Bill 16-192 directed HCPF to develop a single, standardized assessment tool for individuals seeking or receiving LTSS, replacing more than 30 different assessment tools used across Home and Community-Based Services (HCBS) programs. The Colorado Single Assessment (CSA) and companion Person-Centered Support Plan (PCSP) were designed to support eligibility, acuity assessment, planning, and resource allocation in one integrated process. Rather than quickly adopt an existing national tool, and after reviewing existing tools, stakeholders and HCPF agreed to develop a customized assessment that reflected Colorado's diverse waiver structures and populations. This required several years of co-design, field testing, and refinement of the assessment instrument itself. Because the instrument is integrated into the new Care and Case Management (CCM) system and will be used by Case Management Agencies (CMA), it also required extensive IT development.

From FY 2017-18 through FY 2019-20, HCPF and stakeholders refined the CSA and PCSP and then piloted them with approximately 650 HCBS members. The pilot period overlapped with the onset of the COVID-19 pandemic, which disrupted in-person assessments and limited the reliability of pilot data. To protect the work already completed, HCPF sought extensions of spending authority rather than moving forward with an implementation based on compromised data.

Beginning in FY 2020-21, the focus shifted from paper design to automation within the new Care and Case Management (CCM) platform and development of the Person-Centered Budget Algorithm that will ultimately use CSA data to inform resource allocation. This work was impacted by IT vendor changes, IT system development delays, and the need to stabilize the CCM when it went live during the initial two phases, starting in July 2023. During this period, the legacy ULTC 100.2 and support plan continued as the operational eligibility assessment and planning instruments in the CCM while the CSA was refined in the background.

At the same time, HCPF and the LTSS ecosystem were managing several other large-scale changes: the unwind of the federal Public Health Emergency (PHE), Case Management Redesign (CMRD), and the CCM System. By FY 2024-25 it became clear that launching the CSA until these efforts were stabilized would exceed what the Case

Management ecosystem and Colorado's broader LTSS infrastructure could reasonably absorb at once. In response, HCPF deliberately sequenced the work, prioritizing IT system stabilization and utilizing an Interim Support Level Assessment for Intellectual and Developmental Disability (IDD) members while continuing to prepare the CSA for statewide use.

In short, the ten-year timeline reflects deliberate choices to build a Colorado-specific, valid, reliable and equitable instrument; to incorporate extensive stakeholder input; to respond to extraordinary events like the pandemic and PHE unwind; and to avoid overwhelming case managers and providers by layering too many major changes at once. It does not reflect a lack of commitment to the CSA. HCPF anticipates implementation of the CSA and PCSP in SFY 2026-27, moving Colorado to a universal, objective and reliable assessment that better aligns services with assessed needs and supports the long-term sustainability of LTSS.

83. [Sen. Amabile] What are the projected savings from the nurse assessor program? Will we actually get the savings, or will people end up in institutional settings or staying longer in hospitals?

RESPONSE: HCPF did not assume savings from implementing the nurse assessor program; instead, it was a budget-positive budget request. The goal of the program was to provide a third-party independent assessment to help members understand all of the skilled care for which they were eligible. However, due to operational challenges, the Department has decided to stop the Nurse Assessor program effective December 15, 2025.

The previously estimated savings for Long-Term Home Health (LTHH) came from resuming and properly administering prior authorization requirements (PAR) that were suspended during the pandemic.

R-12 funds the staffing needed to manage appeals arising from the resumption of PARs and to administer the benefit, ensuring consistent application of existing medical necessity standards. HCPF's forecast assumes that PARs reduce LTHH spending below what it otherwise would have been by about $14.3 million total funds (TF) in FY 2025-26 and $48.1 million TF in FY 2026-27, relative to a scenario with no PARs. Those savings are built into the budget as reduced home-based service expenditures; they do not rely on members moving to nursing facilities or other institutions. The resumption of the PAR requirement ensures that each member receives the appropriate level of service to meet their needs, as determined by the medical necessity review.

84. [Rep. Taggart] Are the savings in jeopardy if the General Assembly doesn't fund the request for home health administration and why? Please address both the temporary staff for appeals and the position to manage the benefit.

RESPONSE: Yes. The savings assumed from resuming Prior Authorization Requests (PAR) for Long-Term Home Health depend on HCPF's ability both to manage a high volume of new long-term home health prior authorization appeals and to actively oversee the benefit going forward. The temporary appeals staff are needed to schedule and staff hearings so cases are decided on the merits rather than default approvals or the prolonged continuation of services while appeals are pending, which would erode the projected savings and increase the risk that HCPF misses the federal 90-day appeals timeliness requirement.

The ongoing one full-time equivalent (FTE) to manage the benefit is needed to oversee existing policy, make policy recommendations for programmatic enhancements, liaise with federal partners to ensure federal compliance, monitor utilization trends, support Utilization Management vendor performance, provide technical support to provider agencies, engage with stakeholders, and make data-driven adjustments to keep services medically appropriate and expenditures on the expected trajectory. Without funding for both the temporary appeals capacity and the benefit manager FTE, HCPF is unlikely to fully realize the forecast savings and faces increased financial and compliance risk.

85. [Sen. Bridges] Why is the requested appeals staff term-limited? What does the Department expect will happen to the appeals?

RESPONSE: HCPF initially requested term-limited appeals staff in R-12 because the increase in home health appeals was expected to be temporary. The new Nurse Assessor program was anticipated to support providers and members to better understand what could be approved under the home health benefit, thus leading to fewer denials and appeals. HCPF is also mindful of budget pressures, so proposed term-limited positions rather than permanent full-time equivalent (FTE). If HCPF does not see appeals decline after the first year it will reassess the need for ongoing appeals support and request additional or permanent FTE through the normal budget process in future years.

86. [Sen. Bridges] The appeals budget request (R12) assumes an increase in appeals related to long-term services and supports changes. Why is the request temporary when prior authorization requests have to be done yearly?

RESPONSE: HCPF initially requested term-limited appeals staff in R-12 because the increase in home health appeals is expected to be temporary. HCPF is also mindful of budget pressures, so proposed term-limited positions rather than permanent full-time equivalent (FTE). If the Department does not see appeals decline after the first year, it will reassess the need for ongoing appeals support and request additional or permanent FTE through the normal budget process in future years.

87. [Rep. Brown] Please provide details on rate increases and utilization for private duty nursing since FY 2019-20. Have rates increased substantially? If so, why? Has utilization increased substantially? If so, why? What is the justification for the focus on rate adjustments rather than utilization management?

RESPONSE: The rates for Private Duty Nursing (PDN) have changed along with the across-the-board rate adjustments every year since FY 2019-20 with the exception of FY 2021-22, when these services received a targeted rate increase of 8.51%. Overall, the average rate paid per unit has increased from $30.74 to $38.91 from FY 2019-20 to FY 2024-25, representing a 26.58% increase in the average rate paid (weighted average rates are $40.26 and $47.48, respectively, a 17.94% increase).

Enrollment and utilization: From FY 2019-20 to FY 2024-25, monthly participants increased a total of 11%, and utilization per participant increased a total of 7%. Additionally, HCPF has seen a 26.82% increase in the total number of services billed from FY 2019-20 to FY 2024-25.

Reason for HCPF's proposed approach: The underlying challenge HCPF is working to address through the requests is access to the service and workforce concerns, not inappropriate or excessive utilization. PDN serves a very small, extremely high-acuity population whose hours are already subject to intensive medical necessity review, prior authorization, and ongoing recertification. Most members are approved only for the minimum hours that clinicians consider safe.

Because of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements and the ADA/Olmstead obligations, HCPF cannot responsibly impose new utilization caps that would reduce medically necessary nursing hours. Cutting hours for this population would increase the risk of hospitalization or nursing facility placement, which would likely shift costs rather than reduce them.

For that reason, the PDN budget requests, which for clarity are located in R15 (not R6.31), focus on rate and payment structure rather than additional utilization management. These changes include: creating a per diem option for 24-hour cases to support stable staffing; and adding a short, "acute" period after hospital discharge to reduce delays and prevent readmissions while gathering necessary documentation and navigating the prior authorization process. These adjustments are targeted at stabilizing the PDN workforce, improving the ability to staff 24/7 cases, and reducing preventable hospital or facility days.

In short, these initiatives are a more effective, member-centric, and legally sound lever for PDN. They address the real constraint—nurse availability—and support federal requirements and the DOJ voluntary agreement. Additional utilization management would add administrative burden and risk without a viable path to sustainable savings.

88. [Sen. Bridges] Where Colorado provider networks may already be inadequate and families are struggling to fill nursing hours, rate cuts could be disastrous. How did the Department assess the adequacy of the provider networks where cuts are proposed, and evaluate the impact of those cuts?

RESPONSE: HCPF would like to emphasize that none of HCPF's requests, other than the rescinding of the 1.6% provider increase, make any rate cuts to nursing services. Members will continue to receive all medically necessary nursing care required to meet their assessed needs, and no reductions to authorized services are being implemented as part of this request.

Service utilization for Long-Term Home Health (LTHH) has increased by 19% over the past five years, demonstrating stable provider capacity and continued need for the benefit. To ensure ongoing fiscal sustainability and to align reimbursement with how services are delivered, HCPF is proposing updates to the payment methodology for Private Duty Nursing (PDN) as well as certain components of LTHH, such as speech therapy (SP), occupational therapy (OT), and physical therapy (PT).

The proposal transitions PDN services to a per diem payment model and updates the unit authorization structure for the others. A per diem approach reduces administrative burden, simplifies billing, and more accurately reflects the mix of resources required to support members' care. For PDN in particular, the per diem rate is designed as a blend of certified nurding assistant (CNA) and registered nurse (RN) staffing, which gives agencies flexibility to meet members' changing care needs and supports fluid staffing throughout the day. This blended structure better reflects real-world service delivery and promotes continuity of care.

HCPF has evaluated potential access impacts and incorporated several safeguards, including a blended PDN per diem rate to support continuous care and a new acute PDN period to reduce administrative barriers for families initiating services. Ongoing monitoring of utilization, expenditures, and provider participation will help ensure member access remains strong as implementation moves forward.

Finally, revising the unit authorization structure increases transparency and consistency across service types. Moving to smaller unit increments for certain LTHH services allows for more accurate billing based on the actual time services are delivered while reducing administrative complexity for both providers and HCPF.

89. [Sen. Bridges] Families are reporting that they are struggling to fill nursing. How will a lower, per diem rate impact this? How did you calculate the per diem rate?

RESPONSE: HCPF recognizes that families across Colorado may be struggling to secure skilled nursing care, especially for children and adults with high medical needs. That concern is central to the design of the Private Duty Nursing (PDN) per diem proposal,

which is included in R15. Families' current access challenges stem primarily from statewide nursing shortages affecting all sectors of care, and not from the Medicaid reimbursement methodology.

The PDN per diem is not intended to reduce members' authorized care, shift members into institutions, or diminish provider capacity. Instead, it is designed to keep PDN financially sustainable and available statewide while aligning reimbursement more closely with the actual mix of registered nurse (RN)- and certified nursing assistant (CNA)-level services delivered over a 24-hour period. Importantly, the per diem applies only when PDN is provided on a 24-hour basis; the existing hourly PDN rates remain in place and fully available when care is not 24/7 or when hourly codes are more clinically appropriate.

HCPF does not expect to exacerbate any access challenges, as this will both maintain member hours and allow greater staffing flexibility. Further, the per diem will be coupled with a newly proposed 60-day acute PDN benefit that is expected to ease some of the access issues families experience today by supporting faster initiation of care and smoother transitions home from hospitals.

The per diem rate was developed using HCPF's existing nursing rate-setting methodology, drawing on HCPF's standard cost framework, the current PDN fee schedule, and program data on how RN and CNA care is typically delivered over a full 24-hour period. By converting these inputs into a blended daily amount, the rate reflects the real-world mix of RN- and CNA-level work rather than relying on multiple hourly billing codes, while keeping member hours and clinical eligibility unchanged.

All underlying assumptions and calculations are detailed in the R-15 technical materials. Overall, the per diem aligns payment with actual care intensity and supports program sustainability and accountability without altering members' assessed needs or authorized services. This proposal in particular will have a robust stakeholder process to ensure HCPF has the full set of information needed to inform the rate and methodology behind it.

While workforce challenges are real and driven by broader labor market conditions, HCPF's PDN per diem proposal is designed to support long-term access by keeping member hours intact, giving agencies more staffing flexibility, adding an acute 60-day option to improve transitions from hospital to home, and helping the state live within its revenue limits so that PDN remains a viable home-based alternative to institutional care.

H.R. 1: Rural Health Transformation Program and Rural Provider Issues

90. [Rep. Brown] Please summarize the Department's approach to the rural health transformation program? What models from other states inform the Department's approach?

RESPONSE: First, we want to celebrate that Colorado has been awarded $200 million per year, or $1 billion through the Rural Health Transformation Program (RHTP) based on communications received from the Centers for Medicare & Medicaid Services (CMS) on December 29. This is good news and reflects the outstanding collaborative work across so many passionate voices over a very short timeframe. This $200 million per year and $1 billion total exceeded our expectations and also exceeds the federal funding which was available through the American Rescue Plan Act (ARPA) to transform behavioral health services across the state and to advance Home and Community-Based Services (HCBS) programs serving people with disabilities.

HCPF's approach to the Rural Health Transformation Program (RHTP) application followed the strict guidelines provided by CMS in the notice of funding opportunity. CMS outlined permissible uses, fund restrictions and prohibitions, and indicated that the applications must showcase transformative and sustainable approaches.

All states received the notice of funding opportunity for this program on September 15, 2025, with a November 5, 2025 deadline for a completed, detailed, and strictly page-limited application. The required documents and documentation for the application were extensive and required substantial time to complete. The process was meticulous and the landscape kept changing, with CMS providing changes in guidance and requirements all the way up to five days prior to the November 5 submission deadline. Despite this constraint, HCPF conducted three separate stakeholder meetings with over 200 attendees at each meeting, where we gathered feedback for the direction of the application and permissible uses of grant funds. HCPF also met with provider associations at their request. In addition, HCPF provided the draft submission to the Colorado Rural Health Center prior to submission and held a working session to implement their changes throughout the document where they didn't conflict with application requirements and prohibitions.

Because the grant was competitive with other states, the actual content of the submission was not published for public consumption. This is normal practice during competitive grant processes (other states also did not publish their applications prior to the due date).

Further, every state submitted applications simultaneously, and so models from other states did not exist when the application was developed. The RHTP was a new federal

grant program, with new processes and approaches, without an application history to study; while HCPF had discussions with other states during the process and engaged in every CMS RHTP webinar, a review of other state applications prior to submission was not practical.

91. [Sen. Kirkmeyer] What feedback did the Department hear from rural hospitals regarding the rural transformation program? What recommendations from the rural hospitals made it into the Department's proposal and what recommendations did not? Why? How will the Department revise processes to ensure meaningful co-design with rural communities moving forward?

RESPONSE: In six weeks, HCPF conducted three stakeholder meetings in rural Colorado with more than 200 attendees at each meeting, more than 50 individual stakeholder meetings, and more than 30 internal meetings, to ensure stakeholders were heard and the application met CMS' requirements, such as barring duplication and supplanting existing funding. The Colorado Rural Health Center (CRHC) also provided key insights during the process and indeed reviewed the entire application before it was submitted. HCPF further met with the Colorado Rural Health Center (CRHC) leadership and expert staff to review all their edits to, and comments on, the application, making appropriate changes in a working session and discussing where requests may not have been in compliance with the challenging application requirements.

At these stakeholder meetings, HCPF received feedback from rural hospitals across all of the 11 permissible uses of grant funds. Much of the feedback was concentrated in the areas of: prevention and chronic disease, technology, collaboration and workforce, appropriate availability of care, and innovative care models. This feedback was incorporated into our application and supported with data and analysis.

In addition to broad stakeholder meetings, HCPF staff met with representatives of the Colorado Hospital Association five times since receiving the RHTP Notice of Funding Opportunity. In general, the recommendations were incorporated into the application. Because of tight federal restrictions on the allowable use of funding, two hospital recommendations could not be incorporated into the application. First, recommendations for using the grant funding to increase provider payments were not incorporated in the application because CMS specifically placed severe limitations on provider payments, with both a cap and a prohibition against supplanting current funding. Second, recommendations from hospitals to use the grant funding for construction were not included, because construction funding is specifically prohibited in the application.

The final application reflects stakeholder feedback while acknowledging that there is limited funding available, restrictions on permissible uses of funding, and prohibitions on duplicating other state efforts or initiatives already funded by federal dollars. The

application ultimately targets six permissible uses. The list below details which areas were selected and which were not:

- Recruitment and retention of workforce - included in the application
- Initiating and fostering collaborative partnerships - included in the application
- Providing payments to providers - not included, due to severe CMS restrictions
- Developing innovative models of care - included in the application
- Investing in rural health care facility building infrastructure - not included due to CMS restrictions
- Providing technical assistance, software, and hardware for significant technology advances - a different technology permissible use was chosen due to restrictions and equipment
- Promoting evidenced based, measurable interventions to improve prevention and chronic disease management - included in the application
- Assisting rural communities to right size health care delivery systems - included in the application
- Supporting access to opioid use disorder treatment services, other substance use disorder services, and mental health services - not included as a permissible use, as this would cause duplication due to other programs that receive federal funding. Other quality programs like the Hospital Transformation program offer measures in the focus areas of opioid use disorder treatment and other substance use disorder services, and would cause duplication. However, mental health services are supported throughout the application in other initiatives that would not cause duplication and are allowed by CMS.
- Promoting consumer-facing, technology-driven solutions for the prevention and management of chronic disease - included in the application
- Providing training and technical assistance for the development and adoption of technology-enabled solutions that improve care delivery in rural hospitals, including remote monitoring, robotics, artificial intelligence, and other advanced technologies (did not receive stakeholder feedback on this permissible use).

The RHTP application included the creation of an advisory committee and an executive committee. A draft governance structure released on December 19 requests feedback by January 7.

HCPF will work with that advisory committee and executive committee to continue stakeholder engagement to ensure meaningful co-design with rural communities moving forward. As an example of continued stakeholder engagement, HCPF conducted a stakeholder webinar with more than 1,200 registrants, including

representatives of rural hospitals, on December 2, 2025 to describe the application process with which HCPF was required to comply. HCPF will continue to host webinars and provide written updates to keep interested parties informed and engaged throughout the process.

Finally, the application directions specifically prohibit revision after submission.

92. [Sen. Kirkmeyer] Why was the final rural transformation program application not shared with rural hospitals or key stakeholders before submission?

RESPONSE: HCPF shared Colorado's application draft with the Colorado Rural Health Center (CRHC) prior to submission, reviewed all their changes in a working session with them prior to submission, and implemented those edits that did not conflict with CMS requirements or prohibitions.

For those who may not be familiar with the Colorado Rural Health Center (CRHC), it is Colorado's nonprofit State Office of Rural Health. CRHC works with federal, state, and local partners to offer services and resources to rural health care providers, facilities – including hospitals, and communities. They have a diverse and inclusive statewide constituency serving organizations in every corner of the state. Their mission is to enhance health care services in the state by providing information, education, linkages, tools, and energy toward addressing rural health issues. Their vision is to improve health care services available in rural communities to ensure that all rural Coloradans have access to comprehensive, affordable, high-quality health care. HCPF has worked closely with the CRHC on rural projects for years and leveraged their knowledge, data and boots-on-the-ground experts through the RHTP process, and will continue to do so. The CEO of the CHRC, Michelle Mills, is also the President of the National Rural Health Association.

HCPF also co-hosted a public webinar with the CRHC on December 2 to educate stakeholders on the application protocols, restrictions, scoring methodologies, pending negotiations with CMS and more. The CRHC represents and supports a wide range of rural providers, including rural hospitals, clinics (like Rural Health Clinics and Federally Qualified Health Centers), individual practitioners, and more.

Outside of this line-by-line review of the application and the working session with the CRHC, the final program application was not shared publicly prior to submission for several reasons.

- First, this was a competitive grant with other states. Competitive grants are not usually shared publicly in their final - or near final format.
- Second, there was a limited amount of time between the notice of funding opportunity and the application deadline. All states received the notice of

funding opportunity for this program on September 15, 2025, with a November 5, 2025 deadline for a completed, detailed, and strictly page-limited application - providing about 50 days for completion - an unprecedentedly short timeframe, further complicated by its non-traditional approach to the grant application. Despite this reality, the Department conducted three broad-based stakeholder meetings, which included more than 200 participants each, plus meetings with numerous organizations. The research, data, documents, and documentation necessary to complete the application were extensive and required substantial time to complete.

- Third, the landscape kept changing, with CMS releasing guidance changes up until five days prior to the submission deadline of November 5, 2025 - meaning, Colorado's application was fluid until the final few days, when the application was shared with the Colorado Rural Health Center for a thorough review and incorporation of final, robust, broad-based feedback into the document.
- Fourth, half of the available funding is based on CMS receipt of a compliant application, which is why HCPF focused extensively on following the complex federal requirements. The other half of the available funding is to be distributed through a competitive process, with Colorado competing against other states for the remainder of the funds. Insights into other state's applications were not available prior to Colorado's submissions. The December 2 webinar enabled HCPF to collect further feedback from stakeholders, as will the pending Q1 RHTP webinar, which can be leveraged for the pending negotiations with CMS.

93. [Sen. Kirkmeyer] How will the Department ensure that rural transformation funding is used to stabilize rural hospitals (solvency, workforce, capital needs, OB/Behavioral Health preservation) rather than to fund administrative layers, state-driven regional structures, or continuation of programs (like the Hospital Transformation Program) that rural hospitals report as ineffective or burdensome?

RESPONSE: The RHTP draft governance includes a broad array of providers and their association representations, who will have significant input into the decisions about how funding is allocated; however, such allocations must stay within CMS requirements. States are restricted from using RHTP funds for hospital stabilization based on federal program requirements. CMS specifically requires that the grant funding be used for rural health care transformation.

A priority of the application that addresses stability, while staying within CMS guidelines, focuses on Sustainable Access, which supports stabilizing essential services and strengthening rural providers. In the state's application template submission, more than $100 million was allocated to sustainable access, nearly $150 million to

workforce development as examples. Restrictions for sustainable access in the notice of funding opportunity included:

- No supplanting existing funding
- No use of more than 15% of grant funds for direct provider payments
- Funds cannot be used for construction
- Funds cannot be used for reimbursable services

The state's application was required to address all quality programs to ensure no duplication or supplanting occurs. The state is allowed to align with current quality programs to utilize data already received, such as the Hospital Transformation Program (HTP), to mitigate administrative burden, while not duplicating efforts.

94. [Sen. Kirkmeyer] What analysis did the Department conduct to assess the risks of regionalization and proposed "Centers of Excellence," including potential loss of OB, emergency, and local inpatient services?

RESPONSE: Colorado's application for RHTP funding specifically includes:

- Restoring or introducing maternal health services in rural regions
- Expanding outpatient and specialty care, such as surgery, cardiology, and diagnostics
- Right-sizing inpatient, swing bed, and post-acute care services
- Developing regional rural health networks for shared services and staffing

The inclusion of Centers of Excellence in Colorado's grant does not prevent services from being provided, but rather provides additional resources and assistance to improve care while supporting stronger regional collaboration. HCPF does not believe that improving care and strengthening regional collaboration will result in the loss of obstetrical care, emergency care, or local inpatient services.

CMS prioritizes programs that encourage collaboration amongst rural providers, to develop the ability to share resources, drive efficiencies and support sustainability once the transformation funds end. This focus area helps mitigate low-volume risk for hospitals. Further, this builds upon opportunities the state has created through cooperative agreements via SB 23-298 (allowing public hospital collaboration agreements) and SB 25-078 (allowing nonprofit hospitals to enter into collaborative agreements with other health facilities). HCPF believes that additional funding from Rural Health Transformation Program grants will support these efforts without creating duplication. The state's initiatives on Sustainable Access will encourage increased availability of essential health services for rural providers.

