COLORADO
Department of Health Care Policy & Financing

CO Medicaid Insights & Potential Federal Medicaid Reduction Impact Estimates

Updated: May 22, 2025

On May 22, the House passed the federal reconciliation package, H.R. 1 by a vote of 215-214-1 and now advances to the Senate, where it will be subject to debate, potential amendments, and scrutiny under Senate rules.

The table below does not provide a full list of all provisions in the House-passed legislation, but rather highlights those with the most potential impact to members, providers and the state budget. Further, particular sections of the bill, such as 44125 and 44126, will potentially evolve as the bill moves through the Senate and becomes subject to the Senate's Byrd Rule. We will continue to update this as the bill progresses. Additionally, many of the fraud, waste and abuse provisions included in the draft are best practices that Colorado already employs within our Medicaid program. We have a fact sheet available on this topic. Additional resources can be found on our website.

Provision	Policy	Member Impact	Colorado Impact	Broader Economic Considerations[1]
Section 44141: Establish Medicaid Work Requirements Affordable Care Act (ACA) Medicaid Expansion Population	Beginning Dec. 31, 2026, states would be required to implement work requirements for the expansion population. Members ages 19-64, who do not meet certain exceptions, would be required to attest to conducting 80 hours per month of community engagement (work, community service or work	The current CO expansion population is 377,019 members - some could be subject to exceptions to the requirement. Verifying if an individual is subject to an exception and if not, documenting they have met the requirement, will drive administrative costs for members, employers and the state.	Assuming similar administrative costs as Arkansas of $152/enrollee, Colorado's **administrative costs could total more than $57 million.** Given Colorado's state supervised, county administered model, implementation of this new requirement would have additional administrative costs to consider. HCPF's fact sheet includes more detail.	CBO provided an original estimation of $280 billion reduction in federal spending over 10 years nationally based on a start date of Jan. 1, 2029. CBO has yet to provide an updated cost estimate based on a Dec. 31, 2026 start date. Increased uninsured rate drives increased uncompensated care for health care providers. Rural hospitals, clinics and others

[1] Estimates are based on CBO analysis titled *Estimated Budgetary Effects of a Bill to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, the One Big Beautiful Bill Act* as ordered reported by the House Committee on the Budget on May 18, 2025. Estimates are subject to change depending on changes to the legislative text. Link

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	program, etc.).	Estimates by national organizations indicate 95-108K Coloradans could lose coverage[2].	More precise implementation costs will be difficult to estimate until federal guidance is available.	with reduced Medicaid reimbursement may have to lay off staff, reduce services, close, etc. 80 hours a month at Denver's minimum wage is just under the income limits; slight changes in work schedules could impact coverage. Given potential changes to tax subsidies on the marketplace, other affordable coverage options may be limited for those losing Medicaid coverage.
Section 44111: 10% FMAP reduction for states offering coverage for certain populations, even if state only funds are used	States who provide financial assistance for health insurance coverage or comprehensive coverage to undocumented immigrants would be subject to the FMAP reductions.	Colorado offers full coverage for children who would be eligible for Medicaid except for their immigration status, using state-only funds, as authorized under HB 22-1289. There were 14,639 children enrolled in CO's state-only program in April 2025. Colorado also provides limited coverage for family planning and related services to all individuals who would otherwise be eligible for Medicaid except for their immigration status, using state-only funds, as originally	The Department was appropriated $32.1 million General Fund for the state-only program for children in FY 2025-26 and $2.6 million General Fund for the family planning program in FY 2025-26. If these benefits were maintained, a reduction to the FMAP for the ACA expansion population by 10 percentage points (from 90% to 80%) would result in **a reduction of over $300 million in federal funds, annually.**	$11 billion reduction over 10 years nationally. This provision only impacts states that offer comprehensive coverage for people without documentation. Individuals previously covered would become uninsured, potentially forgoing preventive care, prescription drugs to treat chronic conditions, related care, and accessing emergency care as needed instead. The lack of insurance will increase uncompensated care and related provider financial strain and uncertainty.

