COLORADO
Department of Health Care Policy & Financing

CO Medicaid Insights & Potential Federal Medicaid Reduction Impact Estimates

Updated: June 6, 2025

On May 22, the House passed the federal reconciliation package, H.R. 1 by a vote of 215-214-1 and the bill is now under consideration by 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. Previously discussed potential cuts such as provider fee reductions, per capita caps and changes to federal matching funds for states are included in the Addendum, which starts on page 9. Particular sections of the House-passed bill, such as 44125 and 44126 and others, will potentially evolve as they are 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 bill 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,	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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	community service or work 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 authorized under SB 21-009. In	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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		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 cannot exceed $35 with the	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 provider payments where	$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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	total not to exceed 5% of the member's income.		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, nationality or a qualifying	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 90 days) to provide	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 state continues to provide medical	$844 million reduction over 10 years nationally. This provision would increase unpaid claims for providers.

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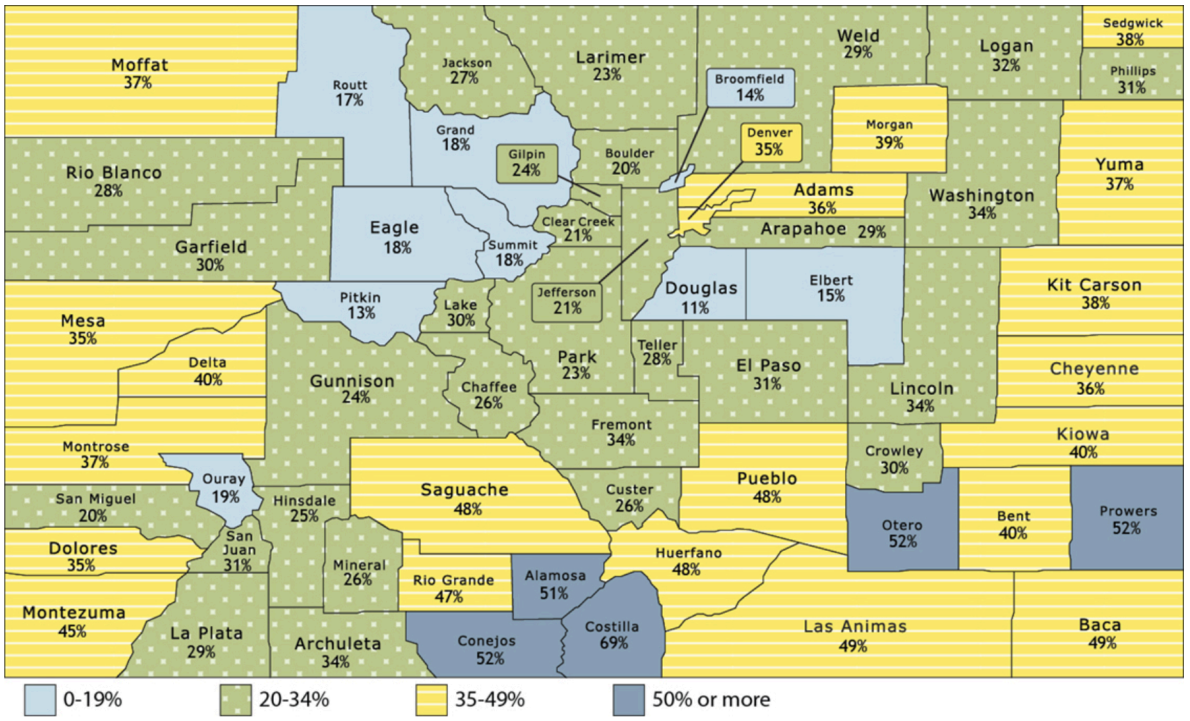
	immigration status has not yet been verified.	documentation and will be in pending status (versus being approved) during this period.	assistance during that time period.	
Section 44122: Modifications to retroactive coverage from three months to one month	For individuals who apply for Medicaid benefits 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.

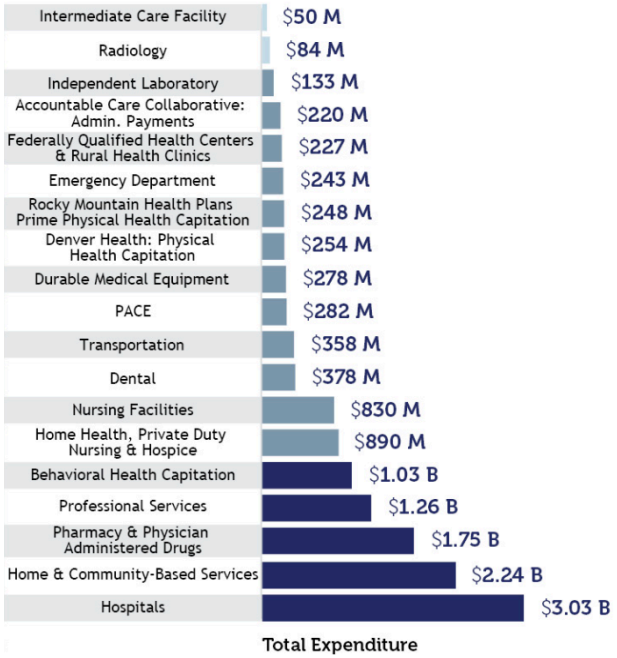
Medicaid's Economic Impact Nationally and In Colorado, Including Federal Match