95. [Sen. Kirkmeyer] How will HCPF guarantee that decisions about which services remain open in rural communities stay in local control rather than being dictated through regional collaboratives?

RESPONSE:
HCPF will work with the advisory committee and will continue stakeholder engagement to ensure the Rural Health Transformation Program grant stays within the guidelines outlined by CMS. The application itself and the allowable uses in the statute, do not allude to the regional collaboratives making decisions on the continuation of services. A high priority for HCPF is to maintain access to services in rural communities and the state's application supports that.

96. [Rep. Brown and Rep. Sirota] The briefing highlighted bundled payment models used in other states for rural providers. Please discuss how Colorado could adopt some of these concepts to stabilize funding. What would be the fiscal impact? Could we draw additional federal funds?

RESPONSE: While other payment approaches are possible for rural and other providers, any new payment methodology that does not increase total payments is not likely to alleviate the financial pressures these providers are facing. Adopting new payment methodologies, like HCPF's current Prospective Payment model in the Accountable Care Collaborative, may shift the timing of payments and provide more predictable month-to-month revenue, even if they do not increase overall payments to providers.

HCPF will continue to explore options with stakeholders and providers. At the same time, caution is needed; for example, if a prospectively-set rate is too low, providers may ultimately receive less money than under current practice. From the state's perspective, while some other states have shown overall savings with payment models, some have had higher costs than fee-for-service. While it is likely that new payment methodologies would receive federal financial participation, HCPF is not aware of any demonstration authority or other mechanism to increase federal funding without also increasing state funding.

To implement any new bundled or global payment, the state would need to work closely with stakeholders to design the model so it meets their needs and positively impacts health outcomes. There are many variations in a potential model design that would need to be thoughtfully considered. Additional authority from CMS would be necessary, potentially including a waiver. State statutory authority and/or budgetary authority would likely also be needed.

It is not clear what the potential fiscal impact would be; the overall impact would depend on the scope of any approved program. A more expansive program will require more time and resources to design and set rates, but might result in more savings. To be effective, new payment methodologies require upfront General Fund investment to design the model, engagement with stakeholders, achieve CMS approval, and set rates for participating facilities. Model costs would depend on the final model design, and

savings are not guaranteed. For example, data from Pennsylvania indicates costs higher than fee-for-service.

Designing and piloting rural value-based care models is a core component of the State's Rural Health Transformation Program application. HCPF will evaluate grant applications received under the Rural Health Transformation Program to determine what, if any, proposed payment methodologies are able to be implemented in ways that improve financial stability for providers.

97. [Rep. Brown] What other states have used 1115 waivers to create payment pools for rural providers? How are the payment pools structured? Could these work in Colorado? What would be the fiscal impact? Could we draw additional federal funds?

RESPONSE: There are a handful of states that either currently use, or have in the past used, 1115 waiver authority to create payment pools for uncompensated care. As of 2022, there were seven states (California, Florida, Kansas, Massachusetts, New Mexico, Tennessee, and Texas) that reported uncompensated care pool spending. A subset of these states are structured to support rural providers through their payment pool. They do this by using the funding for safety-net hospitals, critical access hospitals, sole community provider hospitals, or rural emergency hospitals.

The overarching concept is that states set a "pool size" and decide which providers will be eligible for the payments, which members (uninsured, underinsured, or Medicaid-eligible) the payments will be allowed for, and which care costs are reimbursable, resulting in a wide range of funding outcomes. The matching funds for these pools often come from state funds, intergovernmental transfers, certified public expenditures, or provider taxes (less common). States distribute the matched funds using a state-defined formula. It should be noted that the more recent waiver approvals indicate that CMS intends for these pools to allow payment only for uninsured individuals. In addition, CMS has indicated that the pools cannot be used as a way to make up for low Medicaid rates. Currently, Colorado has programs such as the Primary Care Fund that awards clinics proportionally based on their unduplicated indigent patient count. These awards help in the clinics uncompensated care costs.

It is unclear if CMS will approve future applications from states for uncompensated care pools. Any fiscal impact associated with establishing additional payment pools or similar uncompensated care reimbursement programs would likely be dependent on the amount of funding the General Assembly chooses to make available. The General Assembly has the authority to provide state funding to these providers without limit. Federal funding under Medicaid may be available; this would depend on program design and other factors such as how much room is available for different provider types under federal upper payment limits.

H.R. 1: Financing

98. [Rep. Taggart] We can't afford to replace the loss in federal funds with state funds. What is the solution? Is there a way to cut services without decimating rural access? Should we be looking at a revenue solution, and what would that look like?

RESPONSE: The state will lose billions of dollars in federal funds due to H.R. 1. Given that rural Coloradans are more likely to qualify for Medicaid, these changes may have more severe impacts on rural access. Due to H.R. 1, difficult decisions will need to be made to balance Medicaid expenses with lower revenues to cover them, with base options including: reductions in payments to providers, benefit reductions to Medicaid members, and potential reductions in covered populations.

The loss of federal funds, and the policy changes that result in losses in coverage will impact rural providers, hospitals due to the reductions in federal Provider Fee funding (CHASE in Colorado), which finances supplemental payments to hospitals, as well as coverage for hundreds of thousands of Coloradans under Medicaid and CHP+ Expansion, and Medicaid Buy-In coverage for people with disabilities.

HCPF has worked with stakeholders to create a robust plan to help navigate H.R. 1 and the overall reduction in available state and federal revenues, including the following pillars and a North Star to avoid loss of coverage wherever possible.

- Discipline to Medicaid Sustainability Framework: Grounded in facts/insights and alignment around shared goals
- Understanding H.R.1 impacts and aligned goals:
  - Eligibility ecosystem and state/county modernizations
  - Fraud, Waste, Abuse enhancements
- Seeking other federal funding
- Leverage ACC Phase III and Innovations (eConsults, Prescriber Tools, Value Based Payments, etc.) to control trends and improve quality
- Prioritize engagement, transparency, partnership, leadership
- Leverage third-party insights, state comparisons, learnings (Manatt work).

As Colorado addresses the loss of federal revenue through H.R. 1 with limited state funds, HCPF is committed to finding ways to minimize the effects of this federal law on members and providers. Specifically, HCPF is managing this challenge through the Medicaid Sustainability Framework. Four of the pillars are designed to thoughtfully control overall Medicaid trends by making data-based policy, benefit, and provider rate adjustments that directly respond to the outlier trends within the Medicaid

programs. We thank the Joint Budget Committee for their partnership on this important but difficult work.

The Sustainability Framework also includes a pillar to *Leverage and maximize HCPF's ability to draw down additional federal dollars*. HCPF is pursuing that pillar in two ways:

- First, in June 2025, HCPF submitted two State-Directed Payments pre-prints seeking additional funding for Denver Health and for all Colorado hospitals. More on this process is in our response to Question 101.
- Second, HCPF submitted an application for the Rural Health Transformation Program on November 4, 2025 on behalf of the state and in collaboration with rural providers. More on RHTP in our responses to Questions 90-71.

The state should see hundreds of millions in additional funding for rural providers from both programs in 2026. However, this new funding will not offset the lost federal funds caused by H.R. 1; in fact, the RHTP generally prohibits payments to providers to offset other changes from H.R. 1. HCPF will continue to follow key principles including maximizing coverage, prioritizing high-value services that keep people healthy, enhancing program efficiencies and integrity, and promoting long-term savings over short-term cuts.

99. [Sen. Amabile] What is the Department doing to prepare for the federal phase down of the hospital provider fee? What planning is happening now? What is the Department's recommendation on how the State should respond?

RESPONSE: HCPF is pursuing a host of approaches and initiatives to respond to the fiscal impact of H.R.1, as well as the concurrent state budget challenges. This robust plan was crafted through a multitude of meetings with stakeholders and elected officials.

- Discipline to Medicaid Sustainability Framework: Grounded in facts/insights and alignment around shared goals
- Understanding H.R.1 impacts and aligned goals:
  - Eligibility ecosystem and state/county modernizations
  - Fraud, Waste, Abuse enhancements
  - North Star: Shared efforts to help Coloradans comply and stay covered
- Seeking other federal funding
- Leverage ACC Phase III and Innovations (eConsults, Prescriber Tools, Value Based Payments, etc.) to control trends and improve quality
- Prioritize engagement, transparency, partnership, leadership
- Leverage third-party insights, state comparisons, learnings

HCPF is also conducting targeted analysis to better understand how reduced provider fee revenue may affect hospital payments and financial stability across different regions and hospital types. This work includes reviewing potential impacts on CHASE-funded payments, uncompensated care levels, and overall hospital financials, with particular attention to rural and safety-net hospitals that may be more sensitive to changes. This analysis will help identify where pressures may emerge and support the state in evaluating policy and funding options as the federal phase-down progresses.

HCPF will release three legislatively required hospital transparency reports in January 2026 and host a webinar in the first quarter of 2026 to review report highlights that will support fact-based decision making through this challenging chapter. These reports will illuminate key factors and associated trends for profits/losses, revenue and expenses, payer mix, new and closed service lines, community benefit, CHASE funding distributions and more.

CHASE fees increase Medicaid reimbursement to hospitals and help finance coverage, helping maintain access to care without requiring additional General Fund resources. H.R. 1 includes “Provider Tax” provisions that reduce federal funding available to the CHASE program in future years. The federal phase-down of the allowable hospital provider fee will have a significant impact on the Department’s ability to generate the state share used to draw federal matching funds for hospital payments and coverage for Medicaid expansion and CHP+ members. This presents a substantial challenge as hospital provider fees currently finance more than $1.8 billion in supplemental Medicaid payments to hospitals and support coverage for over 427,000 Medicaid expansion and CHP+ members and Medicaid Buy-In for people with disabilities.

Because the federal phase-down will significantly reduce the amount of provider fee revenue available to support CHASE, HCPF cannot address these impacts on its own. As the funding source for CHASE declines, it will be necessary for the General Assembly to review how the program’s statutory funding obligations, including hospital supplemental payments and the funding that supports Medicaid expansion and CHP+ coverage and the Buy-In population, should be prioritized within the limits of available revenue. Under current law, hospital payments must be funded first before provider fee revenue may be used to support Medicaid expansion coverage. This statutory structure will continue to apply unless the General Assembly chooses to modify it. With a reduction in available hospital provider fee revenue, the state’s policy makers will need to decide how limited provider fee revenue should be allocated across these purposes.

As provider fee revenue declines, HCPF is leveraging other mechanisms available through HCPF to support hospitals and help offset future federal funding reductions.

This includes pursuing State-Directed Payments (SDPs), which will increase Medicaid reimbursement to hospitals for services provided to Medicaid managed-care members (ie: RAE behavioral health, the Denver Health MCO and the Rocky Prime MCO) and will be funded primarily through intergovernmental transfers (IGTs) rather than through the hospital provider fee. Because SDPs do not rely on provider fee revenue, they can help reduce some reimbursement pressures and provide additional financial support as the federal phase-down progresses. HCPF filed two SDPs with CMS in June of 2025, which could bring as much as $390 million to hospitals. While this cannot replace CHASE-funded payments, it can contribute to overall hospital reimbursement and financial stability.

HCPF will continue collaborating with hospitals and stakeholders to consider additional approaches that may help address financial pressures as the federal phase-down progresses.

100. [Sen. Amabile] How will the phase down of the hospital provider fee impact uncompensated care?

RESPONSE: The phase-down of the provider fee revenue will increase uncompensated care. H.R. 1, signed into law by President Trump on July 4, 2025, will continue to ratchet down federal funds to Colorado by billions of dollars over the coming years.

The Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) plays a central role in reducing uncompensated care by increasing hospital reimbursement and supporting coverage for Medicaid expansion and CHP+ members. Under current law, health coverage would decrease due to insufficient provider fee revenue to support the state's required share of Medicaid expansion and CHP+ coverage.

HCPF is working with stakeholders to pursue additional federal funding mechanisms like State-Directed Payments and the Rural Health Transformation Program, to reduce the net amount of funding reductions impacting providers and the state. However, these other funding opportunities will not offset the significant reduction in federal funds due to H.R.1; funding reductions will affect all providers who provide care for Medicaid and CHP+ members.

Coloradans who lack health care coverage are more likely to receive care in the emergency department, thereby increasing hospitals' uncompensated care; also,

Coloradans who lack health care coverage will also delay needed care because they can't afford it, and this will result in worsening health outcomes (KFF).[7,8]

Under current statute, provider fee revenue is used in a defined statutory hierarchy that prioritizes maximizing payments to hospitals first and then uses any remaining provider fee revenue to support coverage for Medicaid expansion and CHP+ populations as well as coverage for people with disabilities who Buy-In to Medicaid coverage. This means, in the current hierarchy, as the provider fee is reduced, access for the expansion and Buy-In populations will shrink before payments to hospitals are affected. Policymakers must decide how the population reductions are prioritized, or whether to change the funding hierarchy itself. Without new funding sources or changes to the current statutory hierarchy and prioritization, insufficient provider fee revenue will create coverage reductions that will directly and significantly increase the number of uninsured Coloradans and drive a substantial increase in provider uncompensated care across Colorado's health care system.

101. [Rep. Brown] Please provide a status update on the state directed payments? Has the federal government approved the payments? What is the projected net benefit to hospitals? Which hospitals benefit? How does H.R. 1 change the state directed payments?

RESPONSE: HCPF has not yet received CMS's final approval for either the physician services or inpatient and outpatient hospital services State-Directed Payments (SDPs).

The preprint for the SDP for physician services provided by the Denver Health Medical Plan was submitted to CMS on June 27, 2025. The projected net benefit from this payment to Denver Health is $7,803,973 for FY 2025-26. The Department has received two rounds of questions from CMS regarding the physician services preprint, and it remains under review by CMS. Legislation will also be necessary to authorize this payment at the state level and allow the intergovernmental transfer (IGT) of funds from Denver Health to go to the CHASE, thus avoiding the General Fund.

The preprint for the SDP for inpatient and outpatient hospital services covered under Medicaid managed care arrangements was submitted to CMS on June 27, 2025. The projected net benefit from this payment is approximately $378 million for FY 2025-26. HCPF has received and responded to two rounds of questions from CMS regarding this preprint, and it remains under CMS review.

[7] https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/#3295c574-a9a8-4170-b0f0-a4f030d849ad
[8] https://www.kff.org/affordable-care-act/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/#f89969af-7af4-45d0-b41c-398865c1d798--themes-in-recent-research

Guidance to states regarding the impact of H.R. 1 was issued via a "Dear Colleague" letter on September 9, 2025. The letter clarified that total payment rates for SDPs will be limited to 100% of the published Medicare payment rate for expansion states. However, CMS indicated that Colorado's pending SDP preprints qualify for temporary legacy exception because they were submitted before July 4, 2025. The temporary legacy exception applies to rating periods beginning on January 1, 2028. Until that date, the total dollar amount of a legacy SDP cannot increase, including through revisions, amendments, or renewals.

H.R. 1: Cost Sharing

102. [Sen. Amabile] What is the potential for cost sharing? Is there a different way to structure cost sharing so the burden isn't on providers to collect it?

RESPONSE: Federal Medicaid law allows states to impose cost sharing only within narrow parameters. In general, premiums may be charged only to members with household income above 150 percent of the Federal Poverty Level (FPL), and total Medicaid premiums plus copays for a family cannot exceed 5 percent of the family's monthly (or quarterly) income. For context, among the 1,157,742 members with at least 6 months of continuous coverage in SFY 22024-25, only 3.33% (38,606) lived in households earning above 150% FPL. Additionally, 341,299 members (29%) are categorically exempt from cost sharing due to having no reported household income, which places them under the federal 5% income cap rule.

In addition, federal rules require broad exemptions from cost sharing for key populations and services, such as children in mandatory eligibility groups, pregnant members, many institutionalized members, emergency services, family planning, and certain preventive services. These income caps and categorical/service exemptions significantly limit the scope and fiscal impact of cost sharing as a Medicaid financing strategy.

Within those constraints, states can structure cost sharing as either premiums (monthly contributions) or point-of-service copayments. Under current Colorado Medicaid policy, cost sharing is limited to an $8 copayment for non-emergent use of the hospital emergency department, intended to incent members to leverage more cost-effective care access opportunities and to build stronger relationships with their primary care physician.

Copayments are collected, if at all, by the provider at the time of service. The copayment amount is then deducted from HCPF's payment to the provider, so copayments do not create new revenue for the program; they function as a small, member-specific reduction in the claim payment. For example, if a service would normally reimburse at $100 and there is a $2 copay, HCPF pays $98. The provider may choose whether to bill or collect the $2 from the member; they are not required to do

so, and many do not. Expanding member copayments should also be observed as a reduction in provider reimbursements and an increase in provider administration burden and expense.

In theory, federal law does allow for different structural approaches, such as greater reliance on premiums or alternative cost-sharing models tested through federal waivers. However, any such design would remain subject to the same 5 percent household cap and categorical/service exemptions, and federal approval is generally required for approaches that deviate from standard copay or premium rules. As a result, there is limited potential to use cost sharing in Medicaid to generate meaningful program savings or to shift the burden of collection away from providers without adding significant administrative complexity for the state, health plans, or members.

103. [Sen. Kirkmeyer] Please provide a history of cost sharing in Medicaid and in CHP+? How much have we charged in the past for copays and CHP+ premiums? When and why did we decrease cost sharing in each program? Include a discussion of the TABOR impacts of different types of cost sharing.

RESPONSE: Historically, Colorado Medicaid had cost sharing in the form of nominal copayments for members who were not otherwise exempt from copayments. These were copayments such as $1 for radiology, $2 for primary care visits, and $3 for prescription drugs, etc.

SB 23-222 eliminated these copayments effective July 1, 2023, leaving only an $8 copay for non-emergency use of the hospital emergency department. While copays are common across commercial health benefit programs, several studies have shown that cost sharing (such as copays) among Medicaid members can result in unintended consequences such as not scheduling or delaying needed health care visits, cutting pills in half or not filling prescriptions, all of which can lead to worsening health conditions and poor health outcomes. Cost sharing can also lead to increased use of the emergency room and higher overall health care costs. Additionally, research finds that cost sharing increases financial burdens for families, whereas the elimination of copays allows members to put those dollars toward other basic needs like rent or food.

Copayments also caused provider abrasion. Because copayment amounts are deducted from the provider's reimbursement from HCPF, they are experienced as a de facto rate reduction, as well as an increased administrative burden. Frequently providers reported being unable to collect the copayment amount from the member and found it to be more trouble than it was worth, so they simply accepted the reimbursement deduction.

Because of federal exemptions and caps, Medicaid's existing copayments affect a small portion of the caseload. In FY 2024-25, less than $30,000 was withheld from provider reimbursement in the form of copayments, affecting only 2,625 members.

Children's Health Insurance Program *Plus* (CHP+)
CHP+ has historically used two types of cost sharing: copayments and enrollment fees. Copayment amounts for CHP+ are based on member household FPL, and federal regulations prohibit co-payments for pregnant and postpartum populations or for preventive services (e.g. well baby visits). Because CHP+ is full risk managed care, the managed care organizations (MCOs) each have their own copay structure, which is factored into the annual actuarial rate-setting process.

CHP+ MCO	Co-Pay Structure
Colorado Access	4 income levels range $1-$50
Denver Health	Does not collect
Kaiser Permanente	Does not collect
Rocky Mountain Health Plans	3 levels range $0-$20
DentaQuest	3 levels range $0-$15

Colorado CHP+ suspended enrollment fees and premiums (annually or monthly) during the public health emergency, and HB 22-1289 removed them permanently. Research shows that removing premiums improves health outcomes for children and reduces state administrative costs. In the past, CHP+ annual premiums were $25-35 per year for CHP+ members with a household income of 157-213%, and $75-105 per year for 214-260% FPL. Based on FY 2024-25 enrollment, reinstating annual premiums for CHP+ members could result in upper bound revenue estimate of as much as $5 million per year; however, the cost to implement, administer and monitor would create an offset to this revenue.

Federal CHIP regulations limit total cost sharing (copays, enrollment fees and premiums) to 5% of the annual household income. Seventeen states currently collect premiums or enrollment fees in CHIP. Under federal regulations, states can collect premiums or enrollment fees annually or monthly, per child or per family. Typically, states that collect premiums or enrollment fees do so starting at household incomes of 133% FPL and higher. Fees range from $15 a month (ID) or $50 a year (TX) to $159 a month (MO).

TABOR
Regarding the intersection with TABOR, member copayments do not count against the TABOR cap because copayments are paid to providers. Changing copay levels (within federal Medicaid limits) affects provider reimbursement and member out-of-pocket costs, not TABOR revenue. However, charging member premiums would be paid to the state. If Colorado were to charge Medicaid premiums, those premium payments would be treated as state revenue subject to the TABOR cap.

104. [Sen. Amabile] Is the buy-in for people with disabilities the only buy-in program? Could we create other buy-in programs? Do other states have different buy-in programs? Are there any buy-in programs the Department recommends?

RESPONSE: Currently, Medicaid administers two buy-in programs in Colorado. There is the Health Insurance Buy-In (HIBI) Program that pays commercial insurance premiums for cost-effective members to ensure Medicaid remains the payor of last resort. There is also the Working Adults with Disabilities (WAwD) Program, which allows individuals with disabilities to buy into Medicaid coverage. WAwD is authorized through Section 201 of the Ticket to Work and Work Incentives Improvement Act (TWWIIA), with additional authority under the Balanced Budget Act of 1997 that allows states to extend eligibility beyond age 65. Colorado implemented this expanded authority through Senate Bill 20-033.

Colorado also covers children with disabilities through authority established under the Family Opportunity Act (FOA), which allows states to provide Medicaid coverage to children with disabilities living at home without counting parental income, and to charge premiums in certain circumstances.

The HIBI program is the only Medicaid buy-in program explicitly authorized in federal statute as a distinct eligibility group and eligible for federal matching funds. While federal law permits states to charge premiums for children with disabilities under FOA, this is an eligibility option rather than a true Medicaid buy-in program.

States may pursue state-funded coverage models or demonstration approaches; however, CMS has not approved any Section 1115 waivers to create new Medicaid buy-in populations with federal matching funds. While several states have explored Medicaid buy-in expansions, no state has successfully implemented a Medicaid buy-in program with federal match beyond those explicitly authorized in federal statute for individuals with disabilities. Expanding Medicaid buy-in authority would require congressional action. At this time, HCPF does not recommend any additional Medicaid buy-in programs beyond those currently authorized for individuals with disabilities.

105. [Rep. Brown] What are the premiums for the buy-in program for people with disabilities? How do the premiums change the financing of the program and the sources of funds used to pay for services? Could we increase the premiums to reduce the burden on the hospital provider fee? Should we increase the premiums? Include a discussion of the TABOR impact of the premiums.

RESPONSE: Medicaid premiums are monthly fees for members enrolled in the Buy-In Program For Working Adults With Disabilities (WAwD) and the Buy-In Program for Children with Disabilities. These programs allow adults and children with disabilities who qualify to "buy into" Colorado Medicaid.

Premiums are calculated using the member's income as a percentage of the Federal Poverty Level (FPL). Eligibility extends to individuals and households with incomes below 450% of the FPL for working adults or 300% of the FPL for children. Premiums are applied on a tiered basis, ranging from $0 to $200 per month for working adults and $0 to $120 a month for children. Federal law and regulation dictate how much can be charged. Premiums were paused in 2020 because of the COVID-19 pandemic, and restarted in May 2025.

SB 25-228 shifted premium revenue from the Medicaid Buy-In Cash Fund to the Healthcare Affordability and Sustainability (HAS) Medicaid Buy-in Cash Fund. Premiums are now TABOR-exempt.