[2] State-by-State Estimates of Medicaid Expansion Coverage Losses under a Federal Work Requirement, Urban Institute, April 14, 2025 available at https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work

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		authorized under SB 21-009. In calendar year 2024, the number of individuals who utilized family planning and related services each month ranged between 842 to 1,219.		
Section 44133: State Directed Payments limited to the Medicare published rate	This provision would cap total directed payments to Medicaid managed care organizations at 100% of the total published Medicare rate. There is a grandfather clause for any arrangement already approved by CMS.	No direct impact to members.	HB 25-1213[3] requires the State to seek federal authorization for a state directed payment up to the average commercial rate. This provision of the bill would reduce the ability to draw down additional federal funds through a state directed payment program and may make it nonviable. If the state is able to gain approval, the Medicare published rate is likely lower than the average commercial rate.	$73 billion reduction over 10 years nationally for the moratorium and limits on provider fee programs.
Section 44142: Cost Sharing for Expansion Population	Beginning in Oct. 2028, expansion population adults earning more than 100% of the federal poverty level would be subject to cost sharing. Certain services are exempt - primary care, mental health care or substance use disorder services. The cost sharing	The current CO expansion population that would be subject to cost sharing is 59,976 members.	Colorado currently only charges a copay for a non-emergent emergency room visit. This provision would require new copays for a subset of the ACA expansion population (those over 100% FPL). The amount would be at the discretion of the states, so the impact is scalable. The copays would result in a reduction to	$13 billion reduction over 10 years, nationally. Because they often can't collect them, copays represent a rate cut for providers and shifts the responsibility to be made whole to the provider. This can have downstream impacts to safety net providers who rely on Medicaid

[3] Updates to Medicaid, Colorado General Assembly, 2025 available at https://leg.colorado.gov/bills/hb25-1213

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	cannot exceed $35 with the total not to exceed 5% of the member's income.		provider payments where applicable. The savings from the increased costs to members and providers would accrue to cash funds and federal funds.	funding and are already feeling economic pressures.
Section 44108: Every 6 month eligibility redeterminations for certain populations	Beginning Dec. 31, 2026, individuals eligible under the ACA expansion must have their Medicaid eligibility redetermined every 6 months versus the traditional 12 months.	The current CO expansion population that would be subject to the biannual redeterminations is 377,019 members. This will result in additional paperwork for members and will increase the number of individuals losing coverage for administrative reasons. Under current eligibility rules, if left unchanged, about 75% of annual renewals for this population can be done through automation (or ex parte) based on information on file or available through third party sources without member engagement. If these rules change, further member impact may result.	Increasing the frequency of eligibility redeterminations from annually to biannually would result in the potential for more members to lose coverage due to administrative reasons if the renewals cannot be done through automation, thereby requiring member action. Counties would also incur far higher costs to complete more redeterminations. Printing and postage costs associated with member correspondence will rise, as will programming costs to restructure and reprogram the state's eligibility system.	$53 billion reduction over 10 years, nationally.
Section 44110: No Federal Funds without verified citizenship	This provision prohibits federal financial participation for any Medicaid or CHP+ expenditures for individuals whose citizenship,	Medical services provided during this period may not be covered while waiting for documentation to verify citizenship status. Members will only have 10 business days (versus the current	This provision would result in shifting the financing for costs incurred during the reasonable opportunity period from Medicaid funding (with a state and federal share) to state-only funds if the	$844 million reduction over 10 years nationally. This provision would increase unpaid claims for providers.

