

Department of Health Care Policy and Financing

Funding Request for the FY 2026-27 Budget Cycle

Request Title R-06 Executive Order and Other Spending Reductions

Dept. Approval By: Supplemental FY 2025-26

OSPB Approval By: Budget Amendment FY 2026-27

X Change Request FY 2026-27

Summary Information	Fund	FY 2025-26		FY 2026-27		FY 2027-28
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
Total of All Line Items Impacted by Change Request	Total	\$16,968,055,717	\$0	\$17,025,869,762	(\$530,764,041)	(\$582,293,863)
	FTE	800.7	0.0	795.6	7.0	7.0
	GF	\$5,094,758,265	\$0	\$5,108,965,823	(\$196,124,715)	(\$222,396,269)
	CF	\$1,731,909,868	\$0	\$1,734,870,232	(\$26,777,929)	(\$26,743,367)
	RF	\$127,535,927	\$0	\$127,571,864	\$0	\$0
	FF	\$10,013,851,657	\$0	\$10,054,461,843	(\$307,861,397)	(\$333,154,227)

Line Item Information	Fund	FY 2025-26		FY 2026-27		FY 2027-28
		Initial Appropriation	Supplemental Request	Base Request	Change Request	Continuation
	Total	\$76,602,942	\$0	\$78,913,644	\$623,266	\$623,266
	FTE	800.7	0.0	795.6	7.0	7.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$29,477,201	\$0	\$30,293,906	\$311,633	\$311,633
General Administration - Personal Services	CF	\$6,407,940	\$0	\$6,602,894	\$0	\$0
	RF	\$3,155,881	\$0	\$3,211,037	\$0	\$0
	FF	\$37,561,920	\$0	\$38,805,807	\$311,633	\$311,633
	Total	\$12,823,330	\$0	\$16,840,982	\$113,064	\$124,369
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$5,434,254	\$0	\$6,493,890	\$56,532	\$62,185
General Administration - Health, Life, and Dental	CF	\$702,241	\$0	\$1,438,304	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$6,686,835	\$0	\$8,908,788	\$56,532	\$62,184
	Total	\$51,482	\$0	\$64,918	\$385	\$385
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$23,801	\$0	\$25,314	\$193	\$193
General Administration - Short-term Disability	CF	\$427	\$0	\$5,360	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$27,254	\$0	\$34,244	\$192	\$192
	Total	\$377,655	\$0	\$417,668	\$2,478	\$2,478
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$152,639	\$0	\$162,880	\$1,239	\$1,239
General Administration - Paid Family and Medical Leave Insurance	CF	\$27,098	\$0	\$34,480	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$197,918	\$0	\$220,308	\$1,239	\$1,239
	Total	\$7,918,630	\$0	\$9,281,509	\$55,116	\$55,116
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$3,391,947	\$0	\$3,619,548	\$27,558	\$27,558
General Administration - Unfunded Liability AED Payments	CF	\$365,358	\$0	\$766,216	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$4,161,325	\$0	\$4,895,745	\$27,558	\$27,558

	Total	\$3,400,167	\$0	\$3,097,991	\$5,145	\$5,145
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$1,344,473	\$0	\$1,287,723	\$2,573	\$2,573
General Administration - Operating Expenses	CF	\$296,462	\$0	\$257,147	\$0	\$0
	RF	\$50,071	\$0	\$30,852	\$0	\$0
	FF	\$1,709,161	\$0	\$1,522,269	\$2,572	\$2,572
	Total	\$3,700,205	\$0	\$3,700,205	\$32,550	\$32,550
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$1,482,562	\$0	\$1,482,562	\$16,275	\$16,275
General Administration - Leased Space	CF	\$322,276	\$0	\$322,276	\$0	\$0
	RF	\$38,849	\$0	\$38,849	\$0	\$0
	FF	\$1,856,518	\$0	\$1,856,518	\$16,275	\$16,275
	Total	\$45,936,358	\$0	\$40,397,469	(\$750,000)	(\$750,000)
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (A) General Administration, (1)	GF	\$16,663,486	\$0	\$14,707,769	(\$262,500)	(\$262,500)
General Administration - General Professional Services and Special Projects	CF	\$3,629,148	\$0	\$2,846,853	\$0	\$0
	RF	\$81,000	\$0	\$81,000	\$0	\$0
	FF	\$25,562,724	\$0	\$22,761,847	(\$487,500)	(\$487,500)
	Total	\$104,857,279	\$0	\$101,381,567	\$0	\$0
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (B) Information Technology Contracts and Projects, (1)	GF	\$14,958,219	\$0	\$14,562,664	\$0	\$0
Information Technology Contracts and Projects - MMIS Maintenance and Projects	CF	\$10,671,589	\$0	\$10,614,200	\$0	\$0
	RF	\$12,204	\$0	\$12,204	\$0	\$0
	FF	\$79,215,267	\$0	\$76,192,499	\$0	\$0
	Total	\$136,311,489	\$0	\$136,311,489	(\$1,815,929)	(\$1,815,929)
	FTE	0.0	0.0	0.0	0.0	0.0
01. Executive Director's Office, (C) Eligibility Determinations and Client Services, (1)	GF	\$21,555,147	\$0	\$21,555,147	(\$298,131)	(\$298,131)
Eligibility Determinations and Client Services - County Administration	CF	\$30,777,803	\$0	\$30,777,803	(\$416,092)	(\$416,092)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$83,978,539	\$0	\$83,978,539	(\$1,101,706)	(\$1,101,706)
	Total	\$13,367,552,286	\$0	\$13,418,121,603	(\$401,815,309)	(\$399,054,704)
	FTE	0.0	0.0	0.0	0.0	0.0
02. Medical Services Premiums, (A) Medical Services Premiums, (1)	GF	\$3,883,441,698	\$0	\$3,894,065,321	(\$136,396,992)	(\$135,523,333)
Medical Services Premiums - Medical Services Premiums	CF	\$1,481,967,035	\$0	\$1,484,271,680	(\$21,170,835)	(\$21,136,273)
	RF	\$124,197,922	\$0	\$124,197,922	\$0	\$0
	FF	\$7,877,945,631	\$0	\$7,915,586,680	(\$244,247,482)	(\$242,395,098)

	Total	\$1,451,675,162	\$0	\$1,457,124,162	(\$12,644,332)	(\$12,644,332)
03. Behavioral Health Community Programs,	FTE	0.0	0.0	0.0	0.0	0.0
(A) Behavioral Health Community Programs,	GF	\$349,844,933	\$0	\$352,569,433	(\$3,000,000)	(\$3,000,000)
(1) Behavioral Health Community Programs -	CF	\$121,980,456	\$0	\$121,980,456	(\$3,322,166)	(\$3,322,166)
Behavioral Health	RF	\$0	\$0	\$0	\$0	\$0
Capitation Payments	FF	\$979,849,773	\$0	\$982,574,273	(\$6,322,166)	(\$6,322,166)
	Total	\$11,346,614	\$0	\$11,360,376	(\$178,903)	(\$178,903)
03. Behavioral Health Community Programs,	FTE	0.0	0.0	0.0	0.0	0.0
(A) Behavioral Health Community Programs,	GF	\$2,726,359	\$0	\$2,729,666	(\$42,987)	(\$42,987)
(1) Behavioral Health Community Programs -	CF	\$673,095	\$0	\$673,911	(\$10,612)	(\$10,612)
Behavioral Health Fee-	RF	\$0	\$0	\$0	\$0	\$0
for-Service Payments	FF	\$7,947,160	\$0	\$7,956,799	(\$125,304)	(\$125,304)
	Total	\$943,198,318	\$0	\$943,443,684	(\$55,346,305)	(\$109,646,421)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$469,997,259	\$0	\$470,117,999	(\$27,031,817)	(\$54,181,875)
	CF	\$1,601,900	\$0	\$1,603,843	(\$641,336)	(\$641,336)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$471,599,159	\$0	\$471,721,842	(\$27,673,152)	(\$54,823,210)
	Total	\$125,347,265	\$0	\$127,070,742	(\$1,976,368)	(\$1,976,368)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$47,026,926	\$0	\$47,711,922	(\$741,480)	(\$741,480)
	CF	\$14,346,101	\$0	\$14,363,501	(\$226,197)	(\$226,197)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$63,974,238	\$0	\$64,995,319	(\$1,008,691)	(\$1,008,691)
	Total	\$147,638,446	\$0	\$147,566,019	(\$47,916,604)	(\$47,918,220)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$72,523,503	\$0	\$72,480,701	(\$23,937,872)	(\$23,938,680)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$75,114,943	\$0	\$75,085,318	(\$23,978,732)	(\$23,979,540)
	Total	\$31,570,797	\$0	\$31,446,226	(\$497,782)	(\$497,782)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$15,784,057	\$0	\$15,721,723	(\$248,870)	(\$248,870)
	CF	\$1,342	\$0	\$1,344	(\$22)	(\$22)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$15,785,398	\$0	\$15,723,159	(\$248,890)	(\$248,890)

	Total	\$149,895,987	\$0	\$150,204,002	(\$2,363,431)	(\$2,363,431)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management for People with Disabilities	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$70,613,942	\$0	\$70,762,693	(\$1,113,380)	(\$1,113,380)
	CF	\$4,994,603	\$0	\$5,000,661	(\$78,751)	(\$78,751)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$74,287,442	\$0	\$74,440,648	(\$1,171,300)	(\$1,171,300)

	Total	\$11,436,277	\$0	\$11,450,148	(\$180,318)	(\$180,318)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$11,436,277	\$0	\$11,450,148	(\$180,318)	(\$180,318)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

	Total	\$5,375,632	\$0	\$5,382,152	(\$84,758)	(\$84,758)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$5,375,632	\$0	\$5,382,152	(\$84,758)	(\$84,758)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

	Total	\$5,238,505	\$0	\$5,244,859	(\$82,597)	(\$82,597)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$5,238,505	\$0	\$5,244,859	(\$82,597)	(\$82,597)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

	Total	\$72,271	\$0	\$72,359	(\$1,140)	(\$1,140)
04. Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventative Dental Hygiene	FTE	0.0	0.0	0.0	0.0	0.0
	GF	\$72,271	\$0	\$72,359	(\$1,140)	(\$1,140)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

	Total	\$317,623,772	\$0	\$318,871,140	(\$2,942,269)	(\$2,942,269)
05. Indigent Care Program, (A) Indigent Care Program, (1)	FTE	0.0	0.0	0.0	0.0	0.0
Indigent Care Program - Children's Basic Health Plan Medical and Dental Costs	GF	\$59,616,174	\$0	\$59,888,444	(\$617,876)	(\$617,876)
	CF	\$51,617,146	\$0	\$51,781,455	(\$411,918)	(\$411,918)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$206,390,452	\$0	\$207,201,241	(\$1,912,475)	(\$1,912,475)
	Total	\$1,500,000	\$0	\$1,500,000	(\$500,000)	(\$500,000)
06. Other Medical Services, (A) Other Medical Services, (1)	FTE	0.0	0.0	0.0	0.0	0.0
Other Medical Services - SBIRT Training Grant Program	GF	\$0	\$0	\$0	\$0	\$0
	CF	\$1,500,000	\$0	\$1,500,000	(\$500,000)	(\$500,000)
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0
	Total	\$3,990,358	\$0	\$3,990,358	(\$2,000,000)	(\$2,000,000)
06. Other Medical Services, (A) Other Medical Services, (1)	FTE	0.0	0.0	0.0	0.0	0.0
Other Medical Services - Senior Dental	GF	\$3,962,510	\$0	\$3,962,510	(\$2,000,000)	(\$2,000,000)
	CF	\$27,848	\$0	\$27,848	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0
	Total	\$2,614,490	\$0	\$2,614,490	(\$500,000)	(\$500,000)
06. Other Medical Services, (A) Other Medical Services, (1)	FTE	0.0	0.0	0.0	0.0	0.0
Other Medical Services - Reproductive Health Care Program	GF	\$2,614,490	\$0	\$2,614,490	(\$500,000)	(\$500,000)
	CF	\$0	\$0	\$0	\$0	\$0
	RF	\$0	\$0	\$0	\$0	\$0
	FF	\$0	\$0	\$0	\$0	\$0

Auxiliary Data			
Requires Legislation?	YES		
Type of Request?	Health Care Policy and Financing Prioritized Request	Interagency Approval or Related Schedule 13s:	No Other Agency Impact



Kim Bimestefer, Executive Director
Department of Health Care Policy
& Financing
Nov 3, 2025

Department Priority: R-06

Executive Order and Other Spending Reductions

Summary of Funding Change for FY 2026-27

Fund Type	FY 2025-26 Change Request	FY 2026-27 Incremental Request	FY 2027-28 Incremental Request
Total Funds	(\$262,417,204)	(\$530,764,041)	(\$582,293,863)
General Fund	(\$92,317,713)	(\$196,124,715)	(\$222,396,269)
Cash Funds	(\$15,635,570)	(\$26,777,929)	(\$26,743,367)
Reappropriated Funds	\$0	\$0	\$0
Federal Funds	(\$154,463,921)	(\$307,861,397)	(\$333,154,227)
FTE	3.0	7.0	7.0

Summary of Request

Problem or Opportunity

It is necessary to reduce the rate of growth of Medicaid's General Fund spending to ensure its long term sustainability. The immediate and future budget impacts of H.R. 1 and the increase in Medicaid spending over the last decade require action to align spending growth more closely with the rate of increases in state revenue and the TABOR cap.