Medicaid premiums are intended to offset a portion of program costs, and are projected to be $6,660,761 each year. Premiums only offset a small portion of program costs. Medicaid claims and capitations for the Disabled Buy-In adults and children were $387,596,050 in FY 2024-25, with expected expenditure of $446,494,476 in FY 2025-26.

Premium revenues are deposited into a cash fund and cannot be used as the state share for federal match requirements or to support administrative expenditures. Services for the Disabled Buy-In population are financed through the HAS Fee rather than this cash fund. As a result, any increase in premium levels augments the cash fund and reduces reliance on the HAS Fee; however, it does not decrease General Fund obligations.

Premium increases can lower the HAS Fee, but due to revenue restrictions, only 50% of the increase may offset the fee, with the remainder backfilling reduced federal funds. Given the size of the population, even significant increases in the premiums are unlikely to provide material savings to HAS Fee-related expenditure.

H.R. 1: Work Requirements

106. [Rep. Brown] What guidance has the federal government provided regarding the work requirements? How has the guidance shaped the Department's expectations about the administrative steps needed to implement the work requirements?

RESPONSE: CMS has issued initial, high-level implementation guidance but has not yet promulgated formal regulations. In December, CMS released a CMCS Informational Bulletin outlining the statutory framework for Medicaid community engagement requirements under H.R. 1, including affected populations, qualifying activities, exclusions and exceptions, verification principles, beneficiary notice requirements, and the federal implementation timeline. CMS has indicated that additional operational detail will be provided through an interim final rule required by June 1, 2026.

This guidance has informed, but not fully resolved, outstanding questions in HCPF's implementation planning. HCPF is proceeding with policy development, systems design, and operational planning based primarily on statutory requirements, the December 2025 bulletin, and ongoing verbal discussions with CMS, making reasonable, good-faith assumptions where federal detail is not yet available.

To meet the fixed statutory implementation date of January 1, 2027, HCPF is advancing an initial Minimum Viable Product (MVP) approach, recommended by CMS, while planning for future system enhancements. CMS has since clarified verbally that self-attestation (self-reporting) alone will not be an acceptable method of verification, and the Department therefore anticipates that compliance will need to be demonstrated through documentation or other forms of verification, either through member submissions or automated data sources as they become available.

This limited federal guidance, combined with a non-flexible implementation deadline, requires HCPF to move forward under uncertainty and is expected to increase administrative complexity and member burden in the near term, until more automated verification processes can be implemented through subsequent phases.

107. [Rep. Brown] With the changes to eligibility procedures required in H.R. 1, how will the Department minimize state barriers to people staying enrolled in Medicaid?

RESPONSE: The new H.R.1 federal requirements and limited state flexibilities in implementation are likely to create significant barriers to coverage; this is evident in the Congressional Budget Office estimation of the reduction in Medicaid expenses (federal savings) through the passage of H.R.1, largely attributed to Medicaid disenrollments propelled by provisions in the bill.

HCPF is leveraging lessons learned from several major implementations in the past three years to help mitigate coverage loss for people who qualify for our programs. From an outreach perspective, we are planning for a robust communications effort to reach members affected by the new regulations included in H.R. 1, particularly those

who are subject to community engagement ("work") requirements and six-month renewals. We have released two such member communications already, with a third to be released in Q1 2026.

We learned from the Public Health Emergency (PHE) Unwind that members expect to be outreached in multiple modalities from trusted messengers, including HCPF, their RAE or MCO health plans, providers, and other trusted voices in the community. We are developing a communications toolkit and strategy that leverages these partners and technology, like texting and push notifications, to make sure that people affected by the new H.R. 1 provisions know what they have to do to keep their Medicaid coverage. We'll also be working with our eligibility team to target messaging to members most at risk of losing coverage because we can't automatically verify that they meet community engagement or other eligibility criteria.

We are exploring funding opportunities to do a broader, mass media campaign, like we did with PHE Unwind, to reach members across the state and make sure they know how to apply, renew, and retain their coverage, especially if their situation changes and they become subject to one of the new eligibility requirements of H.R. 1. We will be sharing data to the extent possible with our RAE and MCO health plan partners and Connect for Health Colorado to outreach members who may no longer qualify for Medicaid, but could benefit from a marketplace plan. We are also working with our SNAP partners at CDHS to align renewal dates and outreach wherever possible, particularly for members who will have to renew every six months instead of every 12.

From a process and systems perspective, we have made significant progress upgrading the PEAK eligibility platform so that members can do many functions there instead of having to go to their county office or send in paper forms. Two of the biggest system challenges presented by H.R. 1 are community engagement requirements and six-month renewals for the ACA expansion population. Both of these provisions require significant system builds to increase our ability to automate verifications wherever possible. We estimate that we can automate eligibility approval for about 50-60% of members subject to work requirements by utilizing data and interfaces that already exist. We are focused on outreaching those who cannot be automatically renewed and building a system to capture information in a way that reduces county worker intervention.

Recent preliminary guidance from CMS indicates that states will not be able to leverage "self-attestation" (self-reporting) as evidence that members meet community engagement requirements or certain exemption criteria, such as medical frailty. Because of this, we are working hard to build system connectivity to access

this data across other sources so that members are less burdened with additional paperwork and counties are less burdened by added work.

Because of the extremely compressed implementation timeline, members will still face additional administrative burden to complete forms online or on paper to show they are meeting the work requirement or an exemption. We plan to develop the necessary forms to report community engagement in collaboration with stakeholders to ensure they are clear and understandable while still compliant with federal guidance. We will also utilize intelligent character recognition to pull as much data directly from the forms as possible to minimize county worker lift. As with PHE Unwind, we will be actively monitoring our data to watch for trends in disenrollment that could indicate unanticipated barriers and work to address those as they arise.

HCPF is also working with our county partners to reduce the administrative burden for counties and members and mitigate unnecessary coverage loss. For more information on our county efforts, please see Question 112.

108. [Sen. Bridges] Explain the timeline for any programming changes in CBMS and other systems, including the number of weeks devoted to pre-launch testing of those changes, related to implementing H.R. 1.

RESPONSE: The timeline for changes in CBMS depends on the size and scope. On average, large changes take nine (9) months from idea to implementation with approximately seven to eight (7-8) weeks dedicated to pre-launch testing for those changes.

109. [Sen. Bridges] Will CBMS and T-MSIS have sufficient interoperability by October 2026 to allow the state to exempt Medicaid and SNAP members from work requirements on the basis of diagnosis or service use? If not, why not?

RESPONSE: The December 2026 CBMS Medical Assistance Work Requirements Minimum Viable Product (MVP) will deliver all core functionality necessary for compliance. As part of the MVP, the state will implement a manual data-file upload process that allows diagnosis and service-based exemptions to be applied in time for the mandated January 2027 implementation date. Following successful implementation of the MVP, the next project phase will focus on fully automating the interfaces between T-MSIS and CBMS. This automated exchange of diagnosis and service information is targeted for completion in Spring 2027, enhancing efficiency after the state is already in compliance with federal requirements.

The work requirements expansion required by H.R.1 for SNAP had an effective date of November 1, 2025. As we continue to build the changes for Medicaid, we will continue our partnership with CDHS/SNAP to leverage and reuse data and system changes for both programs to streamline the experience for Coloradans where able. This will

include the interface for the diagnosis or services for individuals, if required by SNAP policy.

110. [Sen. Bridges] Explain how the state will oversee Deloitte's work on OBBBA implementation projects to make sure that projected costs are accurate and errors are fixed without additional cost to the state? How will the state ensure that additional costs are minimized?

RESPONSE: The Department has established a workgroup for the H.R.1 changes that includes all subject matter experts from policy, systems, operations, leadership as well as Deloitte to review the legislation and CMS guidance that will lead to the system changes. The goal for the workgroup is to collectively work together to have clarity of the changes required for policy, operations, and systems. Including Deloitte early in this process helps ensure they have a clear understanding of the system changes which improves the accuracy of cost estimates and mitigation of errors.

This workgroup will continue to meet throughout the system development lifecycle to review the changes and ensure any Deloitte errors are fixed without additional costs. Any concerns with Deloitte's performance or quality of work will be referred to the CBMS/Colorado Benefits Eligibility and Enrollment Systems (CoBEES) Team and ultimately to the Department Executive Director, who has standing meetings with Deloitte leadership. The group will also work on consensus for additional changes required and minimize the costs associated. Please see the answer to Question 114 for review of the cost estimations from Deloitte.

The CBMS/CoBEES team is also looking to onboard a product management team to work more closely with Deloitte to produce mockups of proposed functionality to ensure alignment between proposed solutions and program area goals earlier in the process, and to evaluate and direct technical implementation of these solutions. This will help avoid late-breaking and costly change orders.

111. [Sen. Bridges] Have CBMS and county systems been programmed to prevent termination from public benefits when documents have been received but are unprocessed? Walk us through those programming changes, if done; if not yet done, explain when they are expected to be completed.

RESPONSE: HCPF implemented CBMS system changes in June 2025 to prevent termination from medical assistance when documents have been received but are not yet processed. Federal regulations require that members' coverage remains uninterrupted when they respond to renewal paperwork by no later than the last day of the renewal month, and give eligibility workers time to process those documents. The CBMS system will identify if renewals are complete on the 15th of each month. The changes from June 2025 include the following:

- If a member submits their documents prior to the 15th of the month, CBMS will identify a response to the renewal and will keep the case pending until the eligibility work processes the documentation.
- If the documents are not yet received by the 15th of the month, CBMS will send a termination notice to the member for lack of response to the renewal packet and the effective date will be the last day of the month.
- However, if documents are received between the 15th and the end of the month, CBMS will reinstate coverage for the member, provide an updated notice to let them know of reinstatement, and pend the case until the eligibility worker is able to process the documents.
- If a member submits documents after the last day of the renewal month, their documents will be processed as a late renewal, but federal regulations do not allow for coverage to be reinstated unless they are determined eligible again based on the documents provided.

112. [Sen. Bridges] What programming changes are planned to reduce the administrative burden for counties and members in processing information about exemptions to work requirements? To what extent has the state worked with the county to develop these proposals?

RESPONSE: We estimate that we can automate eligibility approval for about 50-70% of members subject to work requirements by using data and interfaces that already exist. However, for members — those who are not working or for whom we are not able to verify that they meet the new requirements or exemptions and exceptions through existing automated means — we are exploring a variety of options to support members and counties in providing and processing necessary information. A good example related to an exemption is medical frailty. CMS has provided guidance that states should use existing claims data to verify if an individual has claims that meet the definition of medical frailty. However, CBMS does not currently have access to claims data from the Medicaid Management Information System (MMIS), HCPF's Enterprise Data Warehouse (EDW), or the state Health Information Exchange (called Contexture). HCPF will build new interfaces to use Medicaid claims data as well as with Contexture to obtain medical records information to automate the process to help identify when an individual is medically frail. This will reduce the administrative burden for counties and members in processing this type of information.

In addition, HCPF and the Department of Human Services (CDHS) are building initial enhancements into the current CBMS ecosystem due to the timelines associated with H.R.1 work requirements (impact January 1, 2027 renewals). This, while also working with the CBMS/Colorado Benefits Eligibility and Enrollment Systems (CoBEES) team on longer-term CBMS ecosystem modernizations to reduce administrative burden in collaboration with the counties.

HCPF has also shared initial thoughts on the Minimum Viable Product (MVP) with counties, based on the limited informal guidance shared by CMS with states. CMS released formal but incomplete work requirements guidance the week of December 8th. Therefore, HCPF experts are now working to refine MVP plans to meet that guidance and will meet with all stakeholders, including counties on that vision in Q1 2026. (Formal guidance may be released as late as June 2026, so HCPF must build solutions based on limited CMS guidance).

Last, HCPF is working on increasing Intelligent Character Recognition (ICR) to capture data from images to be input into CBMS without (or with less) worker intervention, thereby, increasing automation and reducing workload. (See question #58 for more information on ICR.) In relation, HCPF is stakeholdering with counties the concept of Shared Services, which seeks to centralize some services, including document scanning, intended to advance automation efficiency, accuracy, and timeliness.

In conjunction with these administrative changes, HCPF and CDHS also are moving forward with the Joint Agency Interoperability (JAI) and Unified County System (UCS) projects, which will provide the backbone that supports image processing and county eligibility workflow management. As JAI solutions are refined as part of the CBMS modernization efforts, counties will be part of the stakeholder process.

113. [Sen. Bridges] Is the state planning to program future CBMS changes related to work requirements with "off" switches so that the state can respond more quickly to future federal changes or prevent terminations while problems are being fixed?

RESPONSE: At this time, HCPF is not planning to implement a comprehensive on/off switch for future CBMS work requirement changes, as the scope and complexity of these modifications make a universal toggle difficult to support. However, we are actively exploring whether an on/off switch or similar controllable logic could be applied to specific components of the functionality to provide greater flexibility where feasible.

More broadly, the state is evaluating multiple options to increase system agility, including ways to:

- Implement targeted mitigations without requiring major system changes,
- Respond more quickly to federal guidance updates, and
- Prevent inappropriate terminations while technical issues are being investigated or resolved.

Our goal is to build flexibility into future enhancements, whether through configurable logic, contingency tools, or other mechanisms to help ensure a more responsive and stable eligibility system.

114. [Sen. Bridges] What efforts is the Department taking to make sure contractors are not profiteering off of H.R. 1 changes, specifically Deloitte as the CBMS contractor and Equifax as the provider for income verification? (https://www.nytimes.com/2025/11/03/health/medicaid-cuts-equifax-data.html)

RESPONSE:
Through the implementation of H.R. 1, HCPF will continue to follow best practices for ensuring that all contractors, including Deloitte and Equifax, provide the highest value for the state. At minimum, this includes annual reviews of contract scopes of work and rates, with adjustments as needed based on factors such as, but not limited to, increases or decreases in transactions, requirements, or member volumes; changes in federal or state statutes or rules; changes or updates to underlying technology or solutions; reporting and analytics needs; and changes in funding.

Deloitte
HCPF is closely reviewing the estimates for the system changes required for H.R.1 implementation to ensure they are not profiteering from these changes. Deloitte provides estimates for all system changes, including H.R.1 at the lowest component level (various parts of the needed changes and where the changes are being made). The estimates are evaluated based on prior system changes to ensure consistency and validity of the costs being provided. Any questionable costs identified are discussed with Deloitte leadership to ensure alignment on the change requested and adjustments are made to the costs, if needed. In addition, CMS requested that Deloitte vet their estimates amongst other states as well as reuse where possible.

Equifax
HCPF participates in the Equifax contract through an intergovernmental agreement with CDHS, which administers the contract. We closely collaborate with CDHS to estimate the annual volume of transactions needed to support the counties in processing both CDHS and HCPF program eligibility. We also evaluate the effectiveness and efficiency of the services provided and have built performance standards for both programs into the contract. For example, HCPF and CDHS last year identified that Equifax was double charging for work number access to both departments. We negotiated a $2 million refund from Equifax in this year's contract to reduce the per transaction costs, as well as established performance standards to ensure accurate billing accountability.

HCPF also reviewed current work number access processes to first use data from the Federal Data Services Hub—which provides similar information as Equifax but at a much lower cost—to reduce the overall number of transactions required with Equifax. We continue to explore options to maximize the use of data sources such as that from the FDSH to ensure our processes are as high-quality and cost-effective as possible, and will work with the CBMS/Colorado Benefits Eligibility and Enrollment Systems

(CoBEES) product team to evaluate options.

115. [Sen. Amabile] How will the Department help people plan for and manage the new work requirements? It seems likely that some people may work enough to lose Medicaid eligibility without making enough to be better off financially.

RESPONSE: Final federal guidance from CMS on work requirements is expected in July 2026. In the interim, states are developing outreach plans based on *preliminary* information which will be subject to change when final guidance is available. The timing makes it challenging for states to plan and inform members about specific impacts.

Given the lack of final guidance, HCPF has been meeting with stakeholders to review tentative plans. HCPF will also work with community partners, providers and others to develop general information toolkits with basic information about the new requirements, leveraging the emerging guidance provided by CMS. We recorded and released two member-focused messages, and will record a third during the first quarter of 2026. This is all part of a communications plan intended to help Health First Colorado members understand what they may need to do, based on the knowledge we have. We also have general information about who is and isn't subject to work requirements available on our website and for county and community partners.

In addition to the general educational communications, we are releasing to members, we plan to formally notify impacted members via CBMS communications starting in August (after the final guidance). A request for member outreach resources, an awareness campaign and additional support to help members through the new processes will be submitted through the regular budget process including supplements or amendments.

Yes, this will be confusing to members. First, work requirements impact certain "able-bodied" adults covered under Medicaid Expansion, but members don't know they are covered through increased income levels made possible under the Affordable Care Act's Medicaid Expansion provisions. Further, as their incomes change, they may move in and out of this defined income bracket, changing their obligations to remain eligible. Third, they may move into and out of exemption criteria. Last, the exact income criteria will change year to year, based on adjustments to the Federal Poverty Levels.

Below is a chart of the income levels that would identify which adults, outside of those who are exempt, will be required to satisfy work requirements to maintain Medicaid eligibility. Again, this income level will change in 2026.

Household Size	2025 Income range (100% to 133% FPL)
1	$15,650 - $20,815
2	$21,150 - $28,130
3	$26,650 - $35,445
4	$32,150 - $42,760
5	$37,650 - $50,075

116. [Sen. Bridges] The November request has no specific items related to implementing H.R. 1 (unlike CDHS). Please describe all steps the Department is taking—and their related costs—to reduce unnecessary loss of coverage during H.R. 1 implementation, including programming changes, communications efforts, data collection and public reporting.

RESPONSE: In response to why HCPF did not bring a funding request in November: HCPF submitted and just received approval from CMS on our Advanced Planning Document (APD) which secures federal funding at a 90/10 match to implement the community engagement requirement provision of H.R. 1. This document provides a roadmap for H.R. 1 eligibility ecosystem system builds and enhancements and related implementation. With that clarity, HCPF is better able to limit requests for additional H.R.1 funding needs, above what the APD provides. As a result, HCPF will bring a supplemental request before the JBC in January that targets outstanding needs to implement H.R. 1.

In response to what the Department is doing to mitigate unnecessary coverage loss related to H.R. 1, please reference the answer to Question 107.

H.R. 1: Driving County Efficiencies & R-07

117. [Sen. Amabile] Why do we have so much variation by count in Medicaid enrollment as a percentage of the population? For example, why is Bent County surrounded by counties with much higher enrollment rates? What drives these differences between counties that are close together and look similar? Is it really eligibility differences

based on income? Are some counties better at enrolling people?

RESPONSE: Income is the strongest predictor of enrollment levels, with higher-income counties reliably showing lower enrollment. Still, the relationship is not exact, suggesting that other demographic, economic, and programmatic factors also shape county-level differences:

- Counties with larger working-age populations may show lower enrollment if low-income families receive employer coverage. Counties with larger 65+ populations may show higher enrollment because older adults are more likely to qualify through disability-related pathways or long-term care eligibility.
- Counties dominated by jobs that do not offer employer-sponsored insurance, such as agriculture, service-sector work, or small businesses, tend to have higher Medicaid enrollment rates, while counties with more public-sector or large employers generally see lower enrollment due to greater access to employer-sponsored coverage.
- Counties with larger immigrant populations may have lower enrollment relative to income due to eligibility restrictions.
- Counties with more clinics, hospitals, and community organizations may see higher enrollment because outreach, navigation, and application support are more accessible.
- Cultural norms and perceptions influence enrollment decisions; differences in trust in public programs, stigma, or familiarity with Medicaid may affect whether individuals choose to enroll.
- In counties with small populations, even modest changes can create large swings in enrollment, making rates appear unexpectedly high or low when viewed against income.

County-level enrollment and expenditure information is available at https://hcpf.colorado.gov/county-fact-sheets.

However, it must be noted that the structure of the state's county-administered human services delivery system allows for a wide range of approaches, through local control. In certain counties, outreach to eligible but not enrolled individuals may be a priority. That may not be the case in other counties. Some counties have strong relationships with local community organizations that assist eligible individuals to get enrolled, while others take a more passive approach. HCPF and CDHS are pursuing several county administration modernization workstreams, such as CBMS ecosystem, Shared Services, Regionalizing into Districts, and Business Practice Standardization. The latter will serve to drive more consistency across counties where disparities may currently exist.

While income can, and is, certainly a deciding factor in difference between enrollment levels, the role of the county-administered system also plays an important factor in determining enrollment levels. Data from the Public Health Emergency Unwind also supports this assertion, where differences in how many individuals were disenrolled were not exactly correlated with income levels — pointing to differences between counties in how HCPF programs are administered.

118. [Sen. Kirkmeyer] Please provide a county-by-county list of the data that the Eligibility Quality Assurance Team produces that aligns with the Medicaid Payment Error Rate Measurement (PERM).

RESPONSE: The federal Payment Error Rate Measurement (PERM) program is the federal audit process that determines state disallowances for error rates above 3%; for every 0.1% error rate above the 3% threshold, the State must pay back about $10 million, which will increase as the budget increases. The PERM audit process reviews the state as a whole and does not break out errors by county.

To support county accuracy and quality improvement, HCPF's Eligibility Quality Assurance (EQA) team conducts approximately 120 case reviews each month that covers applications, renewals and case changes across each county, Medical Assistance and Eligibility Application Partner site. These reviews are then aggregated into two types of error rates, both of which serve as proxies for the federal PERM error rate.

- Incorrect Eligibility Determinations: This error rate looks at whether the final outcome of eligibility was correct or incorrect, based on federal and state requirements.
- Errors that do not impact Eligibility: This error rate looks at whether procedural errors occurred, even though the final outcome was correct.

HCPF's proposed Quality Assurance Shared Service uses the same process as used by EQA, but to a much greater extent. Rather than 120 monthly case reviews, the QA Shared Service will complete around 1,000 case reviews each month. This will provide a statistically significant statewide sample size while providing a larger universe of data to help determine error trends over time.

County-by-county error rates produced from EQA reviews are in Appendix D.

119. [Sen. Kirkmeyer] The request assumes that four contracts will be executed with counties to provide these shared services. What happens if the state cannot find a sufficient number of counties with which to contract?

RESPONSE: Although a formal procurement process is an option, the state would first take the step of providing technical assistance to any county that may want to submit

bids, or who submitted bids that didn't pass review, to strengthen those processes. The loss of experienced county personnel would be a huge setback, so the state would first take the steps necessary to support counties becoming the Shared Services contractors prior to moving to a formal procurement process.

If the state is unable to procure a county to provide any of the Shared Services being proposed — with the exception of eligibility processing through the Tier 1 Call Center, which requires merit-based employees — the state will move forward with a formal procurement process to obtain a private sector vendor to perform these functions. The majority of the functions within Shared Services do not require governmental, merit-based employees. Therefore, a private sector vendor could complete a majority of that work.

120. [Sen. Kirkmeyer] How does this request affect county administration costs in FY 2027-28 and ongoing?

RESPONSE: By implementing Shared Services, HCPF and CDHS are aiming to drive a level of cost containment within their respective county administration lines that is used by counties to fund all activities that support the determination of eligibility for benefit programs. By moving to Shared Services, the state will be able to target funding for those specific functions that require statewide support, rather than the current process of dividing funding across 64 different county operations. This will help the state gain operational efficiencies that are unavailable within the current hyper-localized model of county administration. **The departments have not proposed reducing existing county administration funding. Instead, the resources that had supported these shared services will be available for counties to repurpose or focus on core eligibility functions such as processing applications, renewals or case changes to support Coloradans on public assistance programs.**

The county administration lines will continue to support direct eligibility determination, while the need for, and frequency of, determinations will grow due to federal requirements related to HR1 and other federal administrative actions taking place. The Shared Services proposal creates efficiencies in performing the appropriate volume of reviews, and in increasing member program integrity to compliant levels across all counties. It is further designed to free up county capacity to address increasing workload by removing certain administrative functions.