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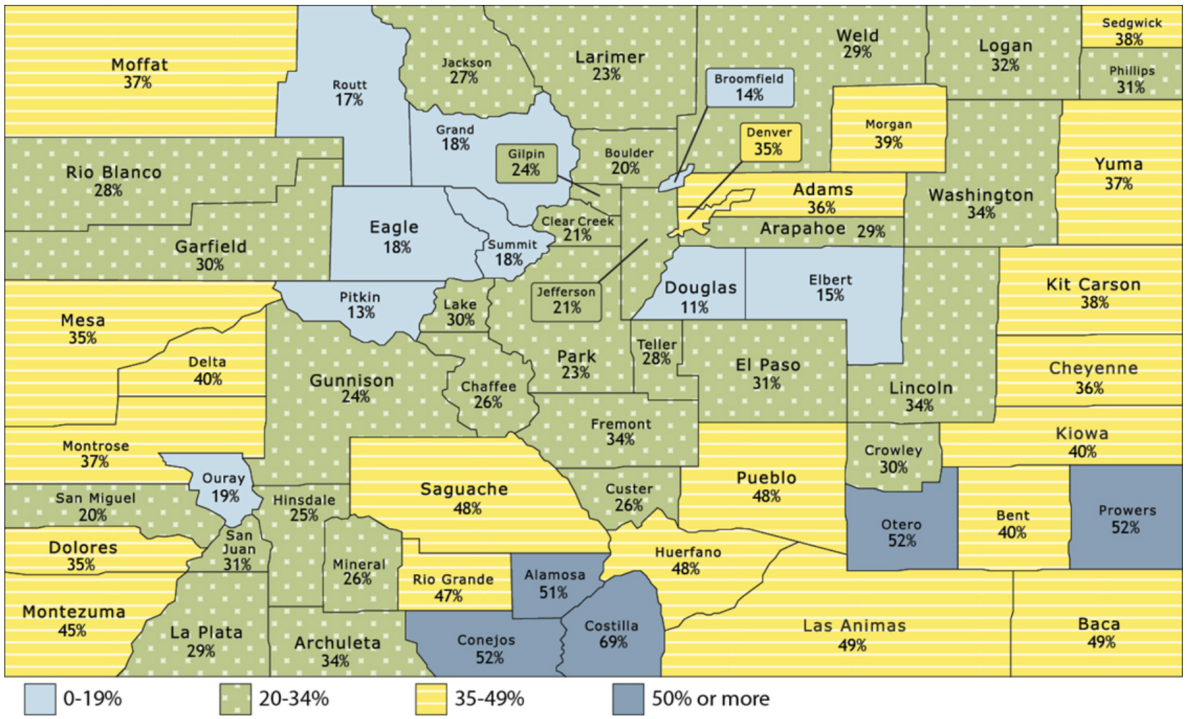
	nationality or a qualifying immigration status has not yet been verified.	90 days) to provide documentation and will be in pending status (versus being approved) during this period.	state continues to provide medical assistance during that time period.	
Section 44122: Modifications to retroactive coverage from three months to one month	For individuals who apply for Medicaid benefits on or after Oct. 1, 2026, this provision reduces the mandatory retroactive coverage period from 3 months to one month prior to the month of application.	All newly enrolled members would potentially have to bear more of the out of pocket costs they may incur for healthcare services received during months they would have been eligible under the current rules.	This provision may result in lower costs to cover members during the retroactive period due to shortening the time period for coverage. Alternatively, it could result in speeding up the time that members apply for and receive coverage as providers, such as hospitals, help facilitate the application process on an expedited timeline.	$6.4 billion reduction over 10 years nationally. This provision would increase unpaid claims for providers.