Proposed Solution

The Department has identified multiple HCPF program areas where there are opportunities to put Colorado's budget on a more sustainable budget trajectory by slowing the growth of the State's Medicaid spending starting in FY 2025-26.

Fiscal Impact of Solution

The Department requests a reduction of \$262.4 M total funds, including \$92.3 M general funds, in FY 2025-26, a reduction of \$530.7 M total funds, including \$196.1 M in general funds, in FY 2026-27, and \$582.3 M total funds, including \$222.4 M in general funds, in FY 2027-28 and ongoing to implement the executive order budgetary adjustments and additional savings initiatives in order to achieve the balanced budget.

Requires Legislation	Colorado for All Impacts	Revenue Impacts	Impacts Another Department?	Statutory Authority
Yes	Neutral	No	No	24-75-201.5, C.R.S.

Background and Opportunity

Colorado’s Medicaid program provides more than 20 percent of residents with critical access to health insurance, medical and behavioral health services, and long-term care support for children and adults with disabilities. It is also the single largest expenditure within the state budget, and it has historically outpaced the growth of state revenue and the TABOR cap. Over the past ten years, General Fund spending for medical services has increased by an average of 8.8 percent per year. In contrast, the TABOR cap increased by an average of 4.4 percent per year over that period. This continued spending growth threatens the program’s long-term sustainability and the broader state budget, as Medicaid spending increasingly crowds out spending on other important priorities, such as human services and education.

Additionally, recent federal budget and policy actions put immediate and long-term budget pressures on Medicaid. H.R. 1 will immediately reduce state tax revenue by over \$1.2 billion in the current fiscal year, 2025-26. And federal Medicaid cuts will soon be implemented will only worsen these budget pressures, especially as the state must increase administrative spending on bureaucratic work requirements and manage the impacts of upcoming hospital provider fee restrictions.

For these reasons, the Polis administration proposes to work with the General Assembly to pass legislation that will enable the State to achieve and maintain a sustainable rate of growth to Medicaid expenditures. This legislation should seek to establish a year-over-year growth rate in Medicaid General Fund spending. Eventually, the growth rate should continue to ramp down rapidly and within the next few years align with growth in the TABOR cap.

Given the urgency for fiscal sustainability in our Medicaid expenditures—and compounded by the negative revenue impact that H.R. 1 imposed on state revenue—we are taking action in the current fiscal year, 2025-26. It is important to adopt measures to curb spending as soon as feasible, because spending would otherwise continue to grow and make it that much harder to reach a sustainable rate of growth in FY 2026-27 and beyond. The longer we wait to implement meaningful reductions, the larger the future reductions will need to be.

On Aug. 28, 2025, Governor Polis signed [Executive Order D25 014](#) that reduces General Fund expenditures to bring Colorado’s budget into balance for FY 2025-26.

In alignment with [HCPF's Medicaid Sustainability Framework](#), the Governor directed HCPF to enact the following budget reduction measures that target Medicaid trend drivers, reduce Medicaid spending, and help balance the state budget.

Following is a summary of the program affected.

ACC Incentive Program

The Accountable Care Collaborative (ACC) began in 2011 as Colorado's cornerstone Medicaid initiative to improve care coordination and outcomes. In 2018, ACC Phase II launched with Regional Accountable Entities (RAEs), enhancing integration of physical and behavioral health while introducing performance-based incentives for RAEs and Primary Care Medical Providers (PCMPs). As of July 1, 2025, Colorado has entered ACC Phase III, with new RAE contracts and operational changes emphasizing integrated care, billing, and regional accountability under updated HCPF guidance. The ACC Quality Program serves as the primary physical health quality program for Medicaid, with 75% of incentive funds distributed directly to primary care providers and 25% allocated to the RAEs.

Behavioral Health Incentive Program

Under ACC Phase II, RAEs became eligible to earn up to an additional 5% of their behavioral health capitation rate by meeting key behavioral health performance metrics. These incentives were designed to strengthen continuity of care and improve outcomes within Medicaid's behavioral health service delivery framework. The program laid the groundwork for value-based payment approaches that align behavioral health performance with funding in Colorado Medicaid delivery reform efforts. These payments are distributed annually to the RAEs with 66%-90% of awarded incentive funds passed through to behavioral health providers.

Stabilization Payments

Access Stabilization Payments were introduced under ACC Phase III to support primary care medical providers (PCMPs) in under-resourced settings—specifically rural, pediatric, and small independent practices—that don't receive cost-based reimbursement, helping to preserve access for Health First Colorado members where it's most fragile. These payments emerged as part of a restructured Primary Care Payment model administered by Regional Accountable Entities (RAEs), intended to repurpose funding to bolster sustainability and capacity in targeted provider types.

Senior Dental Grant Program

The Colorado Senior Dental Grant Program was established by the General Assembly in 2014 to expand access to preventive and restorative dental services for low-income adults age 60 and older who lack dental benefits through Health First Colorado (Medicaid). The program distributes funds to community-based grantees, including public health agencies, community health centers, and nonprofit dental clinics, to provide direct dental care. Through this grant

structure, the program improves oral health, prevents costly emergency visits, and supports seniors in maintaining independence and overall well-being.

Continuous Coverage

HB 23-1300 required the Department to seek federal authorization to provide continuous coverage for children under the age of 3, including non-citizens, and 12 months of continuous coverage for adults released from DOC facilities. The federal authorization was denied in July 2025 and the Department can no longer implement this program.

Immigrant Family Planning

The Immigrant Family Planning program provides family planning and related services to individuals who would otherwise qualify for Medicaid if not for their citizenship status. It is funded entirely with state-only dollars and currently has a budget of \$2.6 million. Historically, the program has underspent its allocation, reflecting both limited utilization and challenges in outreach. Despite this, it plays a critical role in ensuring access to essential reproductive health services for immigrant populations in Colorado.

SBIRT Grants

SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a well-established, evidence-based approach developed in the 1980s for early identification and intervention of risky substance use. Under Colorado's grant structure, funding is allocated to a single vendor for provider training, with no funding distributed directly to individual healthcare providers. Unfortunately, provider engagement remains minimal—by 2022, only about 400 Medicaid providers (approximately 0.37% of the total) attended one of 150 free training sessions. Meanwhile, providers have access to additional federal training resources at no cost, offering alternative avenues to build SBIRT capacity despite the underutilization of state-sponsored sessions.

Cover All Coloradans Outreach Contract

The Cover All Coloradans initiative, established under HB 22-1289, created an outreach grant program funded by legislation to support education and enrollment efforts for undocumented children and pregnant individuals. The Department issued grants to community-based organizations to help launch Cover All Coloradans and build awareness of the new coverage options. As of January 1, 2025, children under age 19 and pregnant or postpartum adults in Colorado—regardless of immigration status—became eligible for Medicaid or CHP+ under this program.

Community Health Worker Services

In Colorado, Community Health Workers (CHWs) play a key role in connecting Medicaid members and other underserved populations to health and social services, particularly in rural and frontier communities. Supported through initiatives such as the Accountable Care Collaborative and recent American Rescue Plan Act (ARPA) investments, CHWs provide

culturally responsive education, care coordination, and resource navigation to address barriers like housing, food insecurity, and transportation. By integrating CHWs into care teams across the state, Colorado is advancing health equity, improving chronic disease management, and reducing costly avoidable health care utilization.

Realigning Children in Rocky Mountain Health PRIME

Including children in Rocky Mountain Health PRIME is a pediatric-focused initiative within Colorado's Accountable Care Collaborative (ACC), operated by Rocky Mountain Health Plans in the Western Slope region. The program would coordinate care for children and youth enrolled in Health First Colorado, emphasizing preventive services, behavioral health integration, and support for children with special health care needs. With the removal of this initiative, these services would no longer go into effect, and only adults will remain eligible for services under Rocky Mountain Health PRIME.

Accountable Care Collaborative (ACC) Credentialing Component

The Centralized Credentialing component of the Department's FY 25-26 R6 Accountable Care Collaborative (ACC) Phase III request was established to create a single, uniform process for verifying provider qualifications across Health First Colorado. This system was intended to reduce duplication and administrative burden by allowing providers to complete credentialing once for participation with all Regional Accountable Entities (RAEs). By streamlining credentialing at the state level, Colorado improves efficiency, ensures consistency in provider standards, and strengthens timely access to care for Medicaid members.

Definitive Drug Testing

As of July 31, 2021, the Department changed how definitive drug testing can be billed by providers. The newly billable codes allow for confirmatory testing of 1 to 22+ drug classes, but are billed without unit limits, prior authorization requirements, or standardized documentation criteria in Colorado Medicaid. In addition, the requirement for documentation of medical necessity or a presumptive positive test was removed in January 2020.

The absence of utilization controls and clinical documentation requirements has led to escalating overuse of definitive drug testing codes. Between 2021 and 2024, the number of Medicaid members receiving these services nearly doubled (from 22,813 to 43,194), and spending rose from \$12 million to \$54 million. This unchecked utilization places a significant financial burden on the Medicaid program, crowds out funding for other essential services, and exposes beneficiaries to unnecessary testing without clinical justification.

To address this, the Department has reviewed utilization patterns, billing trends, and clinical guidance from CMS and local Medicare contractors and has developed potential policy solutions to mitigate the increase in utilization.

Medicaid Prior Authorization of Outpatient Psychotherapy

Senate Bill 22-156 amended CRS Title 25.5 to prohibit Medicaid prior authorization of outpatient psychotherapy. The original legislation was proposed as a reduction of administrative burden. The Department did not oppose the legislation or identify a fiscal

impact because data showed that almost all PARs requested were approved. However, upon prohibition of PARs, provider behavior changed, and the average number of services per person increased, especially for those receiving more than 26 services annually, causing a projected increase in service costs directly related to outpatient psychotherapy of \$31.3 million in FY 2025-26.

Pediatric Behavioral Therapy

Pediatric autism behavioral therapy is typically delivered through Applied Behavior Analysis (ABA), for individuals under age 21 who meet EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) medical necessity criteria. Due to provider complaints about reimbursement rates, providers successfully advocated for adopting a higher benchmark for rate setting. The Joint Budget Committee implemented rate increases effective July 1, 2024 that aligned rates to 100% of the other states benchmarks including Nebraska which was a significant outlier at the time. Since approval expenditure for these services have increased rapidly raising concerns about sustainability of the program. The Department now has the opportunity to implement cost control measures to ensure usage of these services is appropriate.

FY 2025-26 1.6% provider rate increase

For FY 2025-26, the State Budget included a 1.6% provider rate increase for Health First Colorado providers. This annual adjustment is intended to help offset inflationary pressures and support provider sustainability in delivering Medicaid services. The increase applies across most provider types and continues Colorado's statutory commitment to annual rate reviews and adjustments. It does not impact behavioral health providers reimbursed through the RAEs or physical health providers reimbursements from Managed Care Organizations. While modest, the increase reflects the state's effort to balance fiscal constraints with the need to maintain provider participation and access to care for Medicaid members.

Community Connector

The Community Connector service is offered through Colorado's Home and Community-Based Services (HCBS) waivers, most prominently the Children's Extensive Support (CES) Waiver, to help members build social skills and participate in community life. The Department has seen significant increases in Community Connector utilization over the last few years prompting increased pressure to evaluate the reimbursement and access to these services.

Nursing Facility Minimum Wage Supplemental Payment

As a part of HB 22-1333, "Increase Minimum Wage for Nursing Home Workers," the Department administers a Nursing Facility Minimum Wage Supplemental Payment that provides additional funding to nursing facilities that pay workers over 15 dollars per hour. The supplemental payment is in effect until the minimum wage is above 15 dollars per hour. Since the state minimum wage is anticipated to increase to 15 dollars per hour in January of 2026, the supplemental payment is no longer relevant, as all facilities will meet the minimum legal standard.