121. [Sen. Kirkmeyer] How does this request interact with the anticipated budget amendment proposing regionalization of county administration?

RESPONSE: HCPF's R-07 request for Shared Services is directly complementary to, and was developed in coordination with, the CDHS Budget Amendment that will propose reorganizing benefit services delivery into districts for eligibility determination among Medical Assistance, Food Assistance, Temporary Assistance for Needy Families, Adult

Financial, and Old Age Pension. They are complementary because they address two different aspects of work among these programs. Shared Services focuses on the ***ancillary duties*** that support eligibility determination, such as scanning documents, conducting quality reviews, initiating member fraud investigations or taking basic calls from members. Other centralized Shared Services will follow in the future. These are all functions each county must complete independently within Colorado's hyper-localized model of service delivery. In the future state, these functions are centralized and performed by one county on behalf of all.

CDHS's complementary budget amendment proposing regionalization through districts focuses on the ***core duties*** of eligibility determination. With the ancillary duties removed from the individual counties' responsibilities through Shared Services, the regionalization request will drive greater consistency in eligibility determination across the proposed districts. This allows for the state, both HCPF and CDHS, to implement risk mitigation measures to prevent federal clawbacks caused by provisions in H.R. 1, while implementing measures to drive efficiencies and cost containment for county administration. HCPF's county administration funding has increased an average of 14.2% annually over the past decade, which is greater than inflation and a risk to the state budget.

By implementing these complementary approaches, the state is able to drive improved service delivery for applicants, clients and members, while addressing federal risks and administrative efficiencies.

122. [Sen. Bridges] How will the state use Intelligent Character Recognition (ICR) to read PEAK submissions and scanned documents to reduce workload? Is this technology available in all counties? Would this technology be a part of the R7 proposal for a consolidated scanning and processing center?

RESPONSE:

HCPF plans to use Intelligent Character Recognition (ICR) to:

- To reduce county workload; the state intends to expand the use of ICR to support more required forms and verification items submitted through PEAK as well as scanned documentation.
- ICR is currently available in 54 out of 64 Colorado counties via our vendor Hyperscience. We are in active discussion with the remaining 10 counties to bring them on board in the coming year: Chaffee, Baca, Elbert, Summit, Teller, Washington, Yuma, Boulder, Jefferson and La Plata.
- From November 2024 to November 2025, our current ICR implementation has been used to process 191,046 forms, which is 31% of documents.

To further ICR quality and make ICR more impactful for counties, the CBMS/Colorado Benefits Eligibility and Enrollment Systems (CoBEES) team is testing a feature that makes it easier for county workers to understand and fix IRC changes that are made in CBMS.

H.R.1 Expansion for Medical Assistance

The ICR functionality is currently available for 10 types of documents, including long-term care (LTC) verifications. While ICR is already capable of initiating the Medical Assistance (MA) renewal process, it does not yet read or evaluate renewal information submitted through PEAK or other channels. As part of the broader H.R.1 initiative, ICR will be expanded to support more comprehensive, automated evaluation of required forms and verification items.

Under H.R.1, eligibility renewals and redeterminations must adhere to stricter requirements regarding documentation, verification completeness, and timely processing. To meet these expectations, the planned expansion of ICR will enable the system to:

- Read, identify, and interpret required MA forms related to H.R.1 compliance, including those associated with MA renewals.
- Ingest and evaluate required verifications for all applicable MA programs, not just LTC, ensuring automated support for renewal-driven verification needs.
- Determine whether MA renewal information is complete, whether additional action is needed, and whether the case can proceed automatically or requires worker intervention.
- Support individualized review workflows, aligning ICR rules with MA H.R.1 requirements for member-specific renewals and verifications.

This expanded functionality will allow ICR to automate a larger portion of eligibility and renewal processing, reduce manual workload for counties and eligibility workers, improve accuracy, and improve compliance with H.R.1 documentation standards. Once implemented, the system will consistently identify and read required forms, validate verifications, and correctly support renewal processing across programs—not only LTC. The expansion moves ICR from a pilot verification tool into a broader H.R.1 compliance engine supporting renewals, ongoing eligibility, and case maintenance activities.

Shared Services

HCPF has included the ability for the Central Document Scanning Shared Service to use ICR, which in the future would allow for direct mapping into CBMS, as outlined above. Documents not successfully mapped into CBMS using ICR would then be routed

to the individual counties to be processed. However, the R7 proposal does not include funding to expand the types of forms that ICR is available for — beyond those already supported or planned to be supported as described above.

123. [Rep. Taggart] Centralizing services is used in the private sector to reduce costs. This request does not propose any cost reductions or savings. Please explain the benefits of this request.

RESPONSE: While HCPF's R-07 does not request any cost reductions or savings, the implementation of Shared Services addresses several systemic gaps that impact the state's performance, in relation to federal compliance, the administrative burden borne by counties, a structure to better control county administration costs going forward, and the consistency in the member experience provided to Coloradans seeking Medical Assistance benefits. These systemic gaps include:

- Ensuring state compliance with federal mandates: During the Public Health Emergency, the federal government penalized several states for their performance, including call center wait times. Colorado's hyper-localized model of benefit service delivery meant that the 11 large counties with call centers were monitored by HCPF to ensure compliance. However, the differing staffing levels, technologies used, and local approach created a widely disparate experience: some counties had low wait times (Average Speed to Answer) but high abandonment rates, which meant that those getting through county systems had their calls quickly answered, but some call centers had 30% abandonment rates. This means 1 in 3 callers could not actually get through. One county completely stopped accepting calls, which is in violation of federal policy. Others had low wait times and low abandonment rates. The differing approaches meant that the ability to access services depended on where the individual lived. This also doesn't speak to the fact that the remaining 53 counties did not have formal call centers, so HCPF had no data on whether those callers were getting the assistance they needed and to which they are federally entitled.

  Moving to one statewide call center will help ensure Colorado meets federal requirements — this is true for all of the Shared Services proposed.

- Administrative Burden for counties: By shifting to Shared Services, the state is able to fully fund, with state and federal dollars only, the delivery of these types of services. This allows for greater standardization while driving down costs for counties, as they no longer have to contribute their administrative

allocation, nor their local dollars, for these functions. The approach of reducing administrative burden by shifting these functions out of individual counties allows them to repurpose their funding, and staffing, to focus on their core duty of eligibility determination. This is beneficial for both counties and members, as the funding provided to counties is stretched further to meet their obligations for timely, accurate eligibility processing.

- Improved Member Experience: The differing approaches to some of the work to be performed by Shared Services results in a sometimes widely disparate experience from county to county. These disparate experiences are in direct violation of federal regulation, which requires consistency in administration across the state (42 CFR Part 431.50 (b)(1)). The move to Shared Services allows for the state to operationalize a standardized process throughout Colorado that provides the consistent level of access and support that is federally mandated. The need for this is also evident in the amount of complaints and escalations HCPF receives regarding the differing county processes, whether it is long call center wait times or abandoned calls, or inconsistency in fraud investigation processes that may result in fraud prosecution in one county, but not the other.
- Cost Containment and Cost Control: Eliminating duplication in county systems, training and improving oversight across a number of initial and future shared services will mitigate the need for increases of, and ideally reduce, county administration costs in specific areas over time.

Behavioral Health

124. [Sen. Kirkmeyer (from BHA briefing)]: Please provide the following information for the Behavioral Health Initiatives and Coverage Office: Actual expenditures for total funds, General Fund, and FTE for FY 2024-25. Budgeted total funds, General Fund, and FTE for FY 2025-26. Requested total funds, General Fund, and FTE for FY 2026-27.

RESPONSE: In Fiscal Year 2023–24, the Executive Branch and the General Assembly prioritized the transformation of Colorado's behavioral health system. In response, HCPF established the Medicaid and CHP+ Behavioral Health Initiatives and Coverage (BHIC) Office to strengthen accountability and ensure responsiveness to the evolving needs of the General Assembly, the Executive Branch, providers, advocates, and other stakeholders during this complex, statewide transformation.

BHIC was created through an internal reorganization. It did not require any new funding or additional full-time equivalent positions. Existing staff with extensive behavioral health expertise were realigned from across HCPF to better coordinate and oversee Medicaid and CHP+ behavioral health policy and benefits. The BHIC Office Director, Cristen Bates, continues to serve concurrently as Deputy Medicaid Director,

further ensuring alignment with HCPF's statutory responsibilities as the state's Medicaid Single State Agency.

By consolidating behavioral health expertise within a single office, HCPF strengthened its ability to navigate regulatory requirements, leverage federal opportunities, and maximize federal funding. This structure supports HCPF's mission to advance a holistic, person-centered approach to care while strengthening Colorado's behavioral health system for both members and the state.

With just over 30 staff members, BHIC administers a $1.4 billion behavioral health benefit and oversees services and provider supports for more than 300,000 Coloradans enrolled in Medicaid. The office is responsible for benefit design and policy, cost-control strategies, federal compliance, administration of the Medicaid behavioral health delivery system, and maximizing federal Medicaid drawdown. These functions must reside within HCPF to meet federal requirements and ensure the sustainability of Medicaid-funded behavioral health services.

BHIC staff bring extensive and directly relevant experience in Medicaid policy and administration. Approximately 21 percent of the team are trained clinical professionals, 30 percent bring supportive-services experience, six percent have worked in state hospitals, and 21 percent have experience in grant administration; the team also includes two veterans. Partner agencies rely on BHIC's expertise to translate service concepts into Medicaid-compliant benefits with sustainable funding pathways. To develop unified and compliant Medicaid benefits, BHIC integrates Medicaid systems with managed care, budgeting and rate setting, and behavioral health policy and service design. While the Behavioral Health Administration (BHA) leads regulatory updates, BHIC works closely with BHA to ensure those requirements align with Medicaid-reimbursable services, underscoring the necessity of housing this function within HCPF.

BHIC oversees behavioral health services integrated across Medicaid programs and collaborates with other state agencies, including BHA, the Colorado Department of Human Services, the Division of Insurance, the Colorado Department of Public Health and Environment, and others. This coordination helps ensure efficient use of state funds and the thoughtful design and implementation of programs that maximize available federal funding. BHIC also supports enterprise-wide initiatives that include, but are not limited to, behavioral health, such as the American Rescue Plan Act (ARPA), implementation of H.R. 1, and the Rural Health Transformation Program grant.

BHIC leads major system-level initiatives that integrate behavioral health across Medicaid programs and state agencies. This includes management of multiple 1115 waiver demonstrations, administration of the Certified Community Behavioral Health Clinic (CCBHC) Planning Grant, expansion of integrated care through removal of visit limits and new reimbursement pathways, and leadership of Colorado's System of Care for children and youth with the highest acuity needs. Through data-driven oversight,

cross-agency coordination, and a strong clinical and policy foundation, BHIC advances Colorado's goal of an accessible, integrated, and sustainable behavioral health system for Medicaid members.

Key Accomplishments and Responsibilities:

Expanded Access & Utilization:
In FY 2023–24, **303,542 unique Medicaid members** accessed capitated behavioral health services—**23.8% of all Colorado Medicaid members**, representing a **25% increase** over the prior four-year average. Growth was driven by legislatively supported benefit expansions, stronger provider networks, and increased service capacity.

Strategic Investment in Capacity:
Administered **$60+ million in ARPA grants** to **170 organizations**, significantly strengthening workforce and infrastructure, and expanding sustainable Medicaid-funded services for high-need populations, including tribal members, justice-involved individuals, people experiencing homelessness, and those needing intensive outpatient care. As we recognize the current budget challenges, we are moving from growth to maintenance.

Statewide System Transformation for Children and Youth:
Leading implementation of the **Colorado System of Care**, aligning with federal standards and the Settlement Agreement to keep high-acuity children and youth in their homes and communities, reduce institutionalization, and improve outcomes through a phased, evidence-based rollout through **2031**.

Federal Leadership & Innovation:
Successfully secured and now administers Colorado's **CCBHC Planning Grant (awarded December 31, 2024)**, positioning the state for a four-year federal demonstration beginning in 2026 to expand access, integration, and sustainable behavioral health funding.

Integrated Care Expansion:
Implemented $30 million in expansion for primary care providers to better serve those with behavioral health needs, and to set up primary care into behavioral health provider agencies. BHIC eliminated visit caps and expanded integrated behavioral health billing statewide, including **Collaborative Care Model and Health Behavior Assessment and Intervention (HBAI) codes** effective July 1, 2025 — strengthening long-term sustainability of integrated care across primary care settings.

Accountability & Compliance:
Produces Colorado's **annual Mental Health and Substance Use Disorder (SUD) Parity Report**, ensuring full compliance with federal and state parity laws and transparent reporting to the Legislature and CMS.

Core Medicaid Functions Of the BHIC

Behavioral Health Benefit & Managed Care Oversight:
Oversees Medicaid behavioral health benefits and capitation, including policy development, reimbursement strategies, actuarial coordination, and CMS approvals through State Plan Amendments and waivers (1115, 1915(b)(3)).

Data-Driven Policy & Performance Management:
Uses dashboards, utilization data, and outcome monitoring to evaluate policy impact, guide rate-setting, and ensure appropriate growth, access, and provider compliance.

Provider & Community Support:
Reduces barriers to Medicaid participation through hands-on technical assistance, office hours, public forums, and targeted support for non-traditional providers such as peer support, housing, and justice-system partners.

Waiver Implementation & Oversight:
Manages multiple 1115 Demonstrations, including SUD, Serious Mental Illness (SMI), Reentry, and Permanent Supportive Housing, integrating health care with housing and justice systems for high-risk populations.

Cross-Agency & Clinical Leadership:
Leads statewide, multi-agency coordination for high-acuity children and youth, applying nationally recognized wraparound models and translating legal mandates into sustainable policy, rates, contracts, and benefits.

Fiscal & Federal Stewardship:
Oversees behavioral health budgets, ensures timely and accurate CMS reporting, and aligns policy with federal regulations to safeguard funding and system integrity.

All BHIC staff are funded through appropriations in the Long Bill, consistent with how HCPF personnel services are appropriated to administer statewide safety-net coverage programs. These staff work exclusively on state- and federally authorized programs, and they are essential to the effective administration of Medicaid and CHP+ behavioral health services in Colorado.

SFY	FTE	Total Funds
FY 2024-25	32.3 FTE* *Includes 8.0 term-limited FTE that were funded through House Bill (HB) 23-1300, HB 22-1302, and HB 24-1045, for a net 23.0 FTE as of June 30, 2025	$6,984,965 total funds spent - $3,077,749 General Fund
FY 2025-26	32.3 FTE	Budgeted $8,297,250 total funds - $2,738,092 General Fund
FY 2026-27	31.3 FTE	Budgeted $6,918,500 total funds - $2,283,105 in General Fund

R-06: Outpatient Psychotherapy Prior Authorization Requests (PARs)

125. Rep. Brown: Permitting RAEs to reinstate PARs for outpatient psychotherapy prior to legislative changes seems like a violation of current statute. Please describe the implementation timeline, the direction provided to RAEs, and how the Executive Branch assessed the legality of reinstating the PAR.

RESPONSE: During the 2025 Special Legislative Session, the General Assembly passed SB 25B-001. In this bill, the General Assembly created new triggers and reporting for the statute that allows the Governor to suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government by Executive Order if the Governor determines that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of state government and to support its agencies and institutions. *See* § 24-75-201.5.

In accordance with this authority, on August 28, 2025, the Governor issued Executive Order D25-14 which, in relevant part, declared a revenue shortfall and suspended $16,120,810 in General Fund that had been appropriated to HCPF for Behavioral Health Capitation Payments. In order to effectuate this directive by the Governor, HCPF began working with the Regional Accountable Entities (RAEs) to determine the most cost effective and least disruptive way to meet the requirements of the executive order and determined that instituting PARs would be necessary. The removal of the PAR prohibition is a suspension of services that are a part of HCPF's government functions and fit within the authority of the Governor. This is permitted by § 24-75-201.5, as well as by HCPF's own statute at § 25.5-4-105, which states that nothing in Article 5 – where the PAR prohibition statute resides – shall prevent the

state department from complying to maintain a program within the limits of available appropriations.

It is important to note that HCPF worked to create a flexible approach to account for regional variations, with a focus on high rates of psychotherapy that extend beyond standard clinical expectations. On October 30, 2025, HCPF issued a policy transmittal to the RAEs and sent the corrected version on November 7, 2025. The policy transmittal was issued, as opposed to an amendment to the RAE contract, as the prohibition language remains in statute. R-6 requests that prohibition language be removed from statute, allowing RAEs to manage utilization based on regional need.

HCPF has directed the RAEs that, effective January 1, 2026, RAEs are permitted (not required) to prior authorize psychotherapy services in the limited circumstances, beyond 24 sessions annually per member. This will remain allowable until the executive order expires or there is a change to statute. RAEs must notify providers of any changes to utilization management policies and procedures. Some RAEs have determined that uniform application of PARs for psychotherapy services across their network is not the most cost effective way to address the inappropriate use of those services; they will pursue other forms of utilization and network management that are more appropriate for their regions, including the existing allowable practices of retroactive review and prepayment review

126. Rep. Brown: How does the proposed outpatient psychotherapy PAR not violate state and federal Medicaid mental health parity laws, including but not limited to NQTL standards? How is parity determined if there is not a comparable physical health service?

RESPONSE: State and federal parity laws require that limitations applied to behavioral health within a benefit classification (inpatient, outpatient, emergency care, and pharmacy) should be comparable to and applied no more stringently than those used in the same physical health benefit classification. Differences at the individual service level are allowed as long as they are not more burdensome in aggregate.

Medical necessity reviews, such as prior authorization review (PAR) and retrospective review, are non-quantitative treatment limitations (NQTLs). They are not caps on services, and in this case, authorization to continue services will be granted if more than 24 psychotherapy sessions are medically necessary. A Regional Accountable Entity (RAE) may approve a certain number of sessions, may recommend an alternative level of care (higher or lower) or an unlimited number of sessions. Conducting medical necessity reviews, retrospectively or prospectively, for psychotherapy services does not inherently create a parity violation.

Prior to the implementation of Senate Bill 22-156, some RAEs conducted prior authorization reviews of outpatient psychotherapy services. Then and now, Colorado Medicaid utilized PARs on an array for fee-for-service outpatient physical health benefits, including physical therapy and occupational therapy which also fall into the outpatient benefit classification. It was determined in HCPF's annual comparative analysis of the RAEs' utilization management policies that the use of authorization for outpatient psychotherapy services did not impact parity compliance.

Any new utilization management policy that could impact parity compliance must be reviewed for parity compliance prior to implementation. As required within their managed care contracts, RAEs must:

- Maintain compliance with all relevant state and federal laws regarding Mental Health Parity and Addiction Equity Act (MHPAEA). [Contract Section 10.5.1.]
- Not impose NQTLs for mental health or substance use disorder (SUD) benefits in any classification unless, under the policies and procedures of contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. [Contract Section 10.5.2.]

127. Sen. Amabile: Please provide the billing codes and services included in the outpatient psychotherapy PAR. Could multiple therapy sessions in one week include different types of therapy, such as individual, couples, and family therapy?

RESPONSE: Yes, a member may receive multiple types of psychotherapy in the same week. Psychotherapy services include individual (90832, 90833, 90834, 90836, 90837 and 90838), family (90846 and 90847), group (90849 and 90853) and crisis (90839 and 90840) sessions.

Prior authorization cannot be required for crisis services, and there are no limits on the number of medically necessary services a member can receive. Prior authorization is a process that requires additional documentation, but if additional services are medically necessary, they are approved. Some members will continue to receive care for more than 24 sessions.

128. Sen. Amabile/Rep Brown: How did the Department estimate the cost savings for outpatient psychotherapy PARs? Do the requested amounts account for increased administrative costs for RAEs and providers? Why does the Department assume the request will save, rather than cost, money?

RESPONSE: HCPF and its actuaries accounted for the anomalous outpatient psychotherapy trend growth within the data used to set state fiscal year (SFY) 2025-26 capitation behavioral health rates. This was then translated into the portion of the projected SFY 2025-26 paid capitations. This calculation resulted in $31.6 million of additional spend in total funds within the fiscal year. To implement the prior authorization on January 1, 2026, the inappropriate utilization would account for half of that, or $15.8 million total funds. The general fund split of that total is the proposed $6.1 million. The adjustment to the utilization assumptions will be included in the SFY 2025-26 rate reset.

HCPF has directed the Regional Accountable Entities (RAEs) to develop strategies to address the unmanageable growth in outpatient psychotherapy and ensure services are medically necessary. However, there is no requirement that utilization management is performed in a specific way or in every case. It is important that RAEs have this flexibility to determine what processes make the most sense for their region, and are able to implement unique approaches based on their networks. RAEs are required to review 1% of paid claims each year and are able to use those resources to focus on areas of overutilization. Implementing PARs for psychotherapy may not be cost effective for all RAEs; this is why it is important that RAEs have the flexibility to determine how they will conduct reviews for medical necessity. Given the flexibility provided to the RAEs to reach the appropriate trend management, HCPF does not believe that additional administrative costs will be required within the rate update.

R-06: Prospective Payment System

129. Sen. Amabile: Providers received guidance that the Department and BHA are developing a Guardrails Plan for the Prospective Payment System (PPS) expected to be made public in early 2026. What are examples of guardrails the agencies may consider implementing, the associated cost savings, and the impact to providers and patients?

RESPONSE: The Department is working with BHA on a Prospective Payment System (PPS) Guardrails Plan that will update standards on the PPS payment, financial and data reporting requirements, and quality requirements. It will also explain the monitoring and oversight processes, and potential impacts of noncompliance including education, and decertification in the most extreme circumstances. The draft plan will be shared publicly prior to the first stakeholder session, scheduled for January 23, 2026.

Some examples of the guardrails under consideration include review for allowable costs and expanded auditing and monitoring activities. For example currently there are guardrails on the amount of salary that can be included for senior executives, based on similar federal grant guidelines, so that the PPS can't include salaries over $338,550 for non-clinical work. Now that the state has access to a full year of utilization data for services provided under the PPS, HCPF will look at the PPS rules

for what is allowable, what is unallowable, and how the PPS is impacting the behavioral health system. This includes review of historic utilization to see if Comprehensive Safety Net Providers (CSNPs) saw an increase in the average number of visits each member has each month. A sharp increase may suggest that the CSNP is requiring members to come into the office more frequently and, in doing so, the CSNPs are increasing their revenue. This practice is referred to as "spreading visits." Another example would be examining purchases of technology, such as the cost of implementing a new HR system. While this is an allowable cost, HCPF will scrutinize if the cost was reasonable or prudent, and properly cost-allocated. CSNPs all submitted their first cost reports in December, HCPF staff will carefully examine what costs are allowed in the cost report. Both of these auditing and monitoring activities are considered guardrails and they will be addressed in the PPS Guardrails Plan.

These guardrails are not intended as a rate reduction or savings plan. The PPS Guardrails Plan will outline compliance standards for providers, and will help preserve the current Medicaid behavioral health benefit for members by ensuring the HCPF and the RAEs are only paying for services that are compliant with state and federal regulations in future cost reports. This will not include retroactive capture of past funds, and HCPF does not have a target number in savings. Instead, this is a process for ensuring appropriate use of funds and using data to determine areas of risk, and then plans to mitigate that risk.

130. Sen. Amabile: What has the Department identified to indicate that PPS needs guardrails, such as increased cost or utilization? During last year's hearing, the Department indicated that there was no increased cost associated with PPS. What has changed?