Who the Colorado Medicaid and Children's Health Insurance Program Covers

As of October 2024, **79,308,002 people** were enrolled in Medicaid and CHIP in the **50 states** and the District of Columbia. This includes **72,058,701 people** enrolled in Medicaid and **7,249,301 people** enrolled in CHIP. Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus* (CHP+) and other health care programs covered 1.31 million individuals as of January 2025, including 22% of Coloradans. Detailed demographics are provided below for the calendar year 2023:

- 55%: adults ages 19-64
- 39%: children, ages 18 and younger
- 6%: adults age 65 and older
- 44% of the state's births were covered by CO Medicaid and CHP+
- 5% of covered Medicaid members were people with disabilities, but more than 40% of Medicaid expenditures financed their care.
- 87% live in urban areas while 14% live in rural or frontier counties, but many rural counties have a far higher percentage of their population on Medicaid and CHP+ (does not total 100% due to rounding)

Percentage of total population enrolled in Health First Colorado and Child Health Plan *Plus*, by county



Source of enrollment data is Medicaid Management Information System (MMIS). Percentages represent people enrolled for one day or more during calendar year 2023. 2023 population data as forecasted by the state demographer.

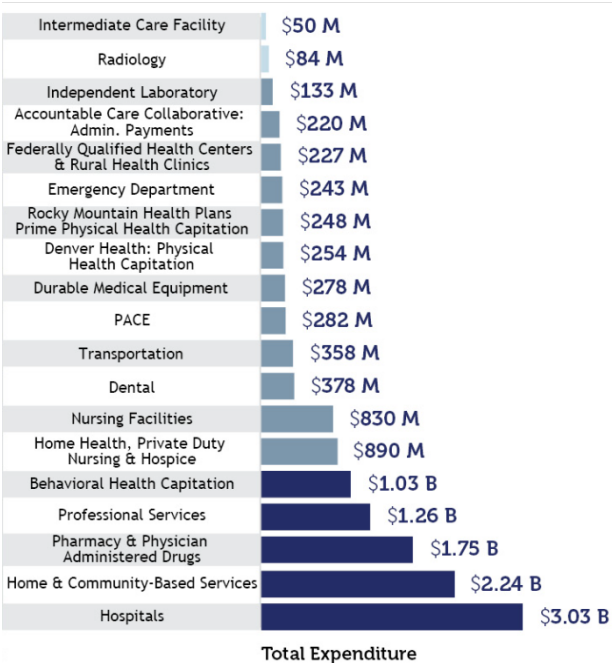
Medicaid's Economic Impact Nationally and In Colorado, Including Federal Match

According to the Centers for Medicare & Medicaid Services, the importance of the health care sector in a state's economy is evidenced by health spending as a share of a state's GDP. In 2023, Medicaid was 18 percent of total national health expenditures.

The National Bureau on Economic Research published a working paper in 2017 that concluded, "Using a nationally representative panel of 5 million credit records, we find that [Medicaid] expansion reduced unpaid medical bills sent to collections by $3.4 billion in its first two years, prevented new delinquencies, and improved credit scores. Using data on credit offers and pricing, we document that improvements in households' financial health led to better terms for available credit valued at $520 million per year. We calculate that the financial benefits of Medicaid double when considering these indirect benefits in addition to the direct reduction in out-of-pocket expenditures."

Buchmueller et al reported that "Evidence from the Great Recession shows that Medicaid spending is a highly effective form of stimulus: for every $100,000 of additional federal Medicaid spending, 2 workers gained a year of employment." The Kaiser Commission on Medicaid and the Uninsured found that "Medicaid funding directly impacts health care service providers, supporting the jobs, income, and purchases associated with carrying out health care services."

96% of CO Medicaid's budget goes to pay health care providers, with only 4% going to administration. CO Medicaid is the most efficiently run health plan in CO. The chart to the right illustrates the major provider types receiving 96% of the Medicaid budget dollars.



For every dollar the state spends on Medicaid, the federal government matches at a specified percentage rate. Current federal law requires a minimum 50% federal matching rate for Medicaid in any state. The federal matching rate is based on a formula that considers each state's per capita income relative to the national average.