Individual Residential Services and Supports

The Individual Residential Services and Supports (IRSS) benefit is offered exclusively under Colorado's Developmental Disabilities (DD) Medicaid waiver, providing residential support in a variety of settings. These include Host Homes, family homes, member-owned or rented residences, and staffed homes operated by provider agencies. In a Host Home, the waiver participant lives in a private residence with a Host Home Provider, who must reside there full-time, with no rotating staff involved. In contrast, for staffed homes, provider agencies are responsible for ensuring access to ongoing rotating staff. The rate for staffed homes is higher to account for increased staffing and overhead costs. IRSS emphasizes individual choice, community integration, and safety, making it a vital component of Colorado's HCBS approach for individuals with developmental disabilities.

Dental Reimbursement Rates

Colorado Medicaid sets dental reimbursement rates through its fee schedule, which is periodically updated to reflect state budget decisions and program priorities. These rates determine how much dental providers are paid for services like preventive care, restorative work, and other covered procedures. Recent adjustments, including across-the-board increases and targeted rate increases, are intended to help sustain provider participation and ensure member access to essential dental care.

Medicaid Reimbursement Rates

Colorado's Medicaid program currently provides health care access to about 1.2 million people with a budget of \$18 billion. Most providers are paid on a fee-for-service basis, meaning the Department pays for each incurred service based on a set rate. Pursuant to Section 25.5-4-401.5, C.R.S., the Department is required to periodically perform reviews of provider rates under the Colorado Medical Assistance Act. Section 25.5-4-401.5, C.R.S. also established the Medicaid Provider Rate Review Advisory Committee (MPRRAC) to assist in the review of provider reimbursement rates.

Pharmacy Cost Reduction Initiatives

Pharmacy costs are complex but can be understood at a basic level as a function of utilization patterns, reimbursement rates, and dispensing fees. The methodology associated with both pharmacy rates setting and dispensing fee structure must be approved federally by CMS and at the state level by MSB. Utilization patterns can be modified by state level policy but are often shaped by patient acuity and medical necessity. The following specific initiatives aim to reduce pharmacy costs by targeting utilization patterns, reimbursement rates, and dispensing fees.

Dispensing Fee Reduction

Dispensing fees are tiered based on the volume of prescriptions that individual pharmacies fill with higher volumes receiving a lower fee. The tiers are: \$13.40 for less than 60,000 prescriptions, \$11.49 for 60,000-90,000, \$10.25 for 90,000-110,000, and \$9.31 for over 110,000. FQHC pharmacies and rural pharmacies have different fee structures.

Outpatient Drug Rate Reduction

States generally reimburse pharmacies for prescribed covered outpatient drugs dispensed to Medicaid beneficiaries based on a two-part formula consisting of the ingredient cost of a drug and a professional dispensing fee. States have flexibility to determine reimbursement amounts, consistent with applicable statutory and regulatory requirements. These reimbursement amounts are subject to review and approval by the Centers for Medicare & Medicaid Services (CMS) through the SPA process.

Shifting Utilization to Cost-Effective Biosimilars and Other Agents

In pharmaceutical terms, a biosimilar is a biological medicine that is highly similar to an already-approved “reference” biologic drug, with no clinically meaningful differences in safety, purity, or effectiveness. A biologic is a drug made from living cells – such as proteins, antibodies, or hormones (examples: insulin, Humira). Biosimilars are similar to generic drugs in that they can be a more cost effective solution than the original brand name. They are pharmacologically distinct however, because generic drugs are chemical compounds synthesized to be identical to the original, whereas biosimilars will always have a natural degree of non-clinically meaningful variation.

Rate Reduction to Specialty Drug Carveout Program

After implementing a prospective payment system (the Enhanced Ambulatory Payment Grouping system, or EAPGs) for outpatient hospital reimbursements in October 2016, the Department required a payment mechanism for specialty drugs. As EAPGs bases its reimbursements on historic cost and utilization data, newer drugs did not have their costs and utilization data considered into the new methodology. Therefore, to pay for Specialty Hospital Drugs, the Department sought and obtained state and federal authority to reimburse certain specialty drugs on a cost-basis. Effective August 2018, the Department was able to reimburse specialty drugs at 72% of invoiced cost. During the Public Health Emergency, this reimbursement was temporarily increased from 72% to 90%. This change to 90% reimbursement was made permanent in May 2023. In January 2024, the Department expanded the scope of its specialty drug payments to include drugs administered in the inpatient setting, as well as increased reimbursements to 97 to 100% of cost.

Third Party Liability Secondary Payer Shift

There is a subpopulation within the Medicaid caseload for which Health First Colorado serves as the secondary form of insurance. Pharmaceutical costs for secondary payers are typically lower than those required of primary payers. For this population, a commercial health plan functions as the primary payer. Instances have been identified where members have chosen to fill prescriptions at non-network or retail pharmacies rather than through the primary plan’s contracted pharmacy network. Because some primary plans operate a closed pharmacy network, prescriptions filled outside of that network are not eligible for primary coverage, resulting in Medicaid paying as the primary payer instead of as the secondary.

Presumptive Eligibility for Long Term Services and Supports

The Department requested funding for Presumptive Eligibility for Long-Term Services and Supports (LTSS) as part of the FY 2023-24 BA-7 “Community-Based Access to Services” budget request. This initiative sought federal authority to allow individuals who appear eligible for LTSS to begin receiving community-based services while their full Medicaid eligibility determination is pending. This approach aims to expedite transitions from institutional settings and prevent unnecessary facility stays. Federal approval is required to implement.

Developmental Disabilities Waiver

The Developmental Disabilities (DD) Waiver provides comprehensive HCBS for adults with intellectual and developmental disabilities who require access to round-the-clock supervision or support to live safely in the community. The DD Waiver offers residential habilitation, day habilitation, behavioral services, specialized therapies, and related community services, allowing participants to remain integrated in their communities rather than in institutional settings. Unlike all other HCBS waivers, the DD Waiver does not require members to make contributions for residential services, also known as post-eligibility income deductions (PETI).

Personal Care, Homemaker, and Health Maintenance Activities

Personal Care, Homemaker, and Health Maintenance Activities are core HCBS benefits that support members in performing essential daily tasks and are available under Community First Choice (CFC). Personal Care services assist with activities such as bathing, dressing, eating, mobility, and hygiene. Homemaker services provide help with household tasks, including meal preparation, cleaning, laundry, and shopping, to maintain a safe living environment. Health Maintenance Activities include medically oriented supports such as medication administration, catheter care, or respiratory assistance that can be safely delegated and performed in the home setting. These services are authorized based on the assessed need of an individual. Services are delivered by Medicaid-enrolled home health agencies or attendant service providers, and in some cases, through the In-Home Support Services (IHSS) model that allows members to direct their own care with agency oversight.

Home Health Aide and Nursing Services

Home health aide and intermittent nursing services are both provided under the Long Term Home Health (LTHH) benefit. These services are provided to qualifying members who require ongoing Home Health services for more than 60 consecutive calendar days in a service year. Effective August 1, 2025, Prior Authorization Requests (PARs) are required in a phased implementation, with full implementation achieved May 1, 2026. Home Health Aide services are offered through either Home Health Aide Basic (HHAB) or Home Health Aide Extended (HHAЕ). These services are provided by a Certified Nurse Aide (CNA) or Certified Nursing Assistant to eligible members. Nursing Services are provided by a qualified Registered Nurse (RN) or Licensed Practical Nurse (LPN). Specifically, LTHH offers RN/LPN services, RN First Visit of the Day, and RN 2nd or More Visit of the Day.

Movement Therapy Services

Movement Therapy refers to therapeutic services that include music and dance therapy intended to support the habilitation, rehabilitation, or maintenance of behavioral, developmental, physical, social, communication, or gross motor skills. In Colorado's HCBS waiver framework, Movement Therapy is listed under the "Professional Services" category, and is available in Children's Extensive Support (CES) waiver, the Children's Habilitative Residential Program (CHRP), and the Supported Living Services (SLS) waiver.

Proposed Solution and Anticipated Outcomes

Reducing Incentive Payments

Reduce the ACC Incentive Program

The Department is proposing a reduction to Incentive Payments in the Accountable Care Collaborative (ACC Quality Program). These funds are contractually obligated and budget decreases for State Fiscal Year 2026 will need to be negotiated retrospectively.

Reduce the Behavioral Health Incentive Program

The Department is proposing a reduction of approximately \$12 million in total funds including \$3 million general fund for the Behavioral Health Incentive Program (BHIP) payments.

Reductions to Access Stabilization Payments

The Department is proposing a one time reduction to the Access Stabilization Payments to rural, small and pediatric providers by implementing these payments effective January 2026, assuming CMS approval, versus retrospectively to July 2025 as was originally requested and approved. Provider eligibility and rate setting criteria remain the same, but the lack of backdated payments will effectively reduce overall payments available by 50%.

Reduction in Programs

Ending Continuous Coverage

The Department is proposing to halt implementation of continuous coverage for children ages 0-3. Colorado included this new Medicaid benefit in its FY 2025-26 budget with an implementation date of January 2026. The Centers for Medicare and Medicaid Services (CMS) has indicated it will not provide federal match funding for this coverage expansion policy and will not approve or renew 1115 waiver provisions that include continuous coverage for Medicaid members. Given this guidance, Colorado will cease implementation and revert the general fund appropriation intended for continuous coverage.

Immigrant Family Planning Reduction

The Department is proposing a reduction to Immigrant Family Planning Services from SB 21-009 Reproductive Health Care Program. This reduction is intended to be absorbable without reducing access to these important services.

Reduction of SBIRT Grants

The Department is proposing reducing grants to train providers for a well-established screening tool and interventions related to substance use, and repurposing the Marijuana Cash Tax Fund to offset the General Fund. Free training at the state level has not been well attended, but free federal training will remain available for providers who wish to utilize it. SBIRT screening will remain a covered Medicaid benefit.

Cover All Coloradans Outreach Contract Elimination

The Department is proposing to eliminate the outreach programs and initiatives for Cover All Coloradans. This will eliminate three contracts, each with maximum spending authority of \$250,000 for a total outreach budget of \$750,000. This appropriation was originally made in HB 22-1289, the same bill that established the Cover All Coloradans program. This reduction will not change eligibility or benefits for the program.

Cost Controls

Definitive Drug Testing

The Department is proposing to cap reimbursement for definitive urine drug testing panels at 16 tests per member per state fiscal year. Prior authorization (PAR) will be required for utilization above this threshold. This policy is expected to establish necessary controls in a benefit category that has experienced unchecked growth—from \$12 million in 2021 to \$54 million in 2024—without any utilization limits in place. The cap will curb unnecessary and potentially fraudulent billing while maintaining access to clinically appropriate care. The policy will also promote compliance with medical necessity criteria, reduce provider overbilling, and generate projected savings of up to \$14 million annually. Success will be measured through decreased utilization volumes, reduced per-member per-year costs, and improved documentation compliance. Service delivery will remain uninterrupted for patients with legitimate clinical need, while excessive use by high-billing providers will be curtailed. Some resistance is expected from high-utilizing laboratories, but broader support is anticipated from stakeholders focused on program integrity. If not implemented, spending on these services will continue to rise unsustainably, diverting funds from higher-value health services. The Department has regulatory authority to require PAR, excluding emergency services and other services explicitly described in statute, so no legislative changes are needed. Implementation is expected by October 1, 2025, with FY 2025-26 impacts included as a supplemental.

Reinstate Medicaid Prior Authorization of Outpatient Psychotherapy

The Department is proposing to reinstate Medicaid prior authorization of outpatient psychotherapy for services that exceed clinical standard best practices. This reform will maintain access for Medicaid members and ensure that members are being referred to appropriate levels of care. As in the past, PARs will not be in place for initial visits, just for providers claiming more than 20-24 sessions per patient in a calendar year.

Implement Pre- and Post- Claim Review of Pediatric Behavioral Therapy

The Department is proposing a reduction of funds by implementing pre- and post- claim review of all pediatric autism behavioral therapy codes due to expected audit findings. The Department will contract with an auditing firm to do pre- and post- review of all providers and claims for autism services to ensure the providers are credentialed & licensed, and the services are necessary and appropriate. The audit findings are expected to be released this fall.