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
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

Addendum: Other Potential Medicaid Cuts, Top Risks Previously Considered

Provision	National Impact/10 years Federal Budget Savings Projections	Colorado Impact (financial and enrollment)
Elimination of the FMAP Floor	$530 Billion Reduction over 10 years, CBO estimate 10 states are exactly at floor: CA,CO,CT,MD,MA,NH,NJ,NY,WA,WY	The Federal Medical Assistance Percentage (FMAP) is used to determine the federal matching rate paid to states. With the elimination of the FMAP floor, Colorado's share of Medicaid FMAP would be reduced from 50% (the current floor) to an estimated 36.63%. Specifically, given the current formula in federal law, if the FMAP floor were removed, our federal match is projected to be 41.85% in SFY 2025-26 and 36.63% in SFY 2026-27. **The impact would range from ~$900 million state General Fund (SFY 2025-26 estimate) to ~$1.5 billion state General Fund (SFY 2026-27 estimate).**

Provision	National Impact/10 years Federal Budget Savings Projections	Colorado Impact (financial and enrollment)
Per Member Caps on Federal Funding - overall population	$907 Billion Reduction over 10 years, CBO estimate Nationally, Medicaid and the Children's Health Insurance Program (CHIP) covers 79.3 million (Oct. 2024), including 72 million in Medicaid and 7.25 million in CHIP. CBO estimates federal funding reductions of this magnitude would cause states to cut Medicaid coverage, including some states dropping the ACA Medicaid expansion, along with other cost-cutting actions such as reducing Medicaid benefits and provider payments. CBO estimates that about half of the people losing Medicaid coverage would become uninsured. In a previous analysis, CBO noted that under a per capita cap or overall cap, households could face significant increases in medical debt and bankruptcies.	The implementation of per-capita caps overall would reduce federal Medicaid funding in Colorado by an estimated **$1.34 - 1.51 billion annually.** Estimate notes: CBO estimated a national $907 billion reduction over 10 years, which is an estimated national annual average of $90.7 billion. Colorado Medicaid's 1.2 million covered lives (Oct. 2024) represents 1.67% of the national 72 million covered lives. **Estimated annual federal funding reduction for Colorado based on covered lives share = $1.51B annually** Colorado Medicaid spend as a share of national Medicaid spend = 1.47%. **Estimated annual federal funding reduction based on funding share = $1.34B annually**
Changes to Provider Fees - Elimination of Provider Fees	$630 Billion Reduction over 10 years, CBO estimate Various options are being considered to limit provider fees. 47 states have some version of a provider fee.	Hospitals contributed $1.3 billion in fees in accordance with CO's federally approved hospital provider fee. Hospitals received $1.75 billion in additional Medicaid payments under the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) program, for a net gain of $495 million to Colorado hospitals. Before the implementation of the provider/CHASE fee in 2010, CO Medicaid paid hospitals on average $0.54 cents on the dollar of hospital costs. In 2023, CO Medicaid paid hospitals $0.79 cents on their dollar of cost due to the CHASE program. The CHASE hospital provider fee with federal match funds Colorado's Medicaid and CHIP programs including the ACA Medicaid Expansion for lower income adults, children and pregnant women in CO CHIP, and Medicaid buy-in coverage for children and working adults with disabilities. A total of 427,000 Coloradans' health coverage was funded by CHASE as of Sept. 2024. **In Federal Fiscal Year 2024, CO Medicaid paid a total of $3.1 billion in health**

Provision	National Impact/10 years Federal Budget Savings Projections	Colorado Impact (financial and enrollment)
		coverage claims for these Medicaid and CHIP members, with approximately 31% or $968 million paid for hospital care.
Changes to Provider Fees - Lower Threshold	$48 Billion Reduction over 10 years, CBO estimate	The Healthcare Affordability and Sustainability (HAS) fee is used to draw federal matching funds to finance coverage for those covered under Medicaid Expansion and CHIP, while also financing hospital supplemental payments that serve to increase Medicaid reimbursements. **A reduction in fees collected would reduce the federal funds Colorado would receive *by well over double* the value of the HAS fee reduction.** Based on the draft FFY 2024-25 CHASE model, **if the threshold is reduced from its current 6% to 5%, Colorado would be able to collect $205 million less in HAS fees.** (The CHASE threshold is the Net Patient Revenue (NPR) limit, and the reduction would occur in the HAS fee, which are the funds collected from the hospitals**).** **If the threshold were lowered from 6% to 4%, Colorado would collect $440 million less in HAS fee, while 3% would result in $675 million less in HAS fee.**
Reduce Expansion Population Enhanced Federal Match from 90% to 50%	$596 Billion Reduction over 10 years, CBO estimate	Reducing the current 90% match to Colorado's 50% matching rate would translate to an estimated more than **$1 billion reduction in federal matching funding annually.** 377,019 Coloradans are covered through the expansion population. Costs would be felt by the economy, families going into bankruptcy, as well as hospitals and other providers left with increased uncompensated care costs.

Source notes: State FMAP levels are based on 2026 estimates by KFF available here. States with provider fees are from Medicaid Provider Taxes, Congressional Research Service, updated December 2024. The above chart is not all inclusive of all options being considered by Congress but rather lists frequently mentioned reduction items. Once bill language is available, additional analysis can be conducted and HCPF will develop new resources or publish updates to this document.