RESPONSE: Guardrails are needed to protect the state from paying for unsupported or unallowable costs in the future, particularly as provider costs increase over time. One of the elements of these guardrails is to monitor the cost effectiveness of the model and determine if we are getting what the system needs and are we getting what we are paying for as a state. An early analysis suggested that the change to a PPS methodology may save the state up to $10 million in general fund compared to the previous cost-based methodology. This is a very preliminary analysis that we are updating - now that the state has a full year of utilization to consider.

The state must implement an accountability structure around the PPS to ensure that the state, in compliance with the cost accounting principles defined by CMS, is only reimbursing for prudent, reasonable, and allowable costs. The Certified Community Behavioral Health Clinic (CCBHC) planning grant technical assistance also advised, based on experiences from other states, that states have a strategy to ensure compliance with CMS cost accounting principles, to ensure providers are creating

access and serving priority populations, and to monitor for inconsistencies in provider billing. For these reasons, the Department and BHA determined it necessary to create the PPS Guardrails Plan to ensure transparency and clarity in the cost reporting process. Without guardrails around how costs become part of paid rates, federal financial participation is at risk. Efforts to develop the plan with stakeholder input and collaboration signals the state's commitment to ensuring the appropriate use of federal funds; efforts will be referenced in the state's CCBHC Demonstration application to make the application more competitive. (The CCBHC Demonstration application is due in the spring of 2026.)

131. Sen. Amabile: PPS was intended to incentivize providers to join the BHA safety net. What is the Department's plan to ensure that PPS guardrails do not result in a decrease of comprehensive providers? Will any other provider types be impacted?

RESPONSE: HCPF does not believe implementing guardrails on PPS rates would result in a decrease in comprehensive providers. Providers will still be paid for all reasonable costs in accordance with state and federal laws and regulations. These guardrails exist to ensure that the program can still accomplish its goals of paying providers appropriately while protecting the state's General Fund from unreasonable cost increases and federal disallowances.

The PPS guardrails apply only to CSNPs, and will apply to CCBHCs if the state is approved for a CCBHC Demonstration. No other providers will be impacted.

R-06: Behavioral Health Incentives

132. [Sen. Amabile] How will the behavioral health incentive payment decrease impact rate setting negotiations with RAEs? Will there actually be cost savings realized if a reduction to incentive payments simply results in RAEs negotiating higher rates?

RESPONSE: The Behavioral Health Incentive Program (BHIP) is an incentive program that allows Regional Accountable Entities (RAEs) to earn up to 5% above their earned capitations (5% is a federal limitation). To earn these dollars, the RAEs must meet quality standards that are set in advance. Historically, the RAEs have earned approximately 60% of the available dollars.

Any dollars paid out under the BHIP are mutually exclusive from the rate-setting process. No portion of the BHIP payments can be included within the actuarially sound capitation rates or the medical loss ratio. RAEs do not lose revenue from a reduction in the BHIP. Rate-setting regulations put forth in 42 CFR 438.5. requires HCPF to ensure the RAEs are paid sufficiently to meet their contract obligations while effectively managing risk. A reduction to the BHIP does represent real cost savings and does not impact capitation payments to the RAE, meaning the RAEs will not be able to negotiate for additional dollars to be added to their capitation rates. This

reduction also means that RAEs will have fewer dollars to pass on to providers through value-based payments. (Historically, RAEs have passed on 66-90% of their BHIP earnings.)

R-06: SBIRT

133. Rep. Taggart: Please provide information on the demand for and effectiveness of SBIRT training. Provide the number of providers served each fiscal year, and any data that demonstrates the impact of training on patient outcomes.

RESPONSE: Screening, Brief Intervention, and Referral to Treatment (SBIRT) is designed for early detection of a suspected substance use disorder (SUD), or to refer members for treatment. SBIRT is a Medicaid-billable and required preventive service benefit. SBIRT use is a required reporting element under the evaluation strategy for the SUD Demonstration portion of Colorado's 1115 Waiver. HCPF has monitored and reported on the number of members who received an SBIRT service each quarter for the last 5 years to assess whether utilization has increased alongside the expansion of SBIRT training efforts. To date, the state has not observed a significant increase in members receiving early intervention services as reflected in the 1115 SUD waiver reporting.

Through this grant award, SBIRT Colorado offered 150 SBIRT trainings to 1,082 providers during State Fiscal Year (SFY) 24/25. Of those 1,082 trained providers, 73 billed for SBIRT screenings with 3,447 members during that same time period. 5,297 members received SBIRT the previous year from 110 providers. (That is the largest number of providers to render SBIRT in the last four state fiscal years.)

SBIRT training is also available without cost to providers through a number of national provider organizations. While HCPF has gotten positive feedback about the sparsely attended training, there has not been any known request or community engagement process in recent years that has suggested that SBIRT Training is a priority from provider or member communities.

High Acuity Children and Youth

134. [Sen. Bridges] How many children does the Department expect to serve with high fidelity wraparound services in FY 2026-27?

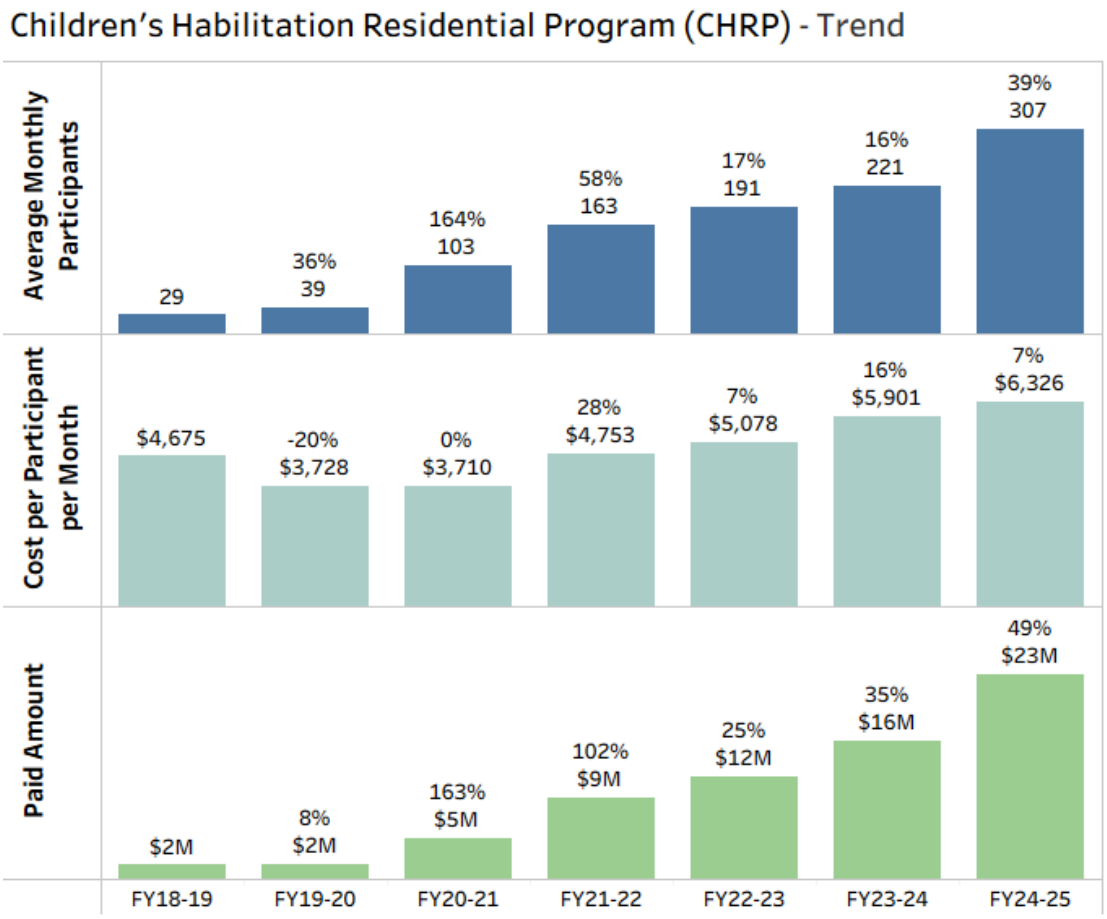
RESPONSE: HCPF estimates in the Colorado System of Care LRFI that 1,500 adolescents will use High Fidelity Wraparound Intensive Care Coordination in SFY 2026-27. (This work remains iterative.) The Colorado System of Care Implementation Plan is expected to be updated annually in compliance with the GA v. Bimestefer Settlement Agreement.

135. [Rep. Taggart (from DHS OCYF briefing)] Please provide an implementation update for H.B. 24-1038 (High Acuity Youth), including the number of youth served and actual expenditures by program for each fiscal year. Programs include assessments, intensive care coordination, CHRP expansion, and the PRTF actuarial analysis.

RESPONSE: HCPF officially started to serve members under the Colorado System of Care in November 2025. There is no utilization or expenditure data available yet for the Standardized Assessment or Intensive Care Coordination. There is generally a 90-day billing lag between the time a service is provided and when HCPF is made aware.

As of January 1, 2025, HCPF contracted with Optumas to conduct an actuarial analysis of current Psychiatric Residential Treatment Facility (PRTF) rates. HCPF, CDHS, and Optumas held weekly meetings to ensure timely completion and address provider feedback. Optumas also met regularly with PRTF providers, gathered financial data, and incorporated it into the analysis. The analysis set the PRTF payment rate at $815.85 per day, a 1.6% increase, reflecting adjustments for higher-acuity populations and updated cost assumptions.

House Bill 24-1038 specifies that “no later than January 1, 2025, the State Department shall seek federal authorization to expand the residential child health-care program established pursuant to Section 25.5-6-903 to include children and youth who have a serious emotional disturbance that puts the child or youth at risk or in need of out-of-home placement.” The intention of this change to the Children’s Habilitation Residential Program (CHRP) waiver is to include Serious Emotional Disturbance (SED) within the CHRP targeting criteria for waiver eligibility. Children or youth must meet the criteria for nursing facility or an inpatient psychiatric hospital level of care. Full implementation, including training of providers and case management agencies of this expanded eligibility criteria, and CHRP enrollments increased in Fiscal Year 25-26, as a result of the expanding SED eligibility criteria, as specified by HB 24-1038. The table below demonstrates the growth since FY 18-19 in total funds, illustrating the significant investment and focus on growing services for children in Colorado.



136. [Sen. Kirkmeyer] How many contracts does the Department have with the Kempe Center? Is there duplication in the work performed?

RESPONSE: In September of 2025, HCPF, in collaboration with the Behavioral Health Administration (BHA), designated Colorado State University (CSU) as the Colorado System of Care (CO-SOC) Workforce Capacity Center (WCC). This is a different institution than the Kempe Center at Colorado University (CU Denver).

The Kempe Center's *Rocky Mountain MST Network* is the only entity in the state that has national approval to certify MST sites and teams. This is why HCPF, in accordance with the GA v. Bimestefer settlement agreement, executed a single-case contract with CU Denver Kempe Center on December 17, 2025. In order to ensure there is no duplication between CU Denver's Kempe Center *Rocky Mountain MST Network* scope of work and Colorado State University's Workforce Capacity Center scope of work, the vendors are required to work in collaboration. HCPF executed separate contracts with CSU and CU Denver eliminated unnecessary administrative costs between the two entities. Having separate contracts provides the state with additional oversight of the

work, in order to advance state goals and to ensure compliance with the settlement agreement.These efforts work in concert to ensure Colorado builds the community workforce capacity necessary to expand access to high-quality, evidence-based services for children, youth, and families with intensive behavioral health needs.

137. [Sen. Amabile] What would be the impact of reducing funding for the Workforce Capacity Center on the Department's response to the GA v. Bimestefer settlement agreement to develop a youth system of care?

RESPONSE: Currently, Colorado suffers from a provider shortage to provide treatment options in the community for Coloradans - especially young people - with significant behavioral health needs. The Workforce Capacity Center is solely focused on closing this gap for children and youth. Without the Workforce Capacity Center, there would be no centralized hub for Colorado System of Care (CO-SOC) providers, including the training, fidelity monitoring, and implementation of the National Wraparound Implementation Center High Fidelity Wraparound Model for Intensive Care Coordination. The Workforce Capacity Center leads these efforts to ensure Colorado builds the CO-SOC network necessary to expand access to high-quality, evidence-based services for children, youth, and families with intensive behavioral health needs. Furthermore, the CO-SOC network is necessary for HCPF to successfully exit the Settlement Agreement resolving the underlying *G.A. v. Bimestefer* lawsuit. Failing to meet the terms of that agreement could result in renewed litigation, which if successfully prosecuted, would likely involve certification of a class action and potential entry of a multi-year consent decree decided by a judge and an independent court monitor.

138. [Rep. Sirota] Please provide an update on the implementation of the Workforce Capacity Center. When did or will the center begin training providers? When will trained providers begin serving youth? What amount of funding from the Workforce Capacity Center is expected to go to the Department, the Kempe Center, or RAEs for FY 2025-26 and FY 2026-27?

RESPONSE: In alignment with the GA et al v. Bimestefer settlement agreement and legislative direction under HB 24-1038 and SB 25-292, HCPF, in collaboration with the Behavioral Health Administration (BHA), designated Colorado State University (CSU) as the Colorado System of Care (CO-SOC) Workforce Capacity Center (WCC). The contract with CSU was executed on August 20, 2025.

HCPF is officially serving members under CO-SOC. The WCC at CSU has partnered with the National Wraparound Implementation Center (NWIC) for training and the coaching of High Fidelity Wraparound (HFW). The funding under HB 24-1038 and SB 25-292 as well as BHA's System of Care federal grant have allowed this training and coaching to be free of charge to HFW providers.

Each Regional Accountable Entity (RAE) has at least one contracted HFW provider who is serving members for CO-SOC. There are a total of 17 individual practitioners who completed at least one HFW training (introduction to wraparound, engagement in wraparound, intermediate wraparound or supervision in wraparound).

The following table breaks down the funds received under SB 25-292 to expand the workforce, including what CSU has been given as the designated Workforce Capacity Center as well as other entities related to workforce expansion and development:

Entity	FY 25/26	FY 26/27	Funding Allocation
Colorado State University (designated Workforce Capacity Center)	$1,776,896 with $245,250 going to FFT, LLC	$2,426,463 with $253,500 going to FFT, LLC	CSU Personnel costs, operating costs, and infrastructure development for data collection, fidelity and quality metrics. CSU has a subcontract with *NWIC* to bring the model to Colorado and develop the workforce and a vendor agreement with *FFT LLC* to provide practice support to Functional Family Therapy (FFT) teams throughout the state. FFT is one of the intensive in-home and community- based behavioral health services provided to adolescents and their families as part of CO-SOC.
RAEs	$958,520	$0	Incentive funds for Agencies to come into the CO-SOC network and expand their staff providing CO-SOC services
Colorado University with the Kempe Center's *Rocky Mountain MST Network*	$400,000	$325,000	To provide practice support to Multisystemic Therapy (MST) teams throughout the state. MST is one of the intensive in-home and community- based behavioral health services provided to adolescents and their families as part of CO-SOC.
HCPF	$454,584	$248,537	High Fidelity Wraparound Services
Suzanne Fields	$250,000	$0	Settlement Agreement Requirement 3.5

BHA	$160,000	$0	OwnPath and Learning Management System
HCPF	$107,894	$107,894	Personal Services, Operating, and Centrally Appropriated costs

139. [Rep. Sirota] The response to RFI 5 outlines the anticipated annual costs for implementing a youth system of care. How does the Department expect these costs to be reflected in the budget submissions in future years? Will increasing costs be reflected in budget requests and legislation, or included in the forecast? Please describe which costs may be included in forecasts, if any.

RESPONSE: In future years, costs for implementing the youth system of care will be reflected in the budget submission through the existing, regular budget process. Ongoing costs for policy that has been previously approved by the General Assembly will be included in HCPF's regular budget request for Behavioral Health Community Programs, which also includes HCPF's forecasts for these programs. Any request for funding for new policy or changes to existing policy will be provided in a separate budget request. In all cases, HCPF will submit budget requests associated with changing costs of implementing the youth system of care.

140. [Sen. Bridges] How will the Department comply with the system of care settlement agreement considering ongoing budget restrictions and efforts to curb the exponential growth of Medicaid expenditures?

RESPONSE: The Settlement Agreement includes language recognizing that all budget decisions are under the authority of the General Assembly and the commitment to the Implementation Plan is contingent upon funds being appropriated, budgeted, and otherwise made available for the purpose of this Agreement and subject to annual appropriation.

HCPF must continue to monitor the growth of the Medicaid program to ensure that it is strategic and sustainable, which includes prioritizing areas where there are deficits while managing areas of unsustainable growth. HCPF will continue to work with the Colorado Department of Human Services (CDHS) and the Behavioral Health Administration (BHA) to coordinate on when and how to move the various levers within our systems in ways that improve outcomes and efficiencies for children and families, providers, and the state.

The Colorado System of Care (CO-SOC) is designed to ensure that members are able to move along the care continuum and are thus able to access the most appropriate level of care. Not only is that what is best for families, it is also financially prudent to

support transition out of those more costly treatments into the community and prevent decompensation and to avoid a need for more costly treatments like residential and hospital stays. The daily cost of the system of care is significantly lower than residential treatment, which is currently the largest driver of youth behavioral health costs in Medicaid.

Service	Per Member Per Day
Inpatient free-standing psychiatric hospital	$736.42
PRTF (Fee-for-Service Schedule)	$803.71
System of Care Services and Operations (all services bundled)	$71.43

To a certain extent, HCPF should be able to use the cost savings from residential care to offset the increases in intensive outpatient services and supports. However, there are some elements of CO-SOC that are not currently covered, and HCPF will need to work with the General Assembly to either prioritize new services or be at risk of not being able to meet the Settlement Agreement terms.

141. [Rep. Gilchrist] Please describe the gaps in the service continuum for high acuity youth between foster care and residential treatment. How did the Department determine that high fidelity wraparound and intensive care coordination were the first priority for developing a youth system of care? How was the Department incorporated feedback from families, counties, hospitals, residential providers, or other stakeholders to identify gaps in the service continuum and develop the youth system of care implementation plan?

RESPONSE: In the fall of 2025, the Behavioral Health Administration (BHA) collaborated with Health Management Associates (HMA) to publish *Behavioral Health in Colorado*, the 2025 Colorado Behavioral Health Needs Assessment. The needs assessment identified a significant gap in intermediate and step-down levels of care for high acuity youth.

The two largest service gaps in the care continuum between foster care and residential are statewide access to both intensive in-home community based services and to both in-home and facility based respite. There is a lack of community-based placements for children to live when they are unable to return home, such as foster care. Without these appropriate placements, children remain in facilities beyond the point of medical necessity. Colorado Department of Human Services (CDHS) reports the professional foster care continuum has grown considerably from two treatment beds total in 2021 to 270 therapeutic, treatment, and professional beds in November of 2025. General foster care, on the other hand, has decreased over the past 10 years with 7,900 beds in 2015 to 6,600 beds in 2025.

HCPF has worked with a national consultant as required under the *G.A. et al v. Bimestefer (1:21-cv-02381) Settlement Agreement (section 3.5)* regarding the *Colorado System of Care Implementation Plan v1*. The development of the Colorado System of Care (CO-SOC) Implementation Plan came after many in-person stakeholder sessions across the state from August 2024 to January 2025. The sessions used both virtual and in-person options, and would focus on gathering input from specific populations such as individuals with lived experience, from urban communities, or from rural communities. HCPF also held virtual sessions focusing on children under the age of 8 offered, and urban and rural needs. These stakeholders sessions were open to anyone and included: members; Regional Accountable Entities (RAEs); Behavioral Health Ombudsman office counties; sheriff's offices; behavioral health and primary care providers; safety net providers; hospitals, including Children's Hospital Colorado; advocacy organizations; American Academy of Pediatrics; Universities; and other state departments.

High Fidelity Wraparound (HFW) with Intensive Care Coordination (ICC) is the core of a system of care. For this reason, it was determined HFW should be the first CO-SOC service to be phased in. HFW is a family and youth driven approach to the development of a single individualized care plan. Members receiving HFW services can be connected to existing home-based services as the state continues to invest in developing and supporting intensive home-based treatment models.

There are three CO-SOC Advisory Committees that support the development of this work, a State Leadership Advisory Committee (under HB 24-1038), an Implementation Advisory Committee (under HB 24-1038) and a Lived Experience Advisory Committee. Throughout the various advisory committees, there is representation from various state departments, counties, county commissioners, hospitals, providers, advocates and lived experience as outlined in HB 24-1038. Under the Settlement Agreement, HCPF is required to update the CO-SOC Implementation Plan annually, taking into account stakeholder feedback.

142. [Sen. Amabile] How many kids are in residential treatment because they are a threat to themselves or others? How does medical necessity evaluate whether a child is a risk to their family if they return home? How can a child not meet medical necessity criteria for residential treatment if they are sufficiently violent that their family does not feel equipped to have them in their home?

RESPONSE: HCPF does not specifically track data on children and youth in residential treatment who are a threat to themselves or others. However, standard criteria for inpatient hospitalization is a threat to self or others as determined by a clinician. Children and youth stay in residential treatment as long as these levels of care are medically necessary for the member. 10 CCR 2505-10 8.076.1 defines a medically

necessary service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
b. Is provided in accordance with generally accepted professional standards for health care in the United States;
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
e. Is delivered in the most appropriate setting(s) required by the client's condition;
f. Is not experimental or investigational; and
g. Is not more costly than other equally effective treatment options.

If a member is ready to transition home and the family is not ready for the member to return home, the county must find an appropriate placement for the member to live and receive intensive in-home and community-based service. Medicaid can pay for treatment (hospital, residential treatment facility, outpatient care) but is federally prohibited from paying for placements (home setting, group home, foster placement). When the state agencies work with providers on discharge, often the challenge is the provider believes the child no longer meets medically necessary criteria to be hospitalized or in a residential treatment facility, but the guardians do not feel prepared to accept a child in the home. This is why the Colorado System of Care is such an important solution. It provides in-home supports and services so that both the child and family can be successful at home.

Home-based settings lead to better outcomes for youth and families. A *2024 Report* from the United States Senate Committee on Finance Staff details that residential treatment often does not provide the care that children with complex needs require, results in inappropriately long stays, and leaves children more traumatized. Children are often without a discharge plan to ensure successful reintegration into the community. These facilities are most effective when youth are going in for short-term utilization, and after a few months discharged. The longer the stay, the less likely the child or youth is to benefit from it. At a certain point, the care and separation from peers, school, family, friends, and socialization becomes more harmful than beneficial.

HCPF, in partnership with the Behavioral Health Administration (BHA), adopted the National Wraparound Implementation Center model for High Fidelity Wraparound

(HFW) under the Colorado System of Care (CO-SOC). HFW is an intensive care coordination intervention and has a family and youth driven approach to the development of a single individualized care plan, in alignment with a *system of care philosophy*. HFW/ICC supports the family system as a member transitions from residential treatment through active discharge planning that involves the member and their family to ensure that when a child or youth is ready to discharge, their parents are guardians and outpatient support is ready as well.

143. [Sen. Amabile] We are hearing that PRTF youth are being placed in specialized group settings, which is not the appropriate level of care. How many PRTF youth are being served in specialized settings?

RESPONSE: Youth who meet medical necessity criteria for Psychiatric Residential Treatment Facility (PRTF) level of care as a Medicaid behavioral health benefit, are served in PRTFs and are not being served in other specialized settings.

When a youth no longer meets medical necessity criteria for PRTF level of care, they transition to a lower level of care, such as a Qualified Residential Treatment Program (QRTP) or intensive home-based treatment. In State Fiscal Year (SFY) 24/25, 319 youth received PRTF services while 268 received QRTP services during that same time period. HCPF estimates that in SFY26/27, 1,500 children and their families will receive intensive behavioral health services under the Colorado System of Care (CO-SOC).

144. [Sen. Amabile] How many placements for QRTP, PRTF, and CHRP youth have been made out of state? Which states? What were the daily rates out of state compared to in state?