Reduction in Rates

Rollback the FY 2025-26 1.6% provider rate increase

The Department is proposing rolling back the 1.6% provider rate increase passed for FY 2025-26. Provider rates will revert to SFY 2024-25 levels on October 1, 2025.

Adjust Community Connector Rate

The Department is proposing to reduce the Community Connector rate by 15% in order to reduce expenditures effective January 1, 2026. Furthermore, there will be an additional reduction to align this service with supported community connections, effective for April 1, 2026, to align this service with other similar programs under HCBS. These additional reductions represent approximately a 23% reduction.

Eliminate the Nursing Facility Minimum Wage Supplemental Payment

The Department is proposing to eliminate the nursing facility minimum wage supplemental payment and recoup the funding as savings. This payment is currently set to sunset next year, but under this change, the Department would end the distribution of funds one year early. Because the state minimum wage is expected to exceed \$15 per hour in FY 2026-27, the supplemental payment will no longer be necessary. Nursing facility rates will not be impacted by the 1.6% ATB reduction.

Align Individual Residential Services and Supports

The Department is proposing to change rules to require providers to bill IRSS when it is provided in a family home at the same rate as Host Home, as the cost for rendering the service is the same. Currently, many providers are billing different rates for Host Home services and services provided by a family caregiver, with a higher rate paid to family caregivers (they are billing at the 'Staffed Home' rate). This should not be the case; Host

Homes and family caregiver homes are staffed in the same manner, with those providing services sharing the residence. Staffed homes that provide rotating staff are different from these other settings and should be reimbursed the higher of the two IRSS rates set by the Department. Only a small portion of IRSS utilizers reside in a staffed home and therefore require the higher rate. Ensuring that the higher rate is only billed for settings where shift staff are provided will generate savings. The Department will enforce this through case management agencies, who are responsible for authorizing services in alignment with our policies. There are no additional resources required for this initiative.

Reset Pediatric Behavioral Therapy Rates

The Department is proposing a reduction of funds by resetting the pediatric behavioral therapy rates to 95% of the new benchmark. This benchmark includes updated rates for all comparator states, including Nebraska. These rates will not be subject to the 1.6% ATB provider rate reduction.

Decrease Dental Reimbursement Rates

The Department is proposing a final rate for each of the effective codes that will be 15.5% lower than the July 2024 rate. This reduction relates to a group of codes that received increases effective July 1, 2024 to align HCPF's Medicaid fee-schedule with commercial rates. Some codes were adjusted to match 100% of the commercial benchmark; others were adjusted to match 70% of the commercial benchmark. This adjustment will reduce those rates which received targeted increases, but will be applied equitably so that rates which had a significant disparity with commercial rates are not disproportionately affected. This reduction preserves the intent of the original rate action to correct significant rate disparities while still achieving the required savings.

Enrollment Changes for the Developmental Disabilities Waiver

Auto Enrollment Changes for Certain Youth Transitions in DD Waiver

The Department proposes ending automatic youth-to-adult Developmental Disabilities (DD) waiver transitions for members aging out of Children's Extensive Supports (CES) waiver effective July 1, 2026. This change would require children to receive care under a separate waiver like Supported Living Services (SLS) or the Elderly Blind and Disabled (EBD). This proposal does not affect authorizations onto the DD Waiver through Emergency Enrollment criteria, transitions from the youth foster care system, or transfers from institutions. To implement this proposal the Department requires one administrative IV FTE to provide training and support to case management agencies through the eligibility pathways for the DD waiver, assist with reviewing emergency enrollment authorizations and reviewing appeals decisions. This proposal requires system changes to the Care and Case Management (CCM) system to track and adjudicate emergency requests and denials.

Reduce DD Waiver Churn Enrollments

The Department proposes to reduce churn enrollments by 50% onto the Developmental Disabilities (DD) waiver effective July 1, 2026. Churn enrollments only occur when someone disenrolls from the DD waiver primarily due to death, moving out of state, or transferring to a different waiver. This proposal will result in more members staying on the waitlist and continuing to receive services under their existing waiver. This proposal does not affect authorizations onto the DD waiver through Emergency Enrollment criteria, transitions from the youth foster care system, or transfer from institutions. To implement this proposal the Department requires one administrative IV FTE to assist with reviewing emergency enrollment authorizations and appeals decisions.

Executive Order Amendment Reductions

The Department is proposing a series of reductions in alignment with the October 31, 2025 amendment to Executive Order D 2025 014. These reductions are outlined below.

Reduce Senior Dental Grants

The Department is proposing a reduction to the Colorado Dental Health Care Program for Low Income Seniors, commonly referred to as the Senior Dental Grants program. This reduction will help align the state appropriations with budget needs.

Delay Implementation of Community Health Worker Services

Delaying implementation of Medicaid coverage for Community Health Workers will not have any impact on current processes or service coverage, as this benefit was intended to go live January 1, 2026. This reduction represents a delay in the final implementation of the benefit. The Department assumes that the estimated service expenditure for this program will be restored by the General Assembly during the 2027 legislative session such that the benefit will go live January 1 2028.

Realigning Children in Rocky Mountain Health PRIME

The Department is proposing to no longer pursue expanding Rocky Mountain Health PRIME to include children as part of the capitation benefit. Children are not currently covered under Rocky Mountain Health PRIME's capitated benefit, and therefore no changes are anticipated to their existing fee-for-service based coverage, the ACC program, or its members due to the elimination of this project.

Removing ACC Credentialing Component

The Department is proposing to remove funding for the ACC Credentialing component of the FY 2025-26 R-6 ACC Phase III Budget Request. This request was made in order to reduce administrative burden on providers by creating one single uniform provider credentialing system. However, with the implementation of ACC Phase III and the corresponding reduction in the number of Regional Accountable Entities from 7 to 4, a reduction in the administrative

burden has already been realized. For this reason, it is no longer considered necessary to implement this change, and will not have any significant impact on the administration of the ACC, providers, or members.

Reducing Certain Rates to 85% of Medicare Benchmark

The Department is proposing reducing certain rates to 85% of the Medicare Benchmark beginning April 1, 2026, excluding Primary Care and Evaluation & Management Services. These reductions will be applied to the service categories listed on Table 6.6 of the Appendix.

Pharmacy Cost Reduction Initiatives

The Department is proposing to implement pharmacy rate adjustments, utilization policy changes, and fee reductions. The pharmacy initiatives are outlined in further detail below.

Outpatient Drug Rate Reduction

The Department worked in partnership with a contractor to estimate how savings could be generated by adjusting the methodology that determines the rate paid to pharmacies for outpatient drugs. The estimate is based on the fee-for-service pharmacy reimbursement methodology that was in effect as of the start of August 2025. The change incorporates maximum allowable cost (MAC) into the lesser-of reimbursement methodology. Currently, a claim will only pay at the MAC rate if no actual acquisition cost (AAC) or national average drug acquisition cost (NADAC) exist for the national drug code (NDC). For some drugs, there is not enough pricing information to create an AAC or NADAC rate. MAC rates are approximately equivalent to NADAC rates.

Shifting Utilization to Cost-Effective Biosimilars and Other Agents

This initiative will be implemented by targeting increased utilization of more cost effective biosimilars and GLP-1 agents. Initial policy changes were initiated on 7/15/25 to require utilization of biosimilar Ustekinumab prior to approval for the branded Stelara. Additional policy implementations will be initiated 1/1/2026 following our Pharmacy and Therapeutics Committee and Drug Utilization Review Board's review of the Targeted Immune Modulators.

Third Party Liability Secondary Payer Shift

The Department is updating the Pharmacy Benefit Management System in order to ensure that pharmacies appropriately bill primary payors. Pharmacies will be allowed to submit only a limited number of codes to bypass primary payor requirements, such as for Medicare coverage exclusions.

Rate Reduction to Specialty Drug Carveout Program

The Department is in the process of preparing a State Plan Amendment that would reset the reimbursement available for outpatient hospital reimbursements for specialty drugs from 100% of cost to 92% of cost.

Dispensing Fee Reduction

The Department is in the process of submitting a State Plan amendment to CMS that would reduce dispensing fee amounts for the highest volume pharmacy tiers. Based on data from the Department's most recent cost of dispensing survey, the reimbursement rate for the lowest two dispensing fee tiers (pharmacies with the highest annual prescription volume) will be adjusted from \$10.25 to \$9.93 and \$9.31 to \$8.72.

Delaying Presumptive Eligibility for Long Term Services and Supports

The Department proposes implementing a delay of the LTSS Presumptive Eligibility program based on feedback and guidance from the Centers for Medicare and Medicaid Services (CMS). This action temporarily postpones program startup and associated expenditures originally funded through the BA-07 Community-Based Access to Services request. The Department anticipates that Presumptive Eligibility for Long Term Services and Supports will begin July 1, 2027.

Implement a Soft Cap on Certain HCBS Services

The Department is proposing a soft cap on Personal Care, Homemaker, and Health Maintenance Activities (HMA). This measure would cap 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). These caps are expected to decrease claims, generate cost savings, and promote equity by applying consistent limits across delivery models and caregiver types. To implement these caps, the Department requests funding for three ongoing FTE to maintain the caps once implemented. These staff will manage the exceptions process including working with stakeholders to manage the exceptions process, then review exception requests and approve or deny the exceptions. The phased implementation for this initiative will start on April 1, 2026 and continue on a rolling basis until complete.

Implement a Cap on Weekly Caregiving Hours

The Department is proposing a 56 hours per caregiver per week cap on the total number of hours a single caregiver may be paid to provide, which will replace the current 16 hour per day cap. This cap would be spread across Home Health Aide, Personal Care, Homemaker, HMA, and Nursing services. The Department will only authorize exceptions to this cap in extraordinary and short term circumstances. Implementing this cap will increase the safety of caregivers and members. While this cap does promote cost savings, the goal of the initiative is to also promote sustainable care delivery within existing resources. To implement this cap, the Department requests funding for 1 ongoing FTE to oversee the cap post implementation. This FTE will manage compliance of this policy and will include reviewing provider files, time sheets, and other paperwork as necessary to ensure a single caregiver is not working more than the allowed 56 hours per week. The projected implementation date for this cap is April 1, 2026.

Implement a Cap on Weekly Homemaker Hours for Legally Responsible Person

The Department proposes to reduce the homemaker service cap for legally responsible persons (LRP's) from 10 hours per week to 5 hours per week. LRP's are typically parents or spouses that have a legal responsibility to take care of a member. Reducing the cap on this service will maintain availability while improving program consistency, and decreasing costs. This reduction is also expected to align with perceived appropriate levels of homemaker care from an LRP. The expected implementation for this initiative is April 1, 2026.

Align Community Connector Rate with Supported Community Connections

The Department is proposing to reduce the reimbursement rate for Community Connector to align with the Tier 3 Supported Community Connections (SCC) rate—approximately \$7.71 per 15-minute unit—based on concerns that the current rate is disproportionately high compared to the training and qualifications required for the service. This reduction is paired with other Community Connector changes (such as age limits and service caps). The current rate structure creates unusually high profit margins for provider agencies. HCPF views the rate cut as necessary for Medicaid cost control, sustainability of the benefit, and more equitable alignment with comparable direct care services. The Department anticipates this change will go into effect April 1, 2026.

Implement New Service Unit Limitations for Community Connector

The Department is proposing to reduce the annual cap on Community Connector services by 50%, lowering the maximum allowable units from 2,080 to 1,040 per support plan year under the Children's Extensive Support (CES) and Children's Habilitation Residential Program (CHRP) waivers beginning April 1, 2026 and on a rolling basis until complete. The Department is also proposing implementing age limitations for Community Connector as a part of the R-19 "Office of Community Living Reductions request. The Department is proposing implementing these age restrictions on April 1, 2026 in alignment with the unit limitations. The Department requires one FTE to implement this change to manage the exception process. By lowering the unit limitation, the Department expects to see hundreds of exception requests. This review process will be individual based and substantial, requiring one FTE to fully conduct. No statutory changes are required. System updates to InterChange and the Bridge will be implemented to enforce the new limits and ensure consistency in service authorization, billing, and claims processing. This change will reduce Medicaid expenditures associated with excessive utilization while maintaining member access to community participation supports.

Reduce Movement Therapy to Align with Rate Methodology

The Department is proposing to reduce Movement Therapy service rates in alignment with recommendations. These rate adjustments will ensure consistency with statewide rate review methodologies. The expected implementation for this initiative is April 1, 2026.