Colorado receives the lowest federal matching rate at 50% - the current federal floor - in most cases. However, certain populations and certain services are matched at a higher federal rate, such as Medicaid expansion provisions, which are matched at 90%. On average, about 58% of all funding for HCPF's budget, including Medicaid, CHIP, other programs and administration, comes in the form of federal matching funds, while 42% comes from state funding sources. For the ACA expansion population, **reducing the current 90% match to Colorado's 50% matching rate would translate to over $1 billion reduction in federal matching funding annually.**

Medicaid Membership and Funding by Congressional District

Congressional District	Counties in Congressional District (county specific fact sheets can be found at: hcpf.colorado.gov/county-fact-sheets)	Average Enrolled in Colorado Medicaid per month	*Average Enrolled in CHP+ per month	ACA Medicaid Expansion Population Members	Total CHASE Supplemental Payments to Hospitals	**Medical Services Expenditures
1	Denver	211,721	7,923	81,614	$327,387,228	$2,230,232,592
2	Clear Creek, Routt, Jackson, Larimer, Grand, Boulder, Gilpin, Eagle, Summit, Weld, Jefferson	115,634	6,020	48,809	$148,260,869	$679,659,063
3	Moffat, Rio Blanco, Garfield, Mesa, Pitkin, Eagle, Gunnison, Delta, Montrose, Ouray, San Miguel, Dolores, Montezuma, La Plata, Archuleta, San Juan, Hinsdale, Mineral, Rio Grande, Conejos, Alamosa, Costilla, Huerfano, Pueblo, Otero, Las Animas, Saguache	228,019	11,810	78,327	$274,301,600	$1,650,379,167
4	Baca, Prowers, Bent, Kiowa, Crowley, Cheyenne, Lincoln, El Paso, Douglas, Elbert, Kit Carson, Yuma, Washington, Arapahoe, Adams, Morgan, Logan, Sedgwick, Phillips, Weld, Larimer	119,814	7,517	37,726	$150,403,566	$731,323,092
5	El Paso	178,644	7,738	61,705	$196,204,472	$1,840,239,329
6	Adams, Arapahoe, Denver, Douglas, Jefferson	176,847	9,083	58,700	$427,153,972	$2,831,805,752
7	Adams, Broomfield, Chaffee, Custer, El Paso, Fremont, Jefferson, Lake, Park, Teller	128,990	5,494	49,993	$102,918,819	$969,488,962

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8	Weld, Adams, Larimer	**214,218**	**12,511**	**65,009**	**$128,347,504**	**$881,140,918**

NOTE: Some counties are in more than one Congressional district (Weld, Jefferson, Adams, Larimer, Arapahoe, Eagle, El Paso, Denver); the above chart is broken out along District lines. Enrollment and expenditure data is from Colorado Interchange for State Fiscal Year 2023-24. It does not include members or providers who were unable to be mapped to Districts due to address/data issues. **Health First Colorado data**: Colorado Department of Health Care Policy and Financing, Business Intelligence and Data Management System (BIDM), July 1, 2023 – June 30, 2024, accessed on April 7, 2025. **District population data:** U.S. Census Bureau, My Congressional District, <https://www.census.gov/mycd/?st=08&cd=01>, accessed on March 4, 2025. **Member and provider Congressional District**: Walker K (2025). tigris: Load Census TIGER/Line Shapefiles. R package version 2.2.0, https://github.com/walkerke/tigris.

*Enrollment in CHP+ has increased since Fiscal Year 2023-24

**Does not include Supplemental Payments (shown in separate column, "Total CHASE Supplemental Payments") or CHP+ capitations. Includes: behavioral and medical services including dental, health care facilities such as hospitals and clinics, long term care services and pharmacy.

Additional Resources:

FY 2023-24 HCPF Report to the Community - December 2024, Annual overview of programs, expenditures
Congressional District specific fact sheets - April 2025
Long Term Services and Supports Fact Sheet - May 2025
Protecting Against Fraud, Waste and Abuse Fact Sheet - April 2025
Medicaid Work Requirements Fact Sheet - April 2025
Medical Assistance Coverage fact sheet - March 2025
Colorado Hospital Affordability and Sustainability Enterprise Annual Report - January 15, 2025 overviews how Colorado uses provider fees