RESPONSE: In fiscal year 2024-2025, 82 children received residential treatment out of state in the following states:

Arkansas (AR)	Oklahoma (OK)
Florida (FL)	South Carolina (SC)
Georgia (GA)	Tennessee (TN)
Kansas (KS)	Texas (TX)
Missouri (MO)	Utah (UT)

Out-of-state treatment is not universally more expensive; around half of all out-of-state stays are paid at a rate equal to or lower than the set in-state rate of $816.57 a day (now $803.71 as of October 1, 2025). The average out-of-state daily rate is $840.00 per day across all residential stays. This variation reflects differences in provider cost structures and individually negotiated single-case agreement rates

under both fee-for-service and across Regional Accountable Entities (RAEs).

145. [Sen. Amabile] Providers are reporting duplicative state visits from HCPF, DHS, BHA, and CDPHE, which is diverting resources to accounting professionals and senior staff, and away from their mission of serving children, which leads to reduced provider capacity. What is the timeline for these visits to be streamlined into BHA or under one roof?

RESPONSE: HCPF relies on collaboration with other state regulatory agencies through use of interagency agreements (IAs) to conduct routine and for cause regulatory audits as well as site visits. HCPF does not routinely conduct onsite visits with providers unless invited to do so, such as for technical assistance or collaborative discussions. HCPF remains committed to coordinating wherever possible to reduce unnecessary administrative burden on providers and to support the shared goal of ensuring children receive high-quality services.

When conducting or participating in site visits, HCPF has two primary goals: 1) ensure Medicaid members are treated in a manner that is safe and respectful, and 2) ensure taxpayer dollars are spent appropriately. Unlike the regulatory agencies, who conduct routine and ongoing site visits, HCPF uses site visits specifically for monitoring of appropriate reimbursement for medically necessary services and in collaboration with other state agencies when there is a quality-of-care concern.

State agencies have created communications and reporting practices to ensure we are sharing information on quality and oversight concerns. It is not always possible to combine site visits that include oversight of facility safety, monitoring of compliance with facility and staff licensure, and assessment of billing activities for fraud, waste, and abuse, as required by federal regulation. Additionally, site visits can involve disclosure of protected information that can't be shared with other agencies.

146. [Sen. Amabile] Why is the Department starting medical necessity assessments for child welfare youth in residential placements when the JBC sponsored legislation to delay the movement of child welfare placement payments to behavioral health capitation with the expectation that medical necessity assessments would not begin until the payments moved to capitation?

RESPONSE:
Medical necessity is the most basic and essential requirement for all Medicaid services, and a critical component to ensuring effective member care and stewardship of taxpayer dollars. In order for Medicaid to pay for services, these basic requirements must be met, and all providers sign a contract committing to only provide and seek reimbursement for medically necessary care.

During the last session, HCPF shared that the impetus for moving payment for these services under the capitation is to promote continuity of care and to ensure that children are only receiving medically necessary services in the least restrictive setting. At that time HCPF indicated that, despite the delay, medical necessity determinations must be implemented for fee-for-service (FFS) covered benefits to ensure compliance with federal regulations. The state risks disallowance if HCPF reimburses for services that are not medically necessary. The state is also at risk for an Olmstead/Americans with Disabilities Act lawsuit if it is determined children are institutionalized when they could be served in the community.

HCPF held multiple stakeholder meetings and has worked in collaboration with our utilization management vendor to design a process that ensures residential treatment paid for by HCPF is medically necessary. This process serves a dual purpose, as it will prepare providers that do not have experience with submitting authorization requests for working with the Regional Accountable Entities (RAEs) upon the FFS to RAE transition on July 1, 2026. This same process will continue to be used in rare instances in FFS after July 1, 2026, when the member's primary diagnosis, indicated for seeking residential treatment, is a non-covered diagnosis under the RAE Capitation (e.g., ASD and I/DD), or, in those rare instances when children are not assigned to a RAE.

Residential services under the Children's Habilitation Residential Program Waiver (CHRP) Waiver are not impacted.

SUD Waiver & Patient Outcomes

147. [Rep. Sirota] The Department's response to RFI 2 indicates that CMS delayed approval of a five-year extension of the Substance Use Continuum of Care waiver. What is the current status of the extension? Please describe if and when the Department expects the waiver to be approved, including any barriers to approval including but not limited to the Department's inclusion of presumptive eligibility and administrative capacity at CMS.

RESPONSE: At this time, Colorado expects the renewal of the 1115 Waiver to be ultimately approved. CMS confirmed during a December 10th meeting that they intend to provide the state with a No Cost Extension for calendar year 2025 by December 31, 2025. As of December 15, HCPF is awaiting formal notification of the No Cost Extension for the 1115 Substance Use Continuum of Care Waiver. A No Cost Extension typically provides a continuation timeline up to a year for all previously approved services. We understand that the delay is due to limited staff capacity at CMS, and was exacerbated by the shut down. For a full approval of the waiver renewal, including the approved amendments (health related social needs, inpatient serious mental illness, and criminal justice reentry), along with the new addition of presumptive eligibility for long-term services and supports, CMS has signaled this conversation will take place ahead of December 31, 2026. (They reserve a year to

negotiate, but it may come sooner.)

148. [Rep. Brown] Please provide an update on the new initiatives to provide health-related social needs and provide reentry services to people leaving incarceration.

RESPONSE:
1115 Waiver including Health Related Social Needs (HRSN) Demonstration and Reentry Services Demonstration

In January 2025, CMS approved amendments to the state's existing 1115 waiver including HRSN and reentry demonstrations. Since receiving the amendment approval, Colorado has also received CMS approval of its implementation plans for HRSN and inpatient serious mental illness (SMI) and is awaiting approval for the reentry implementation plan.

As of July 2025, 13 housing providers are serving members under the new policies offering permanent supportive housing (PSH) services, including: pre-tenancy and housing transition services; navigation services; tenancy sustaining services; rent/temporary housing for up to six months, including utility costs; and one-time transition and moving costs. HCPF is additionally covering rent using Community Access Team (CAT) Vouchers for individuals at risk of institutionalization. (HRSN-supported nutrition services are still in planning stages, as the program builds on the housing benefit.)

As of January 2026, inmates in Colorado Department of Corrections (DOC) and Colorado Department of Human Services (CDHS) facilities will be able to receive a limited benefit of covered Medicaid services, including medication-assisted treatment, for up to 90 days prior to release and 30 days of medications upon release. (The reentry benefit is scheduled to be available in local jails by January 2027.)

HCPF established a financial process for housing and reentry that allows the state to draw down matching federal dollars for services previously covered entirely with state General Fund. HCPF has also established a financial process to deposit General Fund savings resulting from the federal match into the respective cash funds created pursuant to SB 25-308.

As of October 2025, freestanding inpatient hospitals are accepting members with serious mental illness and are able to be reimbursed for 60 days when medically necessary.

Colorado submitted the 1115 waiver renewal in December 2024 for another five-year demonstration. On December 23, 2025, CMS issued the state a temporary three-month

no-cost extension. HCPF will need additional waiver approval or another no-cost extension by March 31, 2026, and will be working closely with CMS to negotiate the associated special terms and conditions.

149. [Sen. Amabile] How does the Department evaluate outcomes for inpatient and residential substance use treatment? Are there persistent implementation challenges? Please provide any data the Department uses to evaluate patient outcomes.

RESPONSE: As part of Colorado's 1115 Waiver, Substance Use Disorder (SUD) Demonstration, HCPF evaluates outcomes for inpatient and residential SUD treatment through CMS-required evaluations, including an independent third-party vendor Midpoint Assessment and Interim Evaluation, and a five-year summative evaluation report that is due in 2026. HCPF also uses quarterly monitoring reports presenting established metrics to monitor trends across the SUD benefit.

Overall, Colorado has increased access to SUD services, and recently data shows expansion of high-intensity outpatient services. Partial hospitalization was the final level of care in the SUD continuum approved by the legislature in the spring of 2024 with an effective date of July of 2024, as an alternative to residential level of care. In 2024, more than 2,900 members received SUD high-intensity outpatient services, a 23% increase over the previous year. In this same timeframe, HCPF tracked a 24% decrease in members utilizing residential and hospital SUD services, showing more members getting care in the community as an alternative.

The data has shown that the most persistent challenges with the implementation of the SUD demonstration are related to transitions of care. In particular growing readmission rates, decreasing engagement statistics, and a disproportionate percentage of the population who receive only withdrawal management (WM) services without transitioning to other treatment levels of care. In year 4 of the Demonstration, WM accounted for 79% of total SUD services, and 25% of members returned to care within 90 days. As Colorado transitions to use of ASAM 4th Edition, WM will be integrated across all levels of care supporting more robust treatment that supports members engagement.

Finally, the Behavioral Health Incentive Program (BHIP), also operated in collaboration with the RAEs, monitors several health quality performance measures to evaluate outcomes for SUD treatment. The BHIP measures provide insight into how members access and utilize behavioral health care. These include engagement in outpatient SUD treatment, and follow-up within 7 days of an emergency department visit for SUD.

BHIP performance by RAE, FY 2023-24

RAE	Engagement in Outpatient SUD treatment	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD
1 (RMHP)	28%	32.6%	28.9%
2 (NHP)	31.4%	25.5%	25.4%
3 (COA)	29%	36.3%	30.7%
4 (HCI)	13.4%	30.1%	26.3%
5 (COA)	31.2%	32.8%	28.3%
6 (CCHA)	24.4%	34.9%	26.3%
7 (CCHA)	21.1%	28%	25.5%

Key: Green = Met target

Other Budget Requests & Miscellaneous Questions

150. [Sen. Kirkmeyer] Are there federal penalties if the Department does not make the changes to the provider directory?

RESPONSE:
Yes. Federal law requires states to comply with multiple requirements governing the accuracy and maintenance of Medicaid provider directories, including 42 CFR § 455.414, which mandates revalidation of all Medicaid providers at least once every five years, and 42 U.S.C. § 1396a(mm)(1), which requires states to identify and list only those providers who are enrolled with the state agency and have received Medicaid payment within the preceding 12 months. In addition, CMS guidance in State Health Office Letter 24-003, implementing the Consolidated Appropriations Act requirements effective July 1, 2025, establishes strengthened federal expectations and standards for accurate, searchable and regularly updated provider directories, including making provider data publicly available in a machine-readable format through Application Program Interfaces (AP and maintaining processes to correct inaccuracies as a consumer protection standard. If HCPF does not meet these requirements, CMS may issue compliance findings, require corrective action plans, increase federal oversight, and potentially impose federal disallowances, withholdings or recouping of federal matching funds.

151. [Rep. Taggart, Sen. Amabile, and Rep. Brown] How will the request incrementally improve the reliability of the provider directory? How will it address ghost providers? Is it possible to make the directory reliable enough that it is actually a useful tool for members to find providers who are willing and able to see them in a reasonable time?

What would that take? Do we have reason to believe that relying on members to identify errors in the provider directory will actually work? Why are we shifting the administrative burden to members to identify inaccurate information in the provider directory?

RESPONSE: HCPF's request incrementally improves the reliability of the provider directory by modernizing the system and strengthening data accuracy through federally required revalidation and billing-based processes. Beginning in May 2024, HCPF disenrolled more than 30,000 providers who failed to revalidate under 42 CFR § 455.414, and HCPF will continue disenrolling approximately 1,000 providers per month. This directly addresses "ghost" providers, as many of those disenrolled are no longer actively participating.

The request also advances compliance with 42 U.S.C. § 1396a(mm)(1) by improving how provider data is presented to members. Providers, who have not billed in the past 12 months, will be positioned at the bottom of the sort, making it clearer which providers are actively participating. Combined with the identification of deceased providers, practice closures, and member feedback, these changes materially improve the usefulness of the directory for members seeking providers, who are willing and able to see them within a reasonable time.

Together, these changes move the directory closer to being a reliable, usable tool for members. Achieving a more reliable directory at scale requires a combination of established controls (revalidation and billing patterns), provider accountability, and timely correction of real-world changes that cannot be detected through claims or enrollment information, such as changes in acceptance of new patients.

The modernization project includes a structured feedback mechanism that builds on and refines existing feedback channels already used by members on the Health First Colorado website and mobile app. This project does not create a new burden for members, nor does it shift administrative responsibility to them. Instead, it separates provider directory feedback from general website and mobile app feedback. It also streamlines the process to ensure that reports of inaccurate provider information are routed and acted upon.

HCPF believes this approach will be effective because members and community partners are often the first to encounter inaccuracies - such as discovering a provider has moved, closed, or is no longer accepting Medicaid - during attempts to access care. Member feedback is therefore used as one supplemental signal, alongside revalidation, billing data and administrative updates, to identify issues that cannot be reliably detected on its own. All reports of provider updates will be reviewed by HCPF-responsible partners based on their contract scope, which may include Regional Accountable Entities, dental partner, etc.

This approach strengthens provider directory reliability through layered, complementary strategies to help ensure the directory contains the most accurate and up-to-date information possible.

152. [Rep. Sirota] What is the basis for the Department's assertion that 3D mammography is the standard of care adopted by commercial insurers?

RESPONSE: Colorado's basis is: (1) Colorado-regulated commercial plans are required to cover appropriate, guideline-concordant breast imaging without cost-sharing, and (2) major commercial carriers now routinely cover digital breast tomosynthesis (3D mammography) as a standard mammography modality consistent with national clinical and quality standards. The Department considers 3D mammography as the standard of care adopted by commercial insurers.

In developing this request, the Department reviewed state insurance requirements and medical policies from large commercial carriers, which show that 3D mammography is treated as a routine covered service for screening and diagnostic mammography, not as an experimental or limited-coverage add-on. These policies align with national clinical guidelines indicating that 3D mammography is an appropriate or preferred modality in many circumstances and is counted toward breast cancer screening quality measures. Given this alignment between state requirements, carrier coverage practices, and clinical standards, HCPF's proposal is intended to bring Colorado Medicaid coverage in line with what is already standard practice in the commercial market.

153. [Rep. Brown] How do we know that the Department's projection of the cost for covering 3D mammography is accurate?

RESPONSE: 3D mammography is billed using add-on codes to the standard 2D mammography codes. This is why adding coverage of 3D mammography comes with a new expense.

The Department's cost estimate for covering 3D mammography uses recent Colorado claims data, calibrated to real-world commercial experience and published evidence, reviewed by staff using our standard Medicaid forecasting methods. We are confident this projection is reasonable, and it will be monitored as part of our standard processes. In areas of uncertainty, the Department used conservative assumptions, such as a gradual uptake of 3D technology and Medicaid-appropriate utilization rates, and did not fully credit potential long-term savings from earlier detection and fewer repeat imaging studies. Any material differences between projected and actual experience will be reflected in future budget adjustments and shared with the Committee.

Medicaid Sustainability & Administration

154. [Sen. Amabile] How good are we at forecasting Medicaid expenditures historically? Why aren't we better at it?

RESPONSE:
HCPF recognizes the critical role our forecasts play in the overall state budget. As such, HCPF has sophisticated forecasting systems and methodologies and a very strong track record of accurate forecasting, with 11 of the last 15 years producing a forecast within about 1% of actual expenditures.

Forecasting, by its very nature, will never be perfectly precise, given inherent challenges including the complexities of health care, the volatility of the economy and its downstreaming impact to the unemployment rate, churn in the Medicaid program, forecasting by population due to variations in federal match, and changing federal policies with heightened Medicaid impact, such as: the Affordable Care Act, the Public Health Emergency's (PHE) Continuous Coverage provision and the subsequent unwind, and soon the marketplace exchange premium tax credits, H.R. 1 work requirements and twice a year eligibility determinations.

HCPF's forecasts experienced higher-than-normal variance from final actuals in FY 2023-24 (2.9%) and FY 2024-25 (1.1%) due to the unwinding of the PHE. This period generated significant volatility impacting the nation, not just Colorado, in both enrollment and per-capita expenditures, which are the two foundational drivers of the forecast.

Due to the last two years of forecasting volatility, the Executive Director took three actions to refine and enhance forecasting methodologies:

1. Asked the prior HCPF chief financial officer, who had more than 20 years of HCPF experience, to review current HCPF forecasting methodologies seeking refinements;
2. Asked a third-party actuary to review HCPF forecasting methodologies;
3. And, in 2025, implemented improvements in inter-departmental collaboration across Data Analytics, Policy Experts, and Finance.

In addition to official published forecasts, HCPF staff also review Medicaid expenditure on a monthly basis with senior Executive Branch staff to ensure all parties are aware of emerging trends.

Below is a summary of the historical forecasted General Fund variance for reference.

Fiscal Year	February Forecast/ Final General Fund Spending Authority	Actuals	Over/ Under	Percent Difference
FY 2010-11	$1,025,873,500	$1,035,679,314	$9,805,814	1.0%
FY 2011-12	$1,432,811,369	$1,432,800,513	-$10,856	0.0%
FY 2012-12	$1,579,969,730	$1,575,505,049	-$4,464,681	-0.3%
FY 2013-14	$1,778,137,687	$1,806,485,460	$28,347,773	1.6%
FY 2014-15	$2,223,978,501	$2,210,621,389	-$13,357,112	-0.6%
FY 2015-16	$2,366,158,672	$2,363,959,242	-$2,199,430	-0.1%
FY 2016-17	$2,495,439,413	$2,407,549,881	-$87,889,532	-3.5%
FY 2017-18	$2,665,335,366	$2,679,582,064	$14,246,698	0.5%
FY 2018-19	$2,802,124,489	$2,824,817,876	$22,693,387	0.8%
FY 2019-20	$2,811,474,569	$2,822,471,742	$10,997,173	0.4%
FY 2020-21	$2,652,388,789	$2,556,644,150	-$95,744,639	-3.6%
FY 2021-22	$2,875,906,363	$2,865,707,774	-$10,198,589	-0.4%
FY 2022-23	$3,459,674,591	$3,452,277,272	-$7,397,319	-0.2%
FY 2023-24	$4,238,111,722	$4,361,954,190	$123,842,468	2.9%
FY 2024-25	$4,944,580,913	$5,000,504,115	$55,923,202	1.1%

155. [Sen. Kirkmeyer] For both Medicaid and CHP+, how have we expanded eligibility and benefits over the last few years?

RESPONSE:

Over the last seven legislative sessions (2018–2025), the General Assembly has enacted more than 50 bills expanding eligibility for Colorado Medicaid and Child Health Plan *Plus* (CHP+), broadening covered benefits, and reducing barriers to care. These expansions fall into several major categories:

- **Eligibility expansions** include extended postpartum coverage (12 months), reproductive health coverage for immigrants, family planning for individuals over-income for Medicaid, coverage of health services for incarcerated individuals prior to release, Medicaid buy-in options for individuals with disabilities, the Cover All Coloradans initiative, and CHP+ expansion to 260% of the Federal Poverty Level (FPL).
- **Behavioral health transformation** encompasses many bills creating a statewide behavioral health system, the Behavioral Health Administration, expanded crisis services, peer supports, mobile crisis response, substance use disorder treatment, and Certified Community Behavioral Health Clinics.
- **Maternal and reproductive health** includes doula services, choline supplements, family planning expansion, and supports for high-risk pregnancies.

- **Reduced barriers to care** includes removal of prior authorization for psychotherapy and equipment repairs, elimination of pharmacy and outpatient copays, step therapy exceptions, and coverage of clinical trial costs.

Year-by-Year Highlights

2018-2019: The General Assembly laid groundwork for behavioral health transformation with the Behavioral Health Care Coverage Modernization Act (HB 19-1269) and Child and Youth Behavioral Health System Enhancements (SB 19-195), which added wraparound services to prevent out-of-home placements. Coverage for substance use disorder residential and inpatient services was established (HB 18-1136).

2020: SB 20-007 required a statewide community behavioral health care system within managed care. SB 20-033 authorized Medicaid buy-in coverage after age 65 for individuals with disabilities. Medicaid began covering routine costs for clinical trial participation (HB 20-1232).

2021: The 2021 session produced significant expansions. SB 21-194 extended postpartum coverage from 60 days to 12 months for both Medicaid and CHP+. New programs were created for reproductive health care (SB 21-009) and family planning up to 260% FPL (SB 21-025). The Behavioral Health Administration was established (HB 21-1097). New covered benefits included secure transport (HB 21-1085), peer supports (HB 21-1021), and clinical pharmacy services (HB 21-1275).

2022: HB 22-1289 (Cover All Coloradans) expanded coverage to qualifying children and pregnant people regardless of immigration status. SB 22-052 raised the CHP+ income limit to 260% FPL. Behavioral health expansion continued with mobile crisis response (HB 22-1214), mental health residential homes (HB 22-1303), supportive housing (SB22-131), and Colorado's Behavioral Health Safety Net (HB 22-1278). Prior authorization was removed for psychotherapy (SB 22-156) and complex rehabilitation technology repairs (HB 22-1290). Criminal justice re-entry services expanded (SB 22-196). New benefits included equine therapy (HB 22-1068).

2023: New covered benefits included doula services (SB 23-288) and community health worker services (SB 23-002). HB 23-1183 required step therapy exceptions for serious conditions, and HB 23-1130 mandated timely review of FDA-approved drugs for serious mental illness.

2024: HB 24-1322 authorized coverage of housing and nutrition supports and expanded coverage for incarcerated individuals prior to release through an 1115 waiver. SUD treatment was further expanded and standardized (HB 24-1045). High-acuity crisis services for children and youth were established (HB 24-1038). Continuous glucose monitor coverage was aligned with Medicare criteria and extended to gestational diabetes (SB 24-168). Choline supplements for pregnant people became covered under both programs (SB 24-175). Antipsychotic medication access improved through preferred drug list exceptions (SB 24-110). LTSS added presumptive eligibility (HB 24-1229).

2025: SB 25-042 expanded inpatient mental health services through an 1115 waiver. Coverage was added for abortion care using state-only funds (SB 25-183) and breast cancer examinations (SB 25-296). LTSS waiver consolidation merged the Children's Home and Community Based Services (CHCBS) and Children with Life Limiting Illness (CLLI) waivers for children with complex health needs (HB 25-1003), and the Complementary & Integrative Health Services (CIHS) waiver was extended to 2030 (SB 25-226).