Alignment of Income Requirement for HCBS Residential Waivers

The Department proposes aligning cost sharing requirements for the Developmental Disabilities waivers with other Medicaid waivers by applying Post-Eligibility Treatment of Income (PETI) for members enrolled in the DD waiver effective July 1, 2026. Under this proposal DD Waiver members would be required to contribute part of their income toward service costs. This change requires system modifications and federal approval.

Additional Executive Order Amendment Reductions

In addition to the above, the Executive Order Amendment includes the following items which are not included in the total dollar amounts estimated in this R-06 and the corresponding exhibits, but will be included in January budget amendment:

- Capping adult dental services for Medicaid members to \$3,000 per year, and capping dental services for members served through Cover All Coloradans at \$750 cap per year, and
- Changing Cover All Coloradans to remove CAC members from the Accountable Care Collaborative and move them to a full fee-for-service benefit to reflect actual utilization.

Additional Reductions Package via Budget Amendment

The Department is proposing additional budget reduction options of \$124,294,518 General fund savings in FY 2026-27 in order to achieve the state's budget balancing targets. The Department will provide this additional budget amendment on January 2, 2026 with additional details including the specific policy adjustments included in order to achieve this target. The Department anticipates including removal of equine therapy services, converting contractors to FTE, and other spending reductions as a part of this budget amendment. These additional savings of approximately \$124M will hold the growth of Medicaid medical claims cost to 5.6%, when comparing final requested appropriation (medical claims costs only) for FY 2026-27 to the current Long Bill appropriation for FY 2025-26. This \$124M in additional savings will include the abovementioned Additional Executive Order Amendment Reductions.

Finally, if and when the federal government approves Colorado's June 2025 request for State Directed Payments, we will review provider fees such as the Healthcare Affordability and Sustainability Fee under the Colorado Healthcare Affordability Sustainability Enterprise (CHASE), to explore potential ways to help address Medicaid budget sustainability.

The Department is working diligently with stakeholders and conducting a third party analysis to provide a global picture of the program, and identify where we are seeing exponential growth. Preliminary results will be completed in December 2025. Based on that forthcoming analysis, we are proposing to work with the General Assembly to pass legislation that will enable the State to achieve and maintain a sustainable rate of growth to Medicaid expenditures. This legislation should seek to establish a year-over-year growth rate in Medicaid General Fund spending. While this budget proposes a 5.6 percent growth rate for FY 2026-27, the growth rate should continue to ramp down rapidly and within the next few years

align with growth in the TABOR cap. Such actions would still satisfy federal Medicaid requirements and maintain Medicaid's status as an entitlement with over-expenditure authority. The Department is working with national experts to examine the Medicaid program in Colorado in comparison to national benchmarks, which will inform discussions on options to bring cost growth in line with the rest of the budget; we will provide an update to the Joint Budget Committee in our January 2, 2026 supplemental and budget amendment submission.

Supporting Evidence and Evidence Designation

Reduction in Programs and Rates

The reductions in programs and rates are reductions in incentive program benefits or rates, and therefore do not meet the evidence designation standards. The Department assumes that an Evidence Designation is not applicable to these requests because the request does not meet the statutory definition for a program or practice. To be considered a program or practice, the request must have specific outcomes, a target population, and defined and replicable elements. The State has existing authority to increase or decrease provider rates and expenditure as long as federal guidelines pertaining to efficiency, economy, and quality of care are met.

Utilization Management

Definitive Drug Testing

This initiative will limit access to definitive drug testing by placing Prior Authorization Requests on the certain codes to prevent improper billing, and therefore does not meet the evidence designation standards. The Department assumes that an Evidence Designation is not applicable to this request because the request does not meet the statutory definition for a program or practice. To be considered a program or practice, the request must have specific outcomes, a target population, and defined and replicable elements.

Reinstating Medicaid PAR of Outpatient Psychotherapy

The program objective of a PAR for outpatient psychotherapy is to implement a third-party assessment process for the intermittent nursing benefits. The outputs being measured are prior authorization approval and denial changes and utilization trends of services within the benefits. The outcome being measured is a reduction in duplicative utilization of skilled care modalities while maintaining better access to care for members to the most appropriate services for their needs. The American Academy of Nursing on Policy published an article, "The value of nursing care coordination: A white paper of the American Nurses Association," in which they highlighted the importance of care coordination as foundational to the health care reform goals of improving the quality of care for individuals and populations via the efficient and effective use of resources.

Pre and Post Payment Review of Pediatric Behavioral Therapy (PBT)

The program objective of a pre and post payment review of PBT is to reduce expenditures due to improper billing. Outputs being measured are identification and recovery of improper

payments related to PBT providers and services. The outcomes being measured is expenditure that the Department can recover from improper payments. The Office of Inspector General (OIG) recently audited multiple states on PBT benefits, also known as Applied Behavioral Analysis (ABA) services. In Indiana, the OIG audit found that the state had made at least \$56 million in improper payments for ABA services provided to children with autism. OIG is currently auditing Colorado and similar results to Indiana are expected.

Executive Order Amendment on October 31, 2025

The Executive Order D 2025 014 amendment actions include reductions to rates, delays in implementation, and other budget reduction proposals. The Department assumes that an Evidence Designation is not applicable to this request because the request does not meet the statutory definition for a program or practice. To be considered a program or practice, the request must have specific outcomes, a target population, and defined and replicable elements.

Core Principles for Reducing the Rate of Spending Growth

As the state continues to grapple with Medicaid's significant budget pressures, we are committed to following a core set of principles while considering targeted budget reductions. These core principles include:

1. **Maximizing Coverage:** Colorado's Medicaid program covers 1.2 million of our state's most vulnerable residents. Attempts to address Medicaid cost growth should prioritize protecting coverage for as many Coloradans as possible who cannot afford insurance or care otherwise.
2. **Prioritizing High-Value Services That Keep People Healthy:** Future budgets should focus on preserving and promoting evidence-based, high-value services that avoid more expensive care down the road, such as prevention of chronic disease. Relatedly, budget reductions can target overutilization patterns where the service need is not supported by data.
3. **Committing to Collaboration:** The administration is committed to collaboration with interested parties as the state implements these difficult but necessary reductions. Long-term changes to spending policy should include consultation with members, stakeholders, and communities whenever possible, including with those most impacted by Medicaid budget reductions. HPCF should maintain an open-door policy to hear the concerns of Medicaid enrollees and other stakeholders.
4. **Honoring Medicaid's Role for Critical Coverage:** The Department recognizes the importance of core Medicaid services that are not offered in commercial plans, such as residential care for youth; long-term services and supports for people with disabilities and people who are aging; and the role of Medicaid in supporting Colorado's health economy.
5. **Enhancing Program Efficiencies and Integrity:** Providing quality and efficient care while minimizing wasteful spending in Medicaid remains a critical priority for the state. This includes streamlining administrative processes at the state and county levels to ensure

that coverage is simple and easy to access and maintain, as well as cracking down on bad actors who take advantage of the Medicaid system.

6. Promoting Long-Term Savings Over Short-Term Cuts: Future budgets should focus on strategies that result in lowering costs over time, or at the very least, slowing the rate of cost increases, rather than implementing short-term budget fixes.

Assumptions and Calculations

The Department's assumptions and calculations are based on the Governor's Executive Orders to decrease the General Fund by specific amounts per service area or program. For further details refer to the appendix. The savings estimates provided are net of administrative costs to implement the reductions which includes personnel costs of FTE and costs of system changes.

Reducing Incentive Payments

Reduce the ACC Incentive Program

The Department calculated a \$2.3 million reduction of the Total Fund, including a \$750,000 General Fund reduction, to Incentive Payments in the Accountable Care Collaborative (ACC Quality Program). This is about a 25% reduction to the total amount that can be earned by PCMPs and the RAEs for the first payment for the primary care quality improvement projects. However, it is only a 4% reduction in the incentive program across funding types. The reduction amount was calculated using the percentage breakdown of the funds within the Total Fund amount, and using those to structure the reduction accordingly.

Reduce the Behavioral Health Incentive Program

The Department calculated a \$12 million reduction of the Total Funds, including a \$3 million General Fund reduction, for Behavioral Health Incentive Program (BHIP) payments. This represents about a 31% reduction in the incentive payments across funds. The reduction amount was calculated using the percentage breakdown of the funds within the Total Fund amount, and using those to structure the reduction accordingly.

Reductions to Access Stabilization Payments

The Department calculated a \$4.6 million reduction of the Total Fund, including a \$1.5 million General Fund reduction to the Access Stabilization Payments to rural, small and pediatric providers by implementing these payments effective January 2026, assuming CMS approval, versus retrospectively to July 2025. This represents a 49% reduction in the stabilization payments across funding types. The reduction amount was calculated using the percentage breakdown of the funds within the Total Fund amount, and using those to structure the reduction accordingly.

Reduction in Programs

Ending Continuous Coverage

The Department calculated a \$13.6 million reduction of the Total Fund, including a \$5.6 million General Fund reduction, for halting implementation of continuous coverage for children ages 0-3. The Department estimated the reduction based on removing the original fiscal impact from HB 23-1300. The Department reflects an offsetting budget impact within this request as savings have already been incorporated in the Department's November 1, 2025, FY 2026-27 R-1 Medical Services Premiums forecast.

Immigrant Family Planning Reduction

The Department calculated a \$500,000 General Fund reduction to Immigrant Family Planning Services from SB 21-009 Reproductive Health Care Program. This program has historically underspent its budget, which is currently \$2.6 million of state-only funds; therefore, this reduction is absorbable and will not reduce access to these important services.

Reduction of SBIRT Grants

The Department calculated a \$500,000 cash fund reduction by reducing grants to train providers for a well-established screening tool and interventions related to substance use, and repurposing the Marijuana Cash Tax Fund to offset the General Fund.

Cover All Coloradans Outreach Contract Elimination

The Department calculated a \$375,000 reduction of the Total Fund, including a \$131,000 General Fund reduction, to eliminate outreach for the Cover All Coloradans program; pause on expenditure was made effective immediately upon the signing of the Executive Order but requires Legislative approval before being made permanent.

Cost Controls

Definitive Drug Testing

The Department calculated a \$12.9 million reduction of the Total Fund, including a \$1.7 million General Fund reduction, for introducing definitive inpatient and outpatient drug testing. To calculate the anticipated savings from limiting definitive drug testing, the Department analyzed total claims data from Calendar Year 2024 across all provider types. The Department modeled post-policy expenditures by assuming the cap is enforced but allows for a portion of members to exceed the threshold through approved PARs. This approach reflects a realistic implementation scenario and accounts for clinical flexibility through the PAR process, while maintaining meaningful cost control through a utilization ceiling.

Reinstate Medicaid prior authorization of outpatient psychotherapy

The Department calculated a \$15.7 million reduction of the Total Funds, including a \$6.1 million General Fund reduction, to reinstate Medicaid prior authorization of outpatient psychotherapy for services that exceed clinical standard best practices, currently prohibited in statute (C.R.S. 25.5-5-406.1(II)).

Implement Pre- and Post- Claim Review of all Pediatric Autism Behavioral Therapy

The Department calculated a \$14 million reduction of the Total Fund, including a \$7 million General Fund reduction, by implementing pre- and post- claim review of all pediatric autism behavioral therapy codes due to audit findings¹.

Reduction in Rates

Rollback the FY 2025-26 1.6% provider rate increase

The Department calculated a \$108.1 million reduction of the Total Fund, including a \$38.3 million General Fund reduction, by rolling back the 1.6% provider rate increase passed for SFY 2025-26. This will go into effect on October 1st, 2025. The savings were calculated by taking a percentage of the total amount budgeted, for the provider rate increase, proportional to the amount of months the rate increase will no longer be in effect.

Adjust Community Connector rate

The Department calculated a \$6.0 million reduction of the Total Fund, including a \$3.0 million General Fund reduction, by adjusting the Community Connector rate to better align with similar benefits and services. To calculate the reduction, a weighted average was taken across rates and a 14.98% decrease was applied effective January 1, 2026.

Eliminate the Nursing Facility Minimum Wage Payment Supplemental Payment

The Department calculated a \$8.7 million reduction of the Total Fund, including a \$4.4 million General Fund reduction, by eliminating the nursing facility minimum wage supplemental payment. The Department assumes ongoing savings from ending the minimum wage supplemental payment. In the fiscal note for HB 23-1228, Legislative Council noted that the Department would have the authority to continue to make the Minimum Wage supplemental payment without statutory language, so no reduction was included in the fiscal note once it was repealed from statute effective in FY 2026-27. The Department is proposing to remove the supplemental payment and recoup all of the funding as savings.