Comprehensive Legislation Reference

Program Key: M = Medicaid only | C = CHP+ only | B = Both programs

Year	Bill	Description	Program
2018	HB18-1136	Covered SUD residential and inpatient services	M
2019	HB19-1193	Behavioral health supports for high-risk pregnant and parenting people	M
2019	HB19-1269	Behavioral Health Care Coverage Modernization Act	M
2019	SB19-195	Child and Youth Behavioral Health System Enhancements; added wraparound services to CHRP waiver	M
2019	SB19-222	Improving access to behavioral health for individuals at risk of entering criminal/juvenile justice system	M

2020	HB20-1232	Coverage of routine costs for participating in clinical trials	M
2020	SB20-007	Required statewide community behavioral health care system within managed care	M
2020	SB20-033	Authorized Medicaid buy-in coverage after age 65 for individuals with disabilities	M
2021	HB21-1021	Established peer supports as a covered benefit	M
2021	HB21-1085	Secure transport benefit	M
2021	HB21-1097	Created the Behavioral Health Administration	M
2021	HB21-1275	Reimbursement for clinical pharmacy services	M
2021	SB21-009	Reproductive health care program for individuals ineligible for Medicaid due to immigration/citizenship status	M
2021	SB21-025	Expanded family planning coverage to individuals up to 260% FPL	M
2021	SB21-139	Reimbursement for dental services delivered via telemedicine	B
2021	SB21-194	Extended postpartum coverage from 60 days to 12 months	B
2022	HB22-1068	Medicaid reimbursement for equine therapy	M
2022	HB22-1214	Mobile crisis response services	M

2022	HB22-1278	Colorado's Behavioral Health Safety Net	M
2022	HB22-1289	Cover All Coloradans—expanded eligibility regardless of immigration status	B
2022	HB22-1290	Removed prior authorization for repairs to complex rehabilitation technology	M
2022	HB22-1302	Integrated care grants and sustainable funding	M
2022	HB22-1303	Expansion of mental health residential homes	M
2022	SB22-052	Expanded CHP+ eligibility to 260% FPL (from 250%)	C
2022	SB22-131	Supportive housing as a covered benefit	M
2022	SB22-156	Removed prior authorization for psychotherapy services	M
2022	SB22-196	Criminal justice re-entry service expansion; standardized SUD treatment	B
2023	HB23-1130	Required timely review of new FDA-approved drugs for serious mental illness	M
2023	HB23-1183	Required exceptions to step therapy for serious or complex conditions	M
2023	SB23-002	Coverage of community health worker services	M
2023	SB23-222	Removed copayments for pharmacy and outpatient services	M
2023	SB23-288	Coverage of doula services	B

2023	SB23-289	Community Medicaid Benefit / Community First Choice—new LTSS options in community settings	B
2024	HB24-1038	High-acuity crisis services for children and youth	M
2024	HB24-1045	Expanded and standardized treatment for substance use disorder	M
2024	HB24-1322	Coverage of housing and nutrition supports; coverage for incarcerated individuals prior to release (1115 waiver)	M
2024	HB24-1384	Required exploration of CCBHCs and application for CCBHC Demonstration	M
2024	SB24-110	Exceptions to preferred drug list for antipsychotic medications	M
2024	SB24-116	Discounted care for indigent patients	M
2024	SB24-168	Continuous glucose monitor coverage aligned with Medicare; includes gestational diabetes	M
2024	SB24-175	Choline supplements coverage for pregnant people	B
2025	SB25-042	Expanded inpatient mental health services through 1115 waiver	M
2025	SB25-183	Coverage of abortion care using state-only funds	B
2025	SB25-296	Coverage for breast cancer examinations	B

Office of Community Living Benefit Expansions

Long-Term Services and Supports, or LTSS, are a subset of Colorado Medicaid benefits that serve older adults and people with disabilities who need help with daily activities and/or ongoing supervision. LTSS includes both institutional care, like nursing facilities and Intermediate Care Facilities, and a broad set of home and community-based services (HCBS) delivered through HCBS waivers and the Community First Choice State Plan option.

Over the past five years, LTSS has expanded primarily through investments in the HCBS system, growth in waiver enrollment, and new community-based benefit options, all built incrementally through JBC and General Assembly action each fiscal year. With the Committee's support, the state has invested hundreds of millions of dollars in LTSS, particularly HCBS, increasing direct care worker wages and reducing turnover and vacancies so that more members can actually access services. Overall, LTSS costs have risen since FY 2020-21, driven by provider rate increases, increased utilization of services by members, and more people qualifying for and enrolling in LTSS. HCBS waiver enrollment continues to grow, particularly in higher-acuity waivers such as the Developmental Disabilities (DD), Children's Habilitation Residential Program (CHRP), and Brain Injury (BI) waivers, and the JBC has repeatedly authorized additional DD waiver slots to bring people off the waitlist into comprehensive community services. These expansions reflect a multi-year pattern where each year's budget decisions build on prior investments.

Colorado has also expanded how LTSS are delivered. Roughly four out of five LTSS members are now served in the community rather than in nursing homes. The new Community First Choice benefit—authorized by the General Assembly—moves core in-home supports into the State Plan with an enhanced federal match, helping sustain and, in some cases, expand access to personal care, homemaker, and health maintenance services. Because a small share of Medicaid members using LTSS now account for a large share of total Medicaid spending, HCPF's current sustainability efforts are focused on moderating growth in specific high-cost LTSS benefits while preserving the core LTSS package and the progress we have made together with the JBC in expanding community-based services over time.

Outlined below are the key legislation and budget requests that have significantly impacted eligibility and benefit expansion in LTSS.

Legislation / Budget Action	HCBS Waiver / Population	Change Implemented
HB18-1407	DD/Individuals with an intellectual and/or developmental disability	Increased certain HCBS I/DD waiver rates with a required pass-through to direct care workers' wages. Directed enrollment of 300 people from the DD waitlist and added requirements for emergency enrollments and reserve-capacity transitions onto the DD waiver from the waitlist.
SB19-195	CHRP/Children at risk of or in out-of-home placement	Add Wraparound services to the CHRP waiver
SB19-197	SCI/Individuals with a Spinal Cord Injury	Continue the HCBS SCI waiver program through 2025
SB19-238	All waivers/Home Care workers	Increase the reimbursement rate for personal care and homemaker service providers
SB21-286	All HCBS	Distribution Federal Funds for Home- and Community-based Services (ARPA)
SB21-038	SCI/Individuals with a spinal cord injury	Expands this waiver statewide
SB21-039	DD, SLS, SCI, Buy-In/Working individuals on HCBS waivers	Elimination of sub minimum wage in Colorado - addition of buy-in program for SLS, DD, SCI, BI
SB 21-210	Elderly, Blind and Disabled	Adds remote supports as an option for PERS under the EBD waiver
HB22-1283	CHRP/Youth Mental Health	Provides operational support for psychiatric residential treatment facilities and qualified residential treatment programs for youth
HB22-1114	BI,CMHS, CIHS, DD, EBD, SLS, State SLS/ Non-Medical Transportation	Adds transportation network company as provider of non-medical transportation

Legislation / Budget Action	HCBS Waiver / Population	Change Implemented
HB18-1407	DD/Individuals with an intellectual and/or developmental disability	Increased certain HCBS I/DD waiver rates with a required pass-through to direct care workers' wages. Directed enrollment of 300 people from the DD waitlist and added requirements for emergency enrollments and reserve-capacity transitions onto the DD waiver from the waitlist.
SB19-195	CHRP/Children at risk of or in out-of-home placement	Add Wraparound services to the CHRP waiver
HB22-1068	CES, CHRP, SLS Members utilizing equine therapy	Allows for Medicaid reimbursement of Equine therapy through state plan
R10	All waivers/HCBS Providers	Provider Rate Adjustments including targeted rate increases
R9	All waivers/ OCL Program Enhancements	OCL program enhancement including: • expanded Home Delivered Meals (HDM) program, • increased rate for Transitional Living Program (TLP) • aligned rates for the same service across waivers, • created a negotiated rate for Supported Living Program (SLP), • and maintained current funding for state-funded programs for people with an IDD.
SB23-289 (JBC)	Community First Choice Benefit (CFC)	Adds CFC to state plan which expands access to certain HCBS to a larger population
BA-7	Community-Based Access to Care	In response to DOJ findings. Initiatives focus on providing more information to members on their options to prevent institutionalization.
R5	DD/Developmental Disabilities Waiver	Increased funding for reserved capacity & emergency enrollments

Legislation / Budget Action	HCBS Waiver / Population	Change Implemented
HB18-1407	DD/Individuals with an intellectual and/or developmental disability	Increased certain HCBS I/DD waiver rates with a required pass-through to direct care workers' wages. Directed enrollment of 300 people from the DD waitlist and added requirements for emergency enrollments and reserve-capacity transitions onto the DD waiver from the waitlist.
SB19-195	CHRP/Children at risk of or in out-of-home placement	Add Wraparound services to the CHRP waiver
R7	All waivers/HCBS Providers	Across the board increase, HCBS direct care worker base wage, Non-Medical Transportation increase
R10	CES, CHRP/ Children with co-occurring disabilities	Expand respite services for CES and CHRP waivers to include Skilled and Therapeutic Respite
HB24-1229	Potential LTSS members	Presumptive Eligibility
R10	Members with nursing services	Implementation of third party reviews for nursing services
R6	All waivers	Provider Rate Adjustments
SB25-226	CIHS/Members living with a primary condition resulting in total inability for independent ambulation	Extends the Complementary and Integrative Health (CIH) HCBS waiver until 2030
HB25-1003	CwCHN/Children with complex health needs	Merge the Children's Home and Community Based Services (CHCBS) waiver with the Children with Life Limiting Illness (CLLI) waiver - expanding access to HCBS.

Legislation / Budget Action	HCBS Waiver / Population	Change Implemented
HB18-1407	DD/Individuals with an intellectual and/or developmental disability	Increased certain HCBS I/DD waiver rates with a required pass-through to direct care workers' wages. Directed enrollment of 300 people from the DD waitlist and added requirements for emergency enrollments and reserve-capacity transitions onto the DD waiver from the waitlist.
SB19-195	CHRP/Children at risk of or in out-of-home placement	Add Wraparound services to the CHRP waiver
R11	CHRP, EBD, CIHS, DD, SLS/ OCL Benefits	Included: • CHRP Group Respite • Hospital Backup Unit Eligibility expansion • ACF tiered rates • CIHS Waiver extension (SB25-226) • Supported Employment pilot

156. [Rep. Taggart, Rep. Sirota, Sen. Kirkmeyer] How would the proposed legislation to reduce the growth of the Department work? How can you cap the growth of entitlement program? Is the Department asking the JBC to carry this bill?

RESPONSE: The Polis Administration proposes to establish a spending target that creates a predetermined goal and better alignment between HCPF and the General Assembly in managing Medicaid expenditures in FY 2027-28 and beyond. It also establishes more transparent expectations across stakeholders. We propose that the target be 5.6% in FY 2027-28. This factor aligns with Medicaid General Fund cost trends averaging a more sustainable 6% annually between 2015-16 and 2018-19. This compares to the unsustainable cost growth trends ranging between 12% and 26% over the last four years, with a four-year average of 19% growth.

The Polis Administration proposes the spending target more closely parallel the TABOR growth rate in out years (on average 4.4% over the last 10 years). This initiative would create a more appropriate distribution of available General Fund across all departments and General Assembly priorities, and address our reality, which is: Medicaid cost trends are crowding out the rest of the state budget.

Fiscal Year	Year End General Fund (in millions)	*Percent Growth*	*General Fund Actuals Growth*
FY 2014-15	$2,210.6	22%	$404.1
FY 2015-16	$2,364.0	7%	$153.4
FY 2016-17	$2,407.5	2%	$43.5
FY 2017-18	$2,679.6	11%	$272.1
FY 2018-19	$2,824.8	5%	$145.2
FY 2019-20	$2,822.5	0%	($2.3)
FY 2020-21	$2,556.6	-9%	($265.9)
FY 2021-22	$2,865.7	12%	$309.1
FY 2022-23	$3,452.3	20%	$586.6
FY 2023-24	$4,362.0	26%	$909.7
FY 2024-25	$5,082.5	16%	$720.5

A growth target does not change the federal statutory requirements that make Medicaid an entitlement program. This proposal would not put a hard cap on HCPF expenditures, nor would it remove or lessen HCPF's over-expenditure authority. Under this mechanism, HCPF would leverage the Medicaid Sustainability Framework, proposing programmatic changes to drive down Medicaid cost trends to the growth target, which HCPF would aim to meet as part of its annual budget proposal. The legislature would then appropriate Medicaid funding in the Long Bill, which could be above or below the target amount. After the Long Bill is signed, HCPF would be able to use its authority to manage spending to the appropriated level, minimizing the need for supplemental requests or overexpenditures.

The target would provide a more transparent picture of how Medicaid expenditures factor into future Administrations' balancing, and it will give the General Assembly more visibility into the long-term effect of each year's budget decisions. It will also help HCPF work collaboratively with the General Assembly to restrain new Medicaid policy considerations within these expected and agreed upon growth targets, while setting shared, transparent expectations across all stakeholders.

The Polis Administration would support JBC-sponsored legislation that establishes a specific growth target level. The mechanism would build on existing HCPF authority at section 25.5-1-120(1)(c), C.R.S. to implement mid-year payment changes aimed at holding spending to the agency's appropriations that were allotted based on their forecast. While this does not remove or lessen HCPF's overexpenditure authority when actual caseload or utilization is higher than forecast, it will further clarify HCPF's authority to make mid-year policy adjustments to control overall expenditures and remain on a sustainable growth trend.

157. [Sen. Kirkmeyer] What criteria did HCPF use to determine that administrative reductions would be limited to minor trims while proposing substantially deeper cuts to hospitals and Medicaid service providers?

RESPONSE: Given the budget situation, HCPF was required to propose significant expenditure reductions. Approximately 96% of HCPF funding goes directly to pay providers for services provided to eligible members. Reductions to administrative costs, while necessary, are not nearly sufficient to balance the budget. Further, the administrative challenges facing Medicaid programs across the nation are going up, due to the provisions in H.R.1 - including work requirements, eligibility determinations every six months, growing inquiries by the CMS, increasing federal audits and federal mandates around IT infrastructure. The federal government is providing a significant match - at 90/10 - to build the systems to administer these significant changes. The state 10% match is needed, covering FTE, contractors and ultimately systemic advances are necessary to comply with federal directives and compliance requirements.

Overall, most of HCPF's administrative funding pays for systems necessary to administer the Medicaid health plan and the other programs the HCPF administers. This includes technology contracts and systems (such as claims payment, eligibility determination, and care and case management systems); county eligibility administration; prospective and retrospective cost controls; fraud, waste, abuse programs; provider network management; member and provider call centers; actuarial and underwriting services; CMS compliance and reporting; state compliance and reporting; and more.

Most of these administrative expenditures receive *enhanced* federal match rates, often 75% or 90%, for critical functions such as claims and eligibility systems, program integrity, CMS-mandated reporting. Because the federal government covers a very large share of these costs, reductions to administration yield comparatively small General Fund savings.

In addition, CMS requires states to maintain adequate administrative and operational capacity to ensure program integrity, accurate eligibility determinations, timely claims payment, federal reporting, and other core functions. Reducing these capacities could place HCPF at risk of non-compliance, financial penalties, or loss of federal funding. Many administrative functions are also tied to federally certified systems and

service-level requirements that cannot be quickly scaled down without jeopardizing program operations or violating federal rules. While some reductions to these administrative expenses are necessary, many of these functions serve to reduce state costs. For example, HCPF could reduce administrative expenditure by paring back utilization management contracts, but would immediately see a significant increase in utilization costs, far offsetting all administrative savings.

Still, to achieve administration savings, HCPF reached out to contracted vendors to seek reductions, as this is the largest portion of HCPF's administration. (HCPF is now working through those responses.)

HCPF continues to look for other operational efficiencies, recognizing the challenges of the state's budget and the importance of all parties, including HCPF, to do what we can to be part of the solution. HCPF may use the regular budget process into the future to account for further reductions.

158. [Rep. Amabile] The JBC staff provided a simplified graph showing the growth of General Fund appropriations for administration compared to General Fund appropriations for the entire department. Can you refine this to include the payments to the RAEs for administration, the administrative appropriations to the Office of Community Living, and any other "administration" that the initial analysis didn't capture?

RESPONSE:

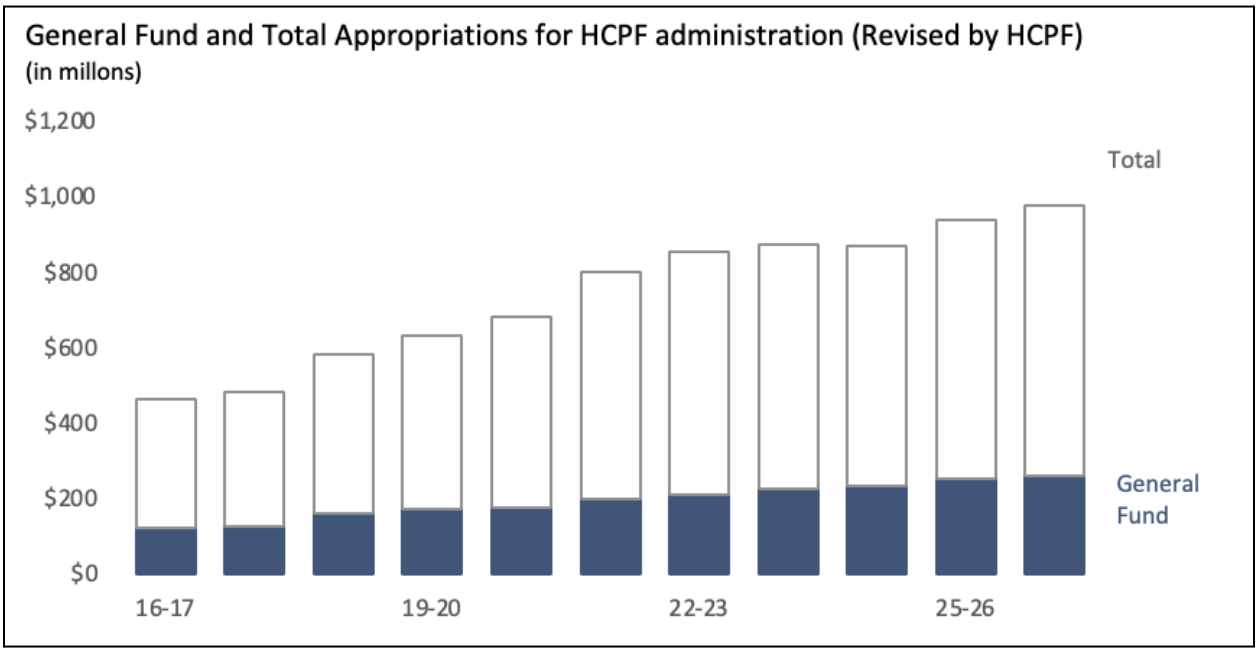
For FY 2025-26, HCPF's administrative budget in total funds is 3.83% of its department-wide budget. HCPF does not include payments to RAEs in this calculation because those payments for medical services as reflected in HCPF's appropriation, reporting to CMS, and in the federal match we receive for payments to RAEs.

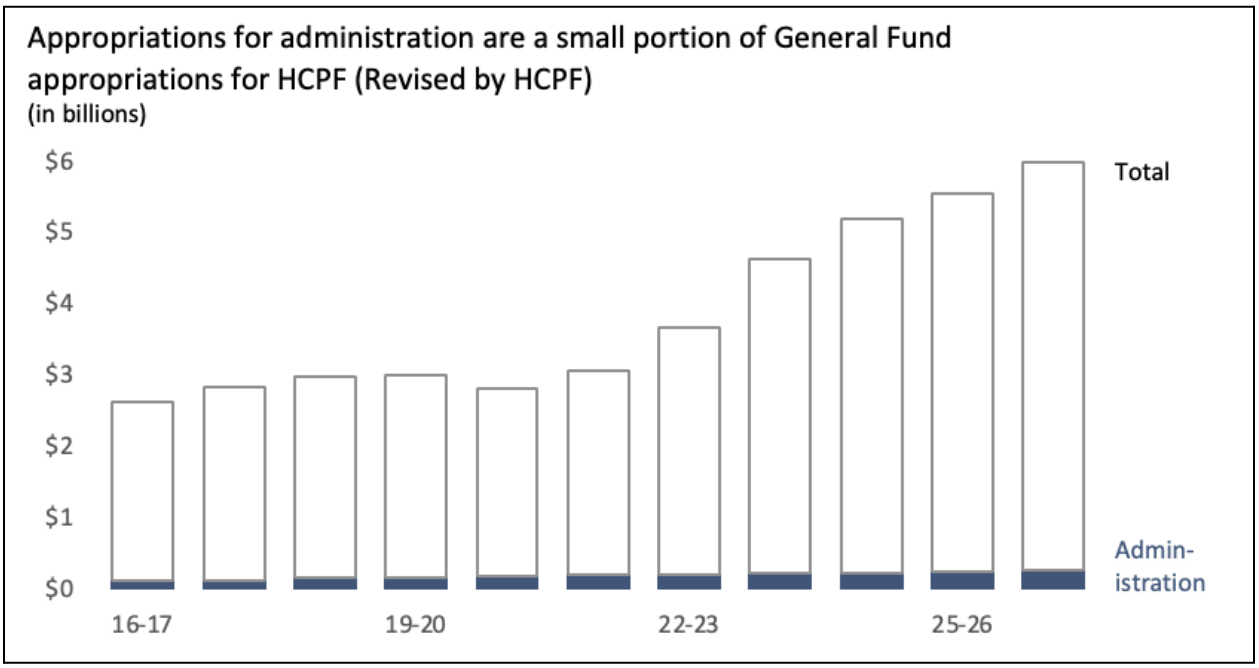
JBC staff presented various graphs detailing HCPF's administrative appropriations, which included only HCPF's Executive Director's Office (EDO) administrative appropriations. Specifically, HCPF was asked to update the graphs showing administrative General Fund growth instead of total funds. HCPF updated JBC staff's graphs to also include administrative appropriations related to payments to the RAEs, Office of Community Living, Children's Basic Health Plan Administration, Public School Health Services Contract Administration, and Payments to the Department of Human Services and other Departments for Medicaid Funded Programs. On average, over the past 11 years, these additional administration appropriations outside of the EDO account for 2.38 percent of HCPF's General Fund administrative budget each year.

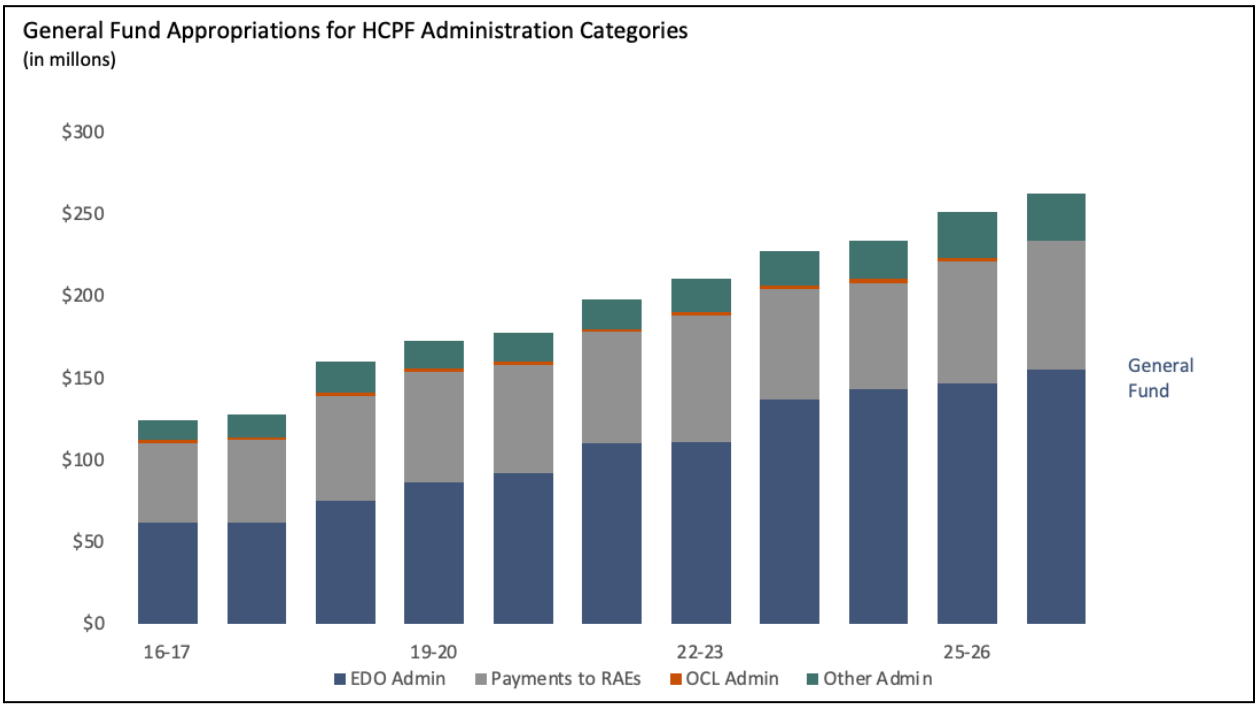
The updated graphs continue to show that appropriations for administration are a very small portion of HCPF's General Fund budget and a very small driver of the General Fund growth in absolute dollars. In FY 2025-26, General Fund appropriations for administration, including the RAE payment, represent 4.52 percent of the total

General Fund appropriations for HCPF. When excluding the RAE administrative payment, HCPF administration is only 3.17 percent of General Fund appropriations in FY 2025-26. Furthermore, of the entire administrative budget of $938,337,480 total funds in FY 2025-26, only 26.73 percent, or $250,803,582 is appropriated from the General Fund. HCPF included a third graph to show the breakout of administrative General Fund appropriations by category.