Align Individual Residential Services and Supports

The Department calculated a \$2.9 million reduction of the Total Fund, including a \$1.5 million General Fund reduction, to align the Individual Residential Services and Supports rates for

¹High-Risk Provider & Services Prepayment Review Initiative - Fiscal Year 2025-26

host home and family caregiver homes. The Department spent approximately \$241,226,158 on IRSS Services and \$228,663,526 on IRSS Host Home Services in FY 2023-24. The Department assumes that approximately 75% of the services billed under IRSS should be Host Home Services based on the low number of staffed homes within the state. Based on inaccurate and confusing guidance regarding the two rates, providers are billing out of alignment with what was originally intended for the service. The two billing options listed are for Host Homes, which is a lower rate, or “Other”, which is a higher rate. Host Home rates are intended for host homes, family caregivers, and member homes, while the “Other” rate is intended for agency-staffed providers. Currently, providers are billing under the “Other” rate when a member is in a setting with a family caregiver or their own home and services are provided by a live-in caregiver. As a result of clarifying billing practices the Department assumes that members receiving care in a Family Home setting will begin to bill at the lower rate. This would be enforced through a rule change accompanied by an issued memo, and case managers would be instructed on how to add the correct service to the individual member’s Prior Authorization Request (PAR).

Reset Pediatric Behavioral Therapy Rates

The Department calculated a \$5.4 million reduction of the Total Fund, including a \$2.7 million General Fund reduction, by resetting the pediatric behavioral therapy rates to 95% of the new benchmark. The previous rates were 99.99% of the benchmark, and this is reducing them to 95%. The benchmark was also updated to include 2025 Nebraska PBT rates, which are substantially higher than the national average.

Decrease Dental Reimbursement Rates

The Department calculated a \$14 million reduction of the Total Fund, including a \$2.5 million General Fund reduction by reducing the July 2024 rates by 15.5%.

Enrollment Changes for the Developmental Disabilities Waiver

Auto Enrollment Changes for Certain Youth Transitions in DD Waiver

The Department calculated the savings from stopping automatic enrollments for youth to the DD waiver based on the average number of youth who enrolled onto the DD waiver in FY 2024-25 and the alternative service options available for the youth. The Department assumed that some youth would continue to gain access to the DD waiver through an emergency enrollment authorization. The Department assumed that 80% of the youth who age out of their existing service delivery option would receive care on the Elderly Blind and Disabled Waiver and the remainder of children would receive care through the Supported Living Services Waiver. The Department assumes that members could continue to become eligible for the DD waiver through Emergency Enrollment requests, transitions from the foster care system, or transitions from institutions, provided they meet the necessary eligibility requirements. The Department assumes this policy would become effective July 1, 2026 following federal approval and system changes.

The Department assumes that the Administrator IV would begin work on January 1, 2026 to develop regulations, federal waiver amendment, contract changes, policy guidance, communication and training for case management agencies on appropriate emergency enrollment authorizations, and develop communications on alternative service delivery options for members. This staff would be required ongoing to continue to provide case management support for this initiative as well as all other initiatives impacting case management agencies to address policy guidance, regulatory changes, stakeholder engagement and post implementation support. Due to the multitude of policy changes, operational guidance necessary to support case managers, member and family correspondence, large increase in expected appeals and emergency enrollment requests the department requires one staff for this initiative and an additional staff for reducing churn enrollments by 50% into the DD waiver.

Reduce DD Waiver Churn Enrollments

The Department calculated the savings from reducing the churn enrollments by 50% to the DD waiver based on the average number of monthly transitions to the DD waiver from January 2024 through June of 2025 and the alternative service options available for waitlist members. The Department assumed that 80% of the existing waitlist members will continue to receive care on the Elderly Blind and Disabled Waiver and the remainder of members will continue to receive care through the Supported Living Services Waiver. The Department assumes that members could continue to become eligible for the DD waiver through churn, Emergency Enrollment requests, or transitions from institutions provided they meet the necessary eligibility requirements. The Department assumes this policy would become effective July 1, 2026 following federal approval.

The Department assumes that the administrator IV would begin work on January 1, 2026 in order to provide case management agency support, review and authorize enrollment requests, daily management and oversight to limit inappropriate emergency enrollment authorizations and communications on alternative service delivery options for members. This staff would be required ongoing to continue to provide case management support, provide grievance support for members, management of emergency and reduced churn enrollment authorizations, and review appeals. Due to the large increase in expected appeals, grievances, and increased emergency enrollment requests the department requires one staff.

Executive Order Amendment Reductions

Reduce Senior Dental Grants

The Department calculated a \$500,000 million dollar reduction in FY 2025-26 growing to \$2 million reduction in FY 2026-27 ongoing.

Delay Implementation of Community Health Worker Services

The Department calculated a \$5.7 million Total Fund reduction, including a \$1.4 million GF reduction, in FY 2025-26 and a \$13.4 million total funds reduction that includes a \$3.2 million GF reduction in FY 2026-27, to postpone the implementation of the community health workers benefit based on the estimated service utilization published in the fiscal note. The Department assumes that this benefit will be reinstated and service expenditure will begin January 1, 2028.

Realigning Children in Rocky Mountain Health PRIME

The Department calculated a \$3.5 million Total Fund, \$1.7 million General Fund, reduction in FY 2026-27 based on the cost of this initiative, which was initially granted budgetary authority via the FY 25-26 R6 ACC PHASE III budget request.

Removing ACC Credentialing Component

The Department calculated a \$650,000 Total Fund, \$40,950 General Fund reduction in FY 2025-26 based on the cost of this initiative, which was initially granted budgetary authority via the FY 25-26 R6 ACC PHASE III budget request.

Reducing Certain Rates to 85% of Medicare Benchmark

The Department calculated the reduction of certain rates to the Medicare Benchmark, excluding Primary Care and Evaluation & Management Services, by taking the current utilization and evaluating the costs based on the current rates versus the proposed rates. The Department assumes this policy will be implemented April 1, 2026.

Pharmacy Cost Reduction Initiatives

Outpatient Drug Rate Reduction

The rate reduction was calculated by increasing the Maximum Allowable Cost (MAC) discount off of Wholesale Acquisition Cost (WAC) from 3% to 4% for branded products and from 10% to 22% for generic products. In addition to changing the Wholesale Acquisition Cost discount applied to brand and generic drug products, this calculation also applies a “lesser of” methodology using the National Average Drug Acquisition Cost (NADAC), Actual Acquisition Cost (AAC), or the discounted Wholesale Acquisition Cost for all products – not just those without a defined National Average Drug Acquisition Cost or Actual Acquisition Cost. The Department assumes this policy will be implemented April 1, 2026.

Shifting Utilization to Cost-Effective Biosimilars and Other Agents

The Department calculated the savings of shifting to more cost effective drugs based on the current reimbursement rates net of rebates of various brand specialty drugs and GLP1's and the alternative cost of shifting to biosimilar versions or lower cost versions of those drugs. The Department is unable to share specific drug names, cost or rebate information as that would violate the terms of confidential rebate agreements and 42 U.S.C. §1396r-8(b)(3)(D). The Department estimates that savings could begin on January 1, 2026.

Third Party Liability Secondary Payer Shift

In FY 2024-25, \$20.6 million in claims bypassed primary coverage for full payment from Medicaid. Based upon the update, the Department estimates that \$9.77 million would still bypass primary coverage policies, reducing Medicaid costs by \$10.8 million. Of this \$10.8 million in claims, it is estimated that Medicaid would pay 10% on average as secondary payer, resulting in a total reduction of \$9.72 million. The Department assumes this policy would become effective January 1, 2026

Rate Reduction to Specialty Drug Carveout Program

The Department estimated the impact of reducing specialty drug reimbursement rates from 100% to 92% by evaluating the current cost based on the 100% reimbursement rate and the difference in costs if services were billed at a 92% reimbursement rate. The Department assumes this policy would become effective April 1, 2026.

To evaluate the potential impact of reducing specialty drug reimbursement rates from 100% to 92%, all specialty drug claims were pulled for FY 2024-25. For each claim, data were obtained for the billed unit quantity, billed amount, and paid amount.

Dispensing Fee Rate Reduction

The Department calculated the reduction by reducing the dispensing fee tiers for pharmacies with the highest annual prescription volume from \$10.25 to \$9.93 and \$9.31 to \$8.72, the Department estimates that dispensing fee expenditures can be reduced by \$0.3 million dollars in FY 2025-26 growing to \$1.7 million dollars in FY 2026-27 ongoing. The Department assumes this policy will be implemented April 1, 2026.

The paid amounts were then multiplied by 0.92 to estimate the adjusted reimbursement under a 92% payment scenario.

Delaying Presumptive Eligibility for Long Term Services and Supports

The Department calculated a \$1.3 million reduction of the Total Fund, including \$690,000 a General Fund reduction, from postponing the implementation of the LTSS Presumptive Eligibility program in compliance with the Executive Order.

Implement a Soft Cap on Certain HCBS Services

The Department is proposing to implement a soft cap that will allow the majority of individuals to continue to receive services without seeking any additional approval but also acknowledge the need for an additional review process. The soft cap limit to achieve this balance will be set at two standard deviations above the mean for Personal Care, Homemaker, and HMA services. The soft cap would be approximately 10,000 units for Personal Care, 4,500 units for Homemaker, and 19,000 units for HMA. The Department used utilization data on the average number of units, number of members, and average paid amount two standard deviations above the mean. To calculate the final savings estimate, the Department is

multiplying the total paid amount for members utilizing services two standard deviations above the mean by various factors to account for member behavior, the overlapping nature of placing multiple caps on the same set of services, and adjustments for the implementation date. The Department prorated the savings based on an April 1, 2026 implementation date and an assumed one month lag in claims billing. The overlap factor is used to account for any duplicative savings that may be captured by other service caps, as well as savings that might have already been captured by other cost reducing measures such as reinstating the PAR's on Long Term Home Health (LTHH) services. This factor is dampening the savings to avoid double counting savings from other initiatives. The factor is applied to each service individually, and has been selected depending on the impact of the other caps within this request, as well as potential overlap with previous cost saving measures. For the Personal Care, Homemaker Services, and Health Maintenance Activities, the Department is assuming that 75% of the savings will be captured within this initiative, as this cap affects members using the highest amounts of this service.

The member behavior factor is used to account for the percentage of members that are likely to substitute other care, which will also dampen the savings effect. The Department is assuming that 50% of members will substitute other care when a cap is applied or go through an exceptions process to continue receiving services. The other 50% of members are expected to reduce services to the allowable cap, which is where the savings is expected.

Within this initiative, the Department is requesting funding for three ongoing Policy Advisor IV FTEs to manage the exceptions process. These duties include working with stakeholders to manage the exception process, review exception requests and approve or deny exceptions that are submitted. These FTE are expected to start on January 1, 2026.

For HMA, the Department has some additional factors and assumptions included in the calculation due to the nature of HMA services. HMA services are clinical services that are assessed and recommended by a nurse in the nurse assessor program. Some members may seek care for hours they have been assessed for because it is determined that they need care. Because of this, the Department is assuming that 80% of the members currently receiving HMA services that would be affected by the cap will transition to receiving care under LTHH, where they will be able to access all assessed hours of care. The calculation for the total cost of members transitioning to LTHH is included in the savings estimate.

Implement a Cap on Weekly Caregiving Hours

The Department is proposing to implement a cap on individual caregivers for Home Health Aide, Personal Care, Homemaker, HMA, and Nursing services provided to a single member. The cap would apply to a single caregiver rendering all services, so they would only be able to provide a total of 56 hours per week of Homemaker, Personal Care, HMA, Health Aide, and Nursing. There will be allowable, rare exceptions for extraordinary and short-term circumstances. The Department has calculated these savings by multiplying the total paid amount for units above the cap during FY 2024-25 by the patient behavior factor, an overlap

factor (set at 20%), and an implementation adjustment. The Department prorated the savings based on an April 1, 2026, implementation date and an assumed one-month lag in claims billing.

The Department has also applied an overlap factor, a member behavior factor, and an implementation factor. The overlap factor is used to account for any duplicative savings that may be captured by other service caps, as well as savings that might have already been captured by other cost-reducing measures, such as reinstating the PARs on Long Term Home Health (LTHH) services. This factor is dampening the savings to avoid double-counting. The factor is applied to each service individually, and has been selected depending on the impact of the other caps within this request, as well as potential overlap with previous cost-saving measures. For Home Health Aide and HMA, Homemaker and Personal Care, the Department is assuming a 20% overlap factor. This is because the majority of the savings for Home Health Aide are already being captured by the LTHH PAR implementation savings, and the Standard Deviation Cap is capturing most of the savings for the combined services.

The member behavior factor accounts for the percentage of members likely to substitute other care or use a rare exemption process to continue services above the cap, which will also dampen the savings effect. For Home Health Aide, the Department is assuming that 70% of members will substitute other care when a cap is applied. The other 30% of members are expected to stop using services altogether, which is where the savings are calculated. For HMA, Personal Care, and Homemaker, the Department is assuming that 80% of members will substitute other care when a cap is applied. The other 20% of members are expected to stop using services above the cap, which is where the savings are calculated.

Within this request, the Department is also requesting funding for one ongoing Compliance Specialist IV FTE to manage the compliance process. These duties include reviewing provider files, time sheets, and other paperwork as necessary to ensure a single caregiver is not working more than the allowed 56 hours per week. This FTE is expected to start on January 1, 2026.

Implement a Cap on Weekly Homemaker Hours for Legally Responsible Person

The Department proposes to reduce the number of hours per week under the Homemaker cap from 10 hours to 5 hours provided by a single LRP. Based on the utilization for the Homemaker benefit, most members are not using 10 hours per week, and instead are in the 5-6 hour range. This is based on the per member average hours per week above the cap, which was 1.33 in FY 2024-25. The Department is expecting that this reduction will not significantly affect member behavior, because most members are near or within the cap already. The Department is basing the calculation on the total number of adult members receiving Homemaker care above 5 hours per week, and the total amount paid above the cap. This total is then multiplied by the implementation adjustment and the overlap factor. The Department

prorated the savings based on an April 1, 2026 implementation date and an assumed one month lag in claims billing.

The Department has also applied an overlap factor, a patient behavior factor, and an implementation factor. The overlap factor is used to account for any duplicative savings that may be captured by other service caps, as well as savings that might have already been captured by other cost reducing measures. This factor is dampening the savings to avoid double counting. The factor has been selected depending on the impact of the other caps within this request, as well as potential overlap with previous cost saving measures. Because there are two other caps being applied to the Homemaker service within this request, the Department is assuming a higher savings overlap factor, which will dampen the overall savings from this initiative. This means that there is a 20% overlap factor applied, meaning the Department is assuming that 80% of the savings from this initiative have already been captured.

Because the population for the service is so small, and there is a smaller amount of average hours over the cap, the Department has not included a patient behavior factor. The Department is assuming that all members will decrease utilization in accordance with the cap.

Align Community Connector Rate with Supported Community Connections

The Department calculated savings based on the estimated decrease in expenditure from moving rates from the current rates to align with Supported Community Connections. The Department prorated the savings based on an April 1, 2026 implementation date and an assumed one month lag in claims billing.

Implement New Service Unit Limitations for Community Connector

The Department estimated the impact of capping the community connector services based on FY 2024-25 data for claims that are above the proposed cap of 1,040 units, and the current cap that began on July 1, 2025 of 2,080 units. The Department prorated the savings assuming an April 1, 2026 implementation data and an assumed one month lag in claims billing.

The Department assumes that this change requires minor system modifications that can be completed within existing resources. The Department assumes one policy advisor IV would start January 1, 2026 to manage the exceptions process including working with stakeholders to manage the exceptions process, review exception requests and approve or deny the exceptions.

Reduce Movement Therapy to Align with Rate Methodology

The Department calculated savings based on the estimated decrease in expenditure from moving rates from the current rates to the appropriate rate based on the current methodology for the service. The Department prorated the savings based on an April 1, 2026 implementation date and an assumed one month lag in claims billing.

Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services

The Department calculated savings based on the estimated percentage of members above 300 percent of the Federal Poverty Limit on the DD Waiver and the total projected number of members on the DD Waiver from the FY 2025-26 R-5 Office of Community Living Forecast. The Department estimated the average DD PETI contribution based on the average contribution from the Brain Injury Waiver. The Department assumes that savings would begin on July 1, 2026 and continue on a phased implementation over the following year. Due to savings being tied to phased implementation, the Department assumes that only 50% of the potential savings could be achieved in FY 2026-27.

In order to achieve savings from implementing PETI on the DD waiver, the Department requires system changes in FY 2025-26. The Department assumes these costs are absorbable within existing pool hours.

Additional Reductions Package Amendment

The Department calculated the reduction package amendment by the approximate amount needed in order to achieve the State's budget balance requirements. The Department is working to compile a comprehensive budget reduction package for January 2, 2026 with additional details that will be submitted as a budget amendment. The approximately \$124M in additional savings would hold the growth of Medicaid medical claims cost to 5.6%, when comparing final requested appropriation (medical claims costs only) for FY 2026-27 to the current Long Bill appropriation for FY 2025-26.

Table 1.1 Summary by Line Item FY 2025-26									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) Administration, Personal Services	\$303,035.00	2.0	\$151,518.00	\$0.00	\$0.00	\$151,517.00	50.00%	N/A
B	(1) Executive Director's Office; (A) Administration, Health, Life, Dental	\$50,974.00	0.0	\$25,487.00	\$0.00	\$0.00	\$25,487.00	50.00%	N/A
C	(1) Executive Director's Office; (A) Administration, Short Term Disability	\$189.00	0.0	\$95.00	\$0.00	\$0.00	\$94.00	50.00%	N/A
D	(1) Executive Director's Office; (A) Administration, Paid Family and Medical Leave Insurance	\$1,208.00	0.0	\$604.00	\$0.00	\$0.00	\$604.00	50.00%	N/A
E	(1) Executive Director's Office; (A) Administration, Unfunded Liability AED Payments	\$26,796.00	0.0	\$13,398.00	\$0.00	\$0.00	\$13,398.00	50.00%	N/A
F	(1) Executive Director's Office; (A) Administration, Operating Expenses	\$51,555.00	0.0	\$25,778.00	\$0.00	\$0.00	\$25,777.00	50.00%	N/A
G	(1) Executive Director's Office; (A) Administration, Leased Space	\$16,142.00	0.0	\$8,071.00	\$0.00	\$0.00	\$8,071.00	50.00%	N/A
H	(1) Executive Directors Office, (A) General Professional Services	(\$375,000.00)	0.0	(\$131,250.00)	\$0.00	\$0.00	(\$243,750.00)	N/A	N/A
I	(1) Executive Director's Office; (C) IT Contracts & Projects, MMIS Maintenance and Projects	(\$650,000.00)	0.0	(\$40,950.00)	(\$33,800.00)	\$0.00	(\$575,250.00)	N/A	N/A
J	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	(\$1,320,676.00)	0.0	(\$216,823.00)	(\$302,612.00)	\$0.00	(\$801,241.00)	N/A	N/A
K	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals Acute	(\$215,891,971.00)	0.0	(\$73,168,675.00)	(\$11,367,541.00)	\$0.00	(\$131,355,755.00)	N/A	N/A
L	(3) Behavioral Health Community Programs, Behavioral Health Capitation Program	(\$11,993,686.00)	0.0	(\$3,000,000.00)	(\$2,996,843.00)	\$0.00	(\$5,996,843.00)	N/A	N/A
M	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	(\$120,102.00)	0.0	(\$28,858.00)	(\$7,124.00)	\$0.00	(\$84,120.00)	N/A	N/A
N	(5) Indigent Care Program; CBHP Medical and Dental Cost	(\$1,471,134.00)	0.0	(\$308,938.00)	(\$205,959.00)	\$0.00	(\$956,237.00)	N/A	N/A
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	(\$12,884,244.00)	0.0	(\$6,425,166.00)	(\$16,956.00)	\$0.00	(\$6,442,122.00)	N/A	N/A
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	(\$1,326,792.00)	0.0	(\$497,777.00)	(\$151,852.00)	\$0.00	(\$677,163.00)	N/A	N/A
Q	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	(\$13,178,518.00)	0.0	(\$6,575,544.00)	\$0.00	\$0.00	(\$6,602,974.00)	N/A	N/A
R	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	(\$334,175.00)	0.0	(\$167,073.00)	(\$15.00)	\$0.00	(\$167,087.00)	N/A	N/A
S	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	(\$1,586,639.00)	0.0	(\$747,444.00)	(\$52,868.00)	\$0.00	(\$786,327.00)	N/A	N/A
T	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	(\$121,052.00)	0.0	(\$121,052.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
U	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	(\$56,900.00)	0.0	(\$56,900.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
V	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	(\$55,449.00)	0.0	(\$55,449.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
W	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	(\$765.00)	0.0	(\$765.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
X	(6) Other Medical Services: Senior Dental Program	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
Y	(6) Other Medical Services: Reproductive Health Care for Individuals Not Eligible for Medicaid	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
Z	(6) Other Medical Services: SBIRT Training Grant Program	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00	N/A	N/A
AA	Total Request	(\$262,417,204.00)	2.0	(\$92,317,713.00)	(\$15,635,570.00)	\$0.00	(\$154,463,921.00)		Sum of Rows A through Z

Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) Administration, Personal Services	\$623,266.00	7.0	\$311,633.00	\$0.00	\$0.00	\$311,633.00	50.00%	N/A
B	(1) Executive Director's Office; (A) Administration, Health, Life, Dental	\$113,064.00	0.0	\$56,532.00	\$0.00	\$0.00	\$56,532.00	50.00%	N/A
C	(1) Executive Director's Office; (A) Administration, Short Term Disability	\$385.00	0.0	\$193.00	\$0.00	\$0.00	\$192.00	50.00%	N/A
D	(1) Executive Director's Office; (A) Administration, Paid Family and Medical Leave Insurance	\$2,478.00	0.0	\$1,239.00	\$0.00	\$0.00	\$1,239.00	50.00%	N/A
E	(1) Executive Director's Office; (A) Administration, Unfunded Liability AED Payments	\$55,116.00	0.0	\$27,558.00	\$0.00	\$0.00	\$27,558.00	50.00%	N/A
F	(1) Executive Director's Office; (A) Administration, Operating Expenses	\$5,145.00	0.0	\$2,573.00	\$0.00	\$0.00	\$2,572.00	50.00%	N/A
G	(1) Executive Director's Office; (A) Administration, Leased Space	\$32,550.00	0.0	\$16,275.00	\$0.00	\$0.00	\$16,275.00	50.00%	N/A
H	(1) Executive Directors Office, (A) General Professional Services	(\$750,000.00)	0.0	(\$262,500.00)	\$0.00	\$0.00	(\$487,500.00)	N/A	N/A
I	(1) Executive Director's Office; (C) IT Contracts & Projects, MMIS Maintenance and Projects	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	N/A
J	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	(\$1,815,929.00)	0.0	(\$298,131.00)	(\$416,092.00)	\$0.00	(\$1,101,706.00)	N/A	N/A
K	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals Acute	(\$401,815,309.00)	0.0	(\$136,396,992.00)	(\$21,170,835.00)	\$0.00	(\$244,247,482.00)	N/A	N/A
L	(3) Behavioral Health Community Programs, Behavioral Health Capitation Program	(\$12,644,332.00)	0.0	(\$3,000,000.00)	(\$3,322,166.00)	\$0.00	(\$6,322,166.00)	N/A	N/A
M	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	(\$178,903.00)	0.0	(\$42,987.00)	(\$10,612.00)	\$0.00	(\$125,304.00)	N/A	N/A
N	(5) Indigent Care Program; CBHP Medical and Dental Cost	(\$2,942,269.00)	0.0	(\$617,876.00)	(\$411,918.00)	\$0.00	(\$1,912,475.00)	N/A	N/A
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	(\$55,346,305.00)	0.0	(\$27,031,817.00)	(\$641,336.00)	\$0.00	(\$27,673,152.00)	N/A	N/A
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	(\$1,976,368.00)	0.0	(\$741,480.00)	(\$226,197.00)	\$0.00	(\$1,008,691.00)	N/A	N/A
Q	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	(\$47,916,604.00)	0.0	(\$23,937,872.00)	\$0.00	\$0.00	(\$23,978,732.00)	N/A	N/A
R	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	(\$497,782.00)	0.0	(\$248,870.00)	(\$22.00)	\$0.00	(\$248,890.00)	N/A	N/A
S	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	(\$2,363,431.00)	0.0	(\$1,113,380.00)	(\$78,751.00)	\$0.00	(\$1,171,300.00)	N/A	N/A
T	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	(\$180,318.00)	0.0	(\$180,318.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
U	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	(\$84,758.00)	0.0	(\$84,758.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
V	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	(\$82,597.00)	0.0	(\$82,597.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
W	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	(\$1,140.00)	0.0	(\$1,140.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
X	(6) Other Medical Services: Senior Dental Program	(\$2,000,000.00)	0.0	(\$2,000,000.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
Y	(6) Other Medical Services: Reproductive Health Care for Individuals Not Eligible for Medicaid	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
Z	(6) Other Medical Services: SBIRT Training Grant Program	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00	N/A	N/A
AA	Total Request	(\$530,764,041.00)	7.0	(\$196,124,715.00)	(\$26,777,929.00)	\$0.00	(\$307,861,397.00)		Sum of Rows A through Z