HCPF is able to leverage the standard (50%) federal financial participation rate for most administrative activities, but additionally draws down an enhanced match of 75% or 90% where applicable. This helps keep the General Fund appropriations for administrative functions relatively low compared to total funds, with the General Fund appropriated at an average of 26.36 percent of total administrative funds over the past 11 years.







[9]

Note: the FY 2026-27 bar reflects the Department's R-19 budget request that would consolidate the Office of Community Living with the Department's EDO administrative line.

[9] Note: the FY 2026-27 bar reflects the Department's R-19 budget request that would consolidate OCL with the Department's EDO administrative line.

159. [Sen. Kirkmeyer] How have the Department's administrative expenses paid from the hospital provider fee change over time compared to expenditures for the eligibility expansions and supplemental payments.

RESPONSE:

The administrative expenses for the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), including administration related to health care coverage financed by CHASE, have grown at an annual rate of 7.7% since the CHASE enterprise was created in 2017 via SB 17-267. This rate is similar to the growth rate for both the health care coverage expenditures financed by CHASE and hospital supplemental payments, 6.0% and 7.6% respectively.

Many of the administrative expenses associated with a health plan increase in correlation with rising claims, such as claims processing expenses; provider call centers; member call centers; prospective and retrospective utilization management; fraud, waste, abuse work and the like. IT costs associated with Medicaid systems nationally (i.e.: MMIS, CBMS) have also risen at outlier rates.

The administrative expenses, as a percentage of total enterprise expenditures, historically range between 2.0% and 2.6%, which complies with the statutory limit of 3%, pursuant to section 25.5-4-402.4(4)(a)(III), C.R.S.. This administration allocation is less than the administrative percentage allocation to the balance of the safety net programs administered through HCPF.

CHASE Program Expenditures in Total Funds

Fiscal Year	Administration	*YOY Growth (%)*	Supplemental Payments	*YOY Growth (%)*	CHASE Financed Health Care Coverage	*YOY Growth (%)*	Admin % of Total Program Expenditures
FY 2017-18	$78,031,479	-	$1,223,040,805	-	$2,113,371,606	-	**2.3%**
FY 2018-19	$79,490,424	*1.87%*	$1,509,350,628	*23.41%*	$1,854,362,399	*-12.26%*	**2.3%**
FY 2019-20	$89,371,631	*12.43%*	$1,301,505,398	*-13.77%*	$2,021,582,570	*9.02%*	**2.6%**
FY 2020-21	$79,361,412	*-11.20%*	$1,408,300,308	*8.21%*	$2,453,559,680	*21.37%*	**2.0%**
FY 2021-22	$89,062,893	*12.22%*	$1,465,075,472	*4.03%*	$2,965,256,856	*20.86%*	**2.0%**
FY 2022-23	$106,004,010	*19.02%*	$1,769,662,779	*20.79%*	$3,368,575,226	*13.60%*	**2.0%**
FY 2023-24	$124,427,613	*17.38%*	$1,696,739,252	*-4.12%*	$3,107,054,694	*-7.76%*	**2.5%**
FY 2024-25	$131,302,311	*5.53%*	$1,837,191,208	*8.28%*	$3,530,635,125	*13.63%*	**2.4%**
Yearly Growth		***7.7%***		***6.0%***		***7.6%***	

Source: CHASE Update, November budget submissions

* Note the yearly growth is a compount rate for the entire period, not an average of each individual year's growth rate.

160. [Rep. Brown] Why have General Fund appropriations for administration been growing faster in recent years?

RESPONSE:

HCPF's General Fund appropriations for administration have grown more quickly in recent years due to a variety of factors. All administrative increases have been approved and appropriated by the General Assembly via budget requests or new legislation. Between FY 2018-19 and FY 2025-26 Governor's Request, HCPF administration has grown from about $75 million General Fund to $176 million General Fund.

HCPF administers many programs, and each new initiative HCPF is tasked with adds a level of administrative funding to manage. There are several areas of the budget that are significant drivers to the increase:

Personnel

HCPF received roughly $16 million in General Fund increases in personnel costs since FY 2018-19. HCPF has been tasked with implementing and operating many new programs and initiatives, and to do that the General Assembly has appropriated additional FTE. A significant contributor to the personnel rise is related to HCPF's efforts to convert a significant portion of contractor dollars to FTE, since FTE cost less than contractors and are more agile in responding to the constantly changing landscape. This places the expertise with HCPF rather than a vendor, while also being budget neutral or better.

HCPF has also received staff to support large initiatives, such as the modularization of the Medicaid Management information Systems (MMIS), 1115 Waiver work and to support HCPF's settlement with the DOJ. Additionally, statewide common policies, such as the implementation of a step pay plan, is a driver in HCPF's increases in personnel costs. As well, 80% of the FTE added following the FY 2018-19 Long Bill, HB 18-1322, were from new state laws and federal compliance needs.

Medicaid Management Information Systems (MMIS)

The budget for HCPF's claims processing system, known as the MMIS, has increased roughly $7.5 million General Fund since FY 2018-19. A significant driver of that increase is due to the federally required modularization of the system. Breaking a single module into many requires typically more expensive contracts and vendors to help integrate all the vendors. Other federal requirements, such as interoperability have also driven increases to the budget. Additionally, HCPF has incorporated Behavioral Health Administration (BHA) claims into its MMIS and that ongoing maintenance has added more than $1 million to the budget. Incremental

improvements, including cost-savings initiatives, also drive significant work in the MMIS in both development and ongoing operational costs.

Development and operations costs for the MMIS receive high federal match rates that help offset the high cost of technology development. Costs for the design, development, and implementation of claims systems receive a 90% federal match, meaning that for each dollar the state invests, the federal government provides nine additional dollars. Costs for ongoing operations receive a 75% federal match.

Colorado Benefits Management System (CBMS)

Similarly to above, the General Assembly has made significant investments in the state's eligibility processing system, the Colorado Benefits Management System (CBMS). While policy changes approved by the General Assembly drive annual costs to CBMS, there have been a few big investments that have largely driven the roughly $6.5 million General Fund increase since FY 2018-19. For example, Office of Information Technology (OIT) common policy rate changes have driven over $1.5 million in increases, while enhancement funding for BHA programs is nearly another $1.0 million. Recent budget cycles have also added nearly $500K in ongoing costs from the FY 2025-26 CBMS and County Administration request. The largest increase was in FY 2019-20 where the legislature made $3.6 million General Fund in ongoing funding to support the new cost allocation methodology which shifted funding from CDHS over to HCPF. This shift was budget neutral to the state as CDHS saw a corresponding reduction.

County Administration

The General Assembly has made significant investments in the counties as part of the County Administration line item. The counties play a significant role in Medicaid - and other state public assistance programs - in that they are on the front lines of determining eligibility for members, particularly in complex cases. General Fund increases have totalled about $10 million General Fund since FY 2018-19. During the Public Health Emergency, this line item received several infusions of funding, but this was temporary and did not impact the base level funding. The General Assembly did, however, approve three significant budget actions that increased the base level of funding to the counties. Those include $1.5 million in FY 2019-20 to create a county incentive program, $4.0 million General Fund in FY 2022-23 to help reduce the funding shortfall to the counties as well as increase the incentive program, and $2.6 million General Fund in FY 2025-26 to further right size the county funding model in accordance with recommendations in SB 22-235.

Other Administrative Costs

HCPF receives appropriations in other line items to implement a number of initiatives that fall outside of specialized areas such as systems, audits, and other routine administrative costs. While much of the funding is term limited and there are inflows and outflows which ultimately keep the base appropriation relatively stable, there have been some funding initiatives that have been appropriated ongoing. Some examples include funding with the purpose of controlling Medicaid costs. SB 18-266 "Controlling Medicaid Costs" appropriated $600K General Fund ongoing. Funding targeted at driving value to the state included FY 2022-23 appropriations to create and support value-based payment methodologies ($1 million). Lastly, a driving factor in the increase is related to HB 22-1289 "Health Benefits For Colorado Children And Pregnant Persons". That bill provided $3.7 million General Fund ongoing to provide consulting and outreach services to the community regarding the program.

Transfer to Other Agencies

HCPF also has administrative funding that ultimately goes to other agencies to cover the Medicaid-related costs for their programs. As the state looks for ways to leverage federal Medicaid funding for programs operated by other agencies that serve Medicaid members, funding is able to be passed through HCPF after drawing down the federal match. Agencies that draw down an administrative match through HCPF include: Department of Education, Department of Human Services, Department of Local Affairs, and Department of Public Health and Environment.

161. [Sen. Kirkmeyer] What administrative efficiencies, vendor reductions, or internal process reforms did HCPF evaluate before deciding that provider rate cuts were necessary?

RESPONSE:

Ninety-six percent of HCPF's expenditures go to pay care providers for caring for Medicaid and CHP+ covered beneficiaries. There is no circumstance where admin reductions could address the significant financial challenges facing the state.

To evaluate administrative savings opportunities concurrent with other cost-savings alternatives, HCPF has asked its vendors to propose reductions to existing contracts and scopes of work. Contracted vendors represent the largest component of HCPF administrative spending. Letters were sent to vendor partners seeking reductions. HCPF is working through the responses to quantify savings opportunities.

HCPF is also working with CDHS on modernization reforms to County Administration that will improve efficiencies over time while also mitigating risk of federal clawbacks and cost shares due to performance compliance challenges. These modernizations will

also drive better controls in overexpenditures on those lines. In the area of eligibility determination, HCPF is also collaborating with CDHS to drive CBMS ecosystem modernizations, which are projected to reduce eligibility ecosystem maintenance costs over the long term, once the modern systems are operational.

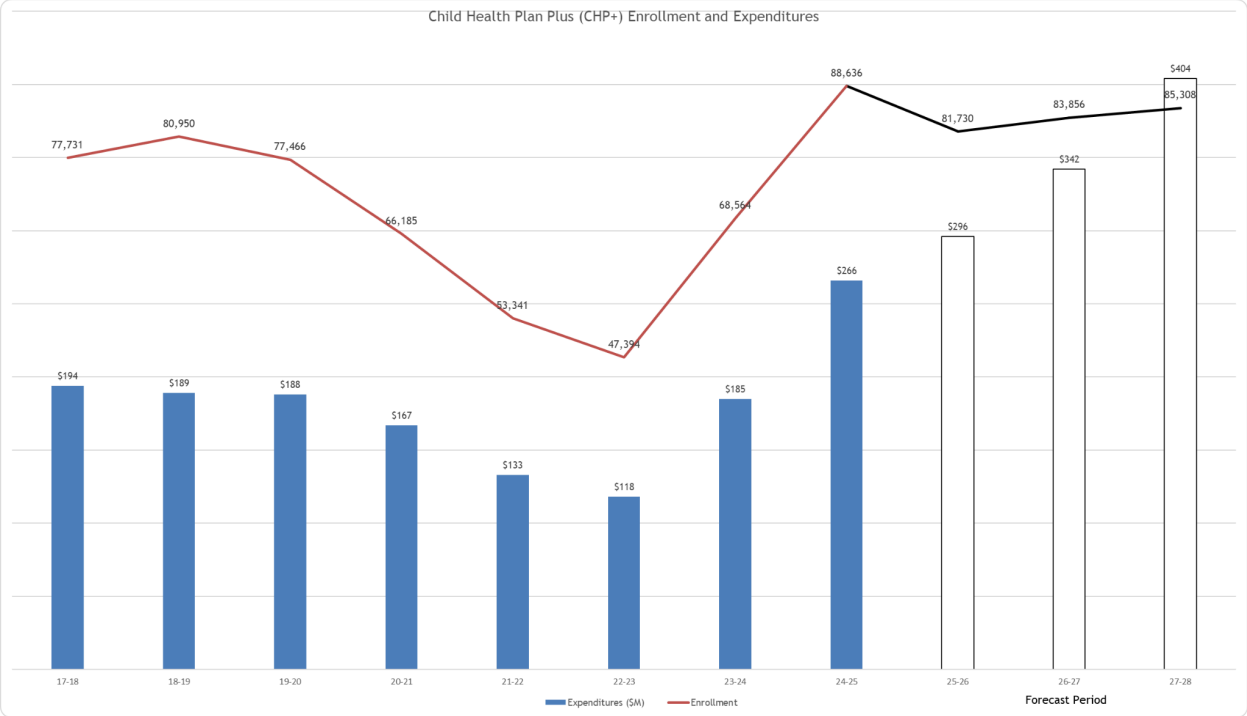
In FY 2024-25, HCPF reduced its workforce by 10 FTE. Other internal administrative efficiencies we are pursuing include: hiring freeze in place through January 1; reviewing all vacancies to revise positions to meet current business needs and rolling out the use of Artificial Intelligence, including Generative AI use, within state guidelines to drive internal efficiencies and share best practices; driving efficiencies in structure related to implementing administration requirements associated with H.R. 1, such as work requirements and eligibility determinations every six months.

HCPF continues to look for other operational efficiencies. We recognize the challenges of the state's budget and the need for all parties, including HCPF, to take reasonable actions to better control costs. In the future, HCPF may use the regular budget process to account for further reductions.

162. [Rep. Brown and Rep. Taggart] Why does the Department project expenditures for the Child Health Plan *Plus* (CHP+) will increase so much faster than enrollment? What drives the dramatic projected increase in per capita expenditures? What could the legislature do to slow the growth in per capita expenditures?

RESPONSE: HCPF is not projecting expenditure for CHP+ to increase much faster than enrollment. The 60 percent increase shown in JBC staff's briefing was the result of a technical error in HCPF's CHP+ historicals exhibit submitted on October 31. FY 2023-24 actuals were inadvertently carried forward into the FY 2024-25 actuals column, which understated FY 2024-25 actuals. Correcting this shows FY 2024-25 actuals at approximately $266 million rather than $185 million, resulting in a projected year-over-year growth rate from FY 2024-25 to FY 2025-26 of about 11 percent rather than 60 percent. This historical correction does not affect the forecasted values for FY 2025-26 through FY 2027-28. The actuals will be corrected in the upcoming forecast submission.

The higher forecasted expenditures is due to projected increases in the capitations, especially with changes in acuity as enrollment decreases. As enrollment decreases, the higher acuity children take up a larger proportion. The growth added in the future years to the rate is about the same as the actual rate growth from last year to this year, basically holding the growth rate constant. CHP+ enrollment has experienced significant fluctuation due to the Public Health Emergency (PHE) Continuous Coverage provision. Enrollment decreased during the PHE, increased back to pre-pandemic enrollment levels with the end of the PHE, and recently has begun to decline again. The CHP+ population frequently changes in the opposite direction of the Medicaid population; it can grow in strong economies as Medicaid enrollment decreases and incomes rise, while it can fall during economic downturns as more people become eligible for Medicaid.



163. [Sen. Kirkmeyer] How many federal funds did Colorado miss out on by not claiming the 90 percent federal match for emergency services to noncitizens newly eligible pursuant to the Affordable Care Act? What is the Department's legal rationale for using the hospital provider fee to pay the state share, rather than the General Fund, since the hospital provider fee statutes do not specifically mention emergency services to noncitizens?

RESPONSE:

Noncitizens Emergency Services (NCES) is for individuals who would have qualified for Medicaid other than meeting citizenship. NCES reflects the services the individual is able to receive under Medicaid and is not an eligibility category. These NCES individuals are ACA expansion members whose services are limited to emergency services.

When HCPF recognized the opportunity, additional federal funds were pursued and HCPF claimed the available enhanced federal match for FY 2023-24 and FY 2024-25, or eight quarters in arrears, as allowable under the federal two-year timely filing limit.

Beginning in FY 2013-14 through FY 2022-23, HCPF could have drawn federal funds under the federal match rate associated with the Affordable Care Act (ACA) for NCES individuals at an average of $6.6 million each year. During the same time, HCPF drew

an average of $18.2 billion in federal funds for coverage for members whose care is financed with hospital provider fees. The federal funds not claimed equals 0.34% of the federal funds drawn for expansion members.

164. [Rep. Taggart] What is the return on investment (ROI) for recent state expenditures for information technology? Can the Department demonstrate that we are saving money? Is developing a ROI analysis a regular part of the Department's approach to information technology?

RESPONSE:

IT investments in HCPF are made within a rigorous federal and state regulatory framework that directly dictates how and when systems must be modernized. Federal and state procurement rules require states to re-procure or replace major system components at least every 10 years to ensure continued competition, avoid vendor lock-in, and promote modularity and innovation across the Medicaid Enterprise. In addition, federal mandates such as the CMS Interoperability and Patient Access Rule require states to adopt modern, standards-based data exchange capabilities; emerging federal legislative directives such as provisions included in H.R. 1 and other federal program integrity and modernization initiatives further require states to implement updated technology to improve data sharing, eligibility oversight, and member experience. Compliance with these requirements is not optional; it is a condition of receiving and maintaining the enhanced federal financial participation (90 percent for system development and 75 percent for operations). To qualify for this enhanced match, HCPF must demonstrate to CMS and other federal partners through its Advance Planning Documents and ongoing reviews that each IT investment is cost-effective, modular, outcomes-driven, and aligned with federal standards and conditions. If HCPF fails to meet the federal requirements or cannot demonstrate continued cost-effectiveness, HCPF will not qualify for enhanced match funding from CMS.

HCPF evaluates ROI not only through operational efficiencies but also through required CMS operational reporting and performance metrics, which directly influence the state’s continued access to enhanced federal match. Per (42 CFR 433.112(b)(15) and 433.116(b), (c), and (i)) States’ Medicaid Enterprise Solutions (MES) must produce data, reports, and performance information that would contribute to program evaluation and continuous improvement in business operations as a condition of enhanced Medicaid federal matching for MES expenditures. CMS requires states to submit monthly operational reports demonstrating whether these systems and modules facilitate more efficient, economical, and effective administration of the program. These metrics are used by CMS to assess whether IT investments are

producing the intended improvements to the Medicaid program and whether the system remains eligible for the enhanced federal match. If system performance declines or required metrics are not met, CMS may request corrective action or reduce the federal match rate, making these reporting requirements a core component of HCPF's ROI assessment and accountability framework.

Recent modernization efforts have helped HCPF meet and improve these federal metrics by reducing manual processing, decreasing rework, improving data quality, and expanding automation allowing staff to redirect time toward higher-value activities. While the resulting efficiencies may not always produce direct budgetary savings, they create significant capacity gains and support compliance with the federal reporting and performance standards necessary to sustain enhanced federal participation. Consequently, the value of IT investment is demonstrated through improved efficiency, strengthened compliance, and protection of the state's access to federal funding.

165. [Rep. Taggart] Are there investments in technology that the JBC should consider to save on administrative expenses, not just to comply with federal regulations?

RESPONSE:

Yes. HCPF is actively pursuing several technology investments beyond those required for federal compliance. HCPF is identifying and pursuing technology investments that will lower administrative costs, reduce manual workload, improve program integrity, and improve payment accuracy across these three initiatives: AI-supported documentation review, identifying opportunities for prepayment edits, and expanding ClaimsXten optimization, and reimagining the CBMS ecosystem. These efforts reflect a proactive strategy to modernize operations and improve fiscal stewardship beyond what federal regulations require.

1. AI-Supported Technology to Reduce Manual Document Reviews

One of HCPF's highest administrative burdens is the manual review of medical records and supporting documentation during pre- and post-payment audits, for example reviews of non-emergent medical transportation trip logs or case management records for HCBS services, and other documentation review efforts to determine the accuracy of claim payments. These reviews currently require staff to examine documentation line-by-line for every single claim to verify service accuracy and appropriateness.

To address this burden, HCPF is evaluating new technology solutions, including generative AI and advanced document-processing tools, that can perform an initial automated review when auditors upload case documentation. These tools could

identify missing or inconsistent documentation, flag improper billing patterns, assign risk scores, and highlight areas requiring targeted human review.

By shifting staff time away from extensive manual review toward only the highest-risk cases, this approach has the potential to significantly reduce administrative workload, shorten review timelines, and improve recovery outcomes. HCPF is actively assessing tools available through existing vendors and, if appropriate, will conduct a solicitation to evaluate additional solutions. HCPF is also assessing its options to modify its ability to extrapolate findings identified with the use of new technology to further decrease administrative costs and increase recoveries. Following the technology assessment, HCPF anticipates requesting funding to support tool acquisition and the resources needed for implementation.

2. Maximizing Cost Avoidance through Prepayment Edits and Conducting Efficient Postpayment Recovery Audit Contractor Audits

HCPF is also working with its claims processing vendor, Gainwell, and the Recovery Audit Contractor (RAC), Health Management Systems (HMS) to identify review activities that would be better conducted as automated prepayment edits within the Medicaid claims system versus potentially more labor-intensive postpayment recoveries.

Shifting more reviews to the front end of the claim's lifecycle would allow HCPF to automatically detect high-risk or noncompliant claims before payment occurs. This represents a strategic, non-federally mandated technology investment that directly reduces administrative expenses by:

- Focusing on manual reviews where they can be most effective
- Avoiding costly post-payment recovery and recoupment activities when prepayment audits would be more efficient
- Ensuring earlier, more accurate application of payment policy when possible

In its R-10 Administrative True-Up request, HCPF is seeking to reallocate $3 million from the Third-Party Liability (TPL) line to the Medicaid Management Information System (MMIS) line to support the MMIS enhancements required for this work. The request also includes two FTE to develop business rules, manage data-sharing agreements, and coordinate the needed system changes.

3. Ongoing Optimization of the ClaimsXten Payment Accuracy Platform

HCPF implemented the ClaimsXten real-time claims editing platform in 2020 under SB 18-266 to enhance program integrity using standardized clinical and coding validation.

While the platform currently uses a foundational rule set, HCPF has not yet fully leveraged its entire capabilities.

Annual optimization studies now being provided by Gainwell and Lyric, which owns the ClaimsXten software, will consistently identify additional ClaimsXten rule sets that could:

- Further reduce inappropriate payments
- Improve alignment with emerging fraud, waste, and abuse trends
- Strengthen automation of policy-driven payment edits

These recommendations are based on historical claims data, projected savings, and Medicaid policy alignment. As part of the S-7/BA-7 Additional Reductions Package, HCPF has requested ongoing funding to implement new ClaimsXten rules each year and estimates a $13 million total funds cost savings in FY 2026-27 from implementation of the new rules.

Expanding use of ClaimsXten is a cost-effective strategy to automate more of the claim's validation process, reduce reliance on manual post-payment audits, and strengthen fiscal oversight. This is a strategic investment driven not by federal mandate, but by the opportunity to increase payment accuracy and reduce administrative expenses.

4. Reimagining Colorado's benefits eligibility systems

HCPF and CDHS are working with the CoBEES team to develop a plan to reimagine the CBMS ecosystem. Recent assessments of CBMS and PEAK reveal a system that leverages modern components but has become overly complex, inefficient to use, and costly to operate. Both departments submitted a budget request to repurpose funds for CBMS reprocurement and JAI implementation to instead build a new system that provides all the capabilities county workers need in a single, integrated system.

By replacing CBMS and integrating JAI, workflows can be streamlined to improve efficiency and accuracy and programs can make system changes more quickly and cost effectively. Full details of the proposal are available in IT-CC-S/BA-01, and additional details about implementation plans and timelines will be refined through the Planning Sprint, which wraps up in January.

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