Table 1.3 Summary by Line Item FY 2027-28									
Row	Line Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
A	(1) Executive Director's Office; (A) Administration, Personal Services	\$623,266.00	7.0	\$311,633.00	\$0.00	\$0.00	\$311,633.00	50.00%	N/A
B	(1) Executive Director's Office; (A) Administration, Health, Life, Dental	\$124,369.00	0.0	\$62,185.00	\$0.00	\$0.00	\$62,184.00	50.00%	N/A
C	(1) Executive Director's Office; (A) Administration, Short Term Disability	\$385.00	0.0	\$193.00	\$0.00	\$0.00	\$192.00	50.00%	N/A
D	(1) Executive Director's Office; (A) Administration, Paid Family and Medical Leave Insurance	\$2,478.00	0.0	\$1,239.00	\$0.00	\$0.00	\$1,239.00	50.00%	N/A
E	(1) Executive Director's Office; (A) Administration, Unfunded Liability AED Payments	\$55,116.00	0.0	\$27,558.00	\$0.00	\$0.00	\$27,558.00	50.00%	N/A
F	(1) Executive Director's Office; (A) Administration, Operating Expenses	\$5,145.00	0.0	\$2,573.00	\$0.00	\$0.00	\$2,572.00	50.00%	N/A
G	(1) Executive Director's Office; (A) Administration, Leased Space	\$32,550.00	0.0	\$16,275.00	\$0.00	\$0.00	\$16,275.00	50.00%	N/A
H	(1) Executive Directors Office, (A) General Professional Services	(\$750,000.00)	0.0	(\$262,500.00)	\$0.00	\$0.00	(\$487,500.00)	N/A	N/A
I	(1) Executive Director's Office; (C) IT Contracts & Projects, MMIS Maintenance and Projects	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	N/A
J	(1) Executive Directors Office, (D) Eligibility Determination and Client Services, County Administration	(\$1,815,929.00)	0.0	(\$298,131.00)	(\$416,092.00)	\$0.00	(\$1,101,706.00)	N/A	N/A
K	(2) Medical Services Premiums, Medical and Long-Term Care Services for Medicaid Eligible Individuals Acute	(\$399,054,704.00)	0.0	(\$135,523,333.00)	(\$21,136,273.00)	\$0.00	(\$242,395,098.00)	N/A	N/A
L	(3) Behavioral Health Community Programs, Behavioral Health Capitation Program	(\$12,644,332.00)	0.0	(\$3,000,000.00)	(\$3,322,166.00)	\$0.00	(\$6,322,166.00)	N/A	N/A
M	(3) Behavioral Health Community Programs, Behavioral Health Fee-for-Service Payments	(\$178,903.00)	0.0	(\$42,987.00)	(\$10,612.00)	\$0.00	(\$125,304.00)	N/A	N/A
N	(5) Indigent Care Program; CBHP Medical and Dental Cost	(\$2,942,269.00)	0.0	(\$617,876.00)	(\$411,918.00)	\$0.00	(\$1,912,475.00)		N/A
O	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Comprehensive Services	(\$109,646,421.00)	0.0	(\$54,181,875.00)	(\$641,336.00)	\$0.00	(\$54,823,210.00)	N/A	N/A
P	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Adult Supported Living Services	(\$1,976,368.00)	0.0	(\$741,480.00)	(\$226,197.00)	\$0.00	(\$1,008,691.00)	N/A	N/A
Q	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Extensive Support Services	(\$47,918,220.00)	0.0	(\$23,938,680.00)	\$0.00	\$0.00	(\$23,979,540.00)	N/A	N/A
R	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Children's Habilitation Residential Program	(\$497,782.00)	0.0	(\$248,870.00)	(\$22.00)	\$0.00	(\$248,890.00)	N/A	N/A
S	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (2) Medicaid Programs - Case Management	(\$2,363,431.00)	0.0	(\$1,113,380.00)	(\$78,751.00)	\$0.00	(\$1,171,300.00)	N/A	N/A
T	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Family Support Services	(\$180,318.00)	0.0	(\$180,318.00)	\$0.00	\$0.00	\$0.00		N/A
U	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services	(\$84,758.00)	0.0	(\$84,758.00)	\$0.00	\$0.00	\$0.00		N/A
V	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - State Supported Living Services Case Management	(\$82,597.00)	0.0	(\$82,597.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
W	(4) Office of Community Living, (A) Division of Intellectual and Developmental Disabilities, (3) State Only Programs - Preventive Dental Hygiene	(\$1,140.00)	0.0	(\$1,140.00)	\$0.00	\$0.00	\$0.00	N/A	N/A
X	(6) Other Medical Services: Senior Dental Program	(\$2,000,000.00)	0.0	(\$2,000,000.00)	\$0.00	\$0.00	\$0.00	\$0.00	N/A
Y	(6) Other Medical Services: Reproductive Health Care for Individuals Not Eligible for Medicaid	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00		N/A
Z	(6) Other Medical Services: SBIRT Training Grant Program	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00		N/A
AA	Total Request	(\$582,293,863.00)	7.0	(\$222,396,269.00)	(\$26,743,367.00)	\$0.00	(\$333,154,227.00)		Sum of Rows A through Z

Table 2.0 Summary by Initiative FY 2025-26									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated	Federal Funds	FFP Rate	Notes/Calculations
Reducing Incentive Programs									
A	Reduce the ACC Incentive Program	(\$2,317,086.00)	0.0	(\$750,000.00)	(\$408,543.00)	\$0.00	(\$1,158,543.00)	50%	Table 3.1 Row A
B	Reduce the Behavioral Health Incentive Program	(\$11,993,686.00)	0.0	(\$3,000,000.00)	(\$2,996,843.00)	\$0.00	(\$5,996,843.00)	50%	Table 3.1 Row B
C	Reductions to Access Stabilization Payments	(\$4,585,035.00)	0.0	(\$1,500,000.00)	(\$169,032.00)	\$0.00	(\$2,916,003.00)	50%	Table 3.1 Row C
D	Total Reduction in Incentive Programs	(\$18,895,807.00)	0.0	(\$5,250,000.00)	(\$3,174,418.00)	\$0.00	(\$10,071,389.00)	50%	Sum of Row A through Row C
Reduction in Programs									
E	Ending Continuous Coverage	(\$13,604,504.00)	0.0	(\$5,613,172.00)	(\$358,438.00)	\$0.00	(\$7,632,894.00)	N/A	Table 4.1 Row A
F	Reduction in Immigrant Family Planning Reduction	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	0.00%	Table 4.1 Row C
G	Reduction in SBIRT Trainee Grants	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00	0.00%	Table 4.1 Row D
H	General Fund Offset from SBIRT Grants	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	N/A	Table 4.1 Row E
I	Eliminate Outreach for Cover All Coloradans	(\$375,000.00)	0.0	(\$131,250.00)	\$0.00	\$0.00	(\$243,750.00)	65.00%	Table 4.1 Row F
J	Total Reduction in Programs	(\$14,979,504.00)	0.0	(\$6,744,422.00)	(\$358,438.00)	\$0.00	(\$7,876,644.00)	N/A	Sum of Row E through Row I
Cost Controls									
K	Definitive Drug Testing	(\$12,930,713.00)	0.0	(\$1,719,785.00)	(\$949,114.00)	\$0.00	(\$10,261,814.00)	N/A	Table 5.1 Row A
L	Amend state statute to reinstate Medicaid prior authorization of outpatient psychotherapy	(\$15,665,471.00)	0.0	(\$6,120,810.00)	(\$479,568.00)	\$0.00	(\$9,065,093.00)	N/A	Table 5.1 Row B
M	Implement pre- and post- claim review of all pediatric autism behavioral therapy	(\$14,000,000.00)	0.0	(\$7,000,000.00)	\$0.00	\$0.00	(\$7,000,000.00)	50.00%	Table 5.1 Row C
N	Total Cost Controls	(\$42,596,184.00)	0.0	(\$14,840,595.00)	(\$1,428,682.00)	\$0.00	(\$26,326,907.00)	N/A	Sum of Row K through Row M
Reduction in Rates									
O	Rollback the FY25-26 1.6% provider rate increase	(\$108,167,253.00)	0.0	(\$38,277,173.00)	(\$5,938,052.00)	\$0.00	(\$63,952,028.00)	N/A	Table 6.1 Row A
P	Community Connector Rate Decrease	(\$6,026,470.00)	0.0	(\$3,013,235.00)	\$0.00	\$0.00	(\$3,013,235.00)	50%	Table 6.1 Row B
Q	Eliminate the nursing facility minimum wage payment supplemental payment	(\$8,719,922.00)	0.0	(\$4,359,961.00)	\$0.00	\$0.00	(\$4,359,961.00)	50%	Table 6.1 Row C
R	Reduce Individual Residential Services and Supports	(\$2,900,558.00)	0.0	(\$1,450,279.00)	\$0.00	\$0.00	(\$1,450,279.00)	50%	Table 6.1 Row E
S	Reduce Pediatric Behavioral Therapy Rates to 95% of the Benchmark	(\$5,440,445.00)	0.0	(\$2,720,222.00)	\$0.00	\$0.00	(\$2,720,223.00)	50%	Table 6.1 Row F
T	Decrease Dental Reimbursement Rates	(\$13,779,299.00)	0.0	(\$2,516,100.00)	(\$2,080,674.00)	\$0.00	(\$9,182,525.00)	N/A	Table 6.1 Row G
U	Total Reduction in Rates	(\$145,033,947.00)	0.0	(\$52,336,970.00)	(\$8,018,726.00)	\$0.00	(\$84,678,251.00)	N/A	Sum of Row O through Row T
Enrollment Changes for the Developmental Disabilities Waiver									
V	Auto Enrollment Changes for Certain Youth Transitions in DD Waiver	\$72,922.00	0.5	\$36,461.00	\$0.00	\$0.00	\$36,461.00	50%	Table 8.1 Row C
W	Reduce DD Waiver Churn Enrollments	\$72,922.00	0.5	\$36,461.00	\$0.00	\$0.00	\$36,461.00	0.5	Table 8.1 Row F
X	Total Enrollment Changes for the Developmental Disabilities Waiver	\$145,844.00	1.0	\$72,922.00	\$0.00	\$0.00	\$72,922.00	50.00%	Row V + Row W
October 31, 2025 Executive Orders									
Y	Reduce Senior Dental Grants	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00		Table 4.1 Row B
Z	Delay implementation of Community Health Workers	(\$5,713,346.00)	0.0	(\$1,364,558.00)	(\$342,750.00)	\$0.00	(\$4,006,038.00)	70%	SB 25-229 Reimbursement for Community Health Workers
AA	Realigning Children in Rocky Mountain Health PRIME	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	Removal of Rocky Mountain Children Costs from FY 2026 R-6 Accountable Care Collaborative Phase III
AB	Removing ACC credentialing component from FY 2026 R-6 Accountable Care Collaborative Phase III	(\$650,000.00)	0.0	(\$40,950.00)	(\$33,800.00)	\$0.00	(\$575,250.00)	89%	Removal of Systems Cost from FY 2026 R-6 Accountable Care Collaborative Phase III
AC	Reducing Certain Rates to 85% of Medicare Benchmark	(\$12,307,017.00)	0.0	(\$3,477,963.00)	(\$873,798.00)	\$0.00	(\$7,955,256.00)	64.64%	Table 6.6 Row AH
AD	Outpatient Drug Rate Reduction	(\$2,634,322.00)	0.0	(\$628,713.00)	(\$196,419.00)	\$0.00	(\$1,809,190.00)	68.68%	Table 7.1 Row A
AE	Shifting Utilization to Cost-Effective Biosimilars and Other Agents	(\$5,131,802.00)	0.0	(\$982,330.00)	(\$516,862.00)	\$0.00	(\$3,632,610.00)	70.79%	Table 7.1 Row B
AF	Third Party Liability Secondary Payer Shift	(\$4,071,186.00)	0.0	(\$1,226,741.00)	(\$268,926.00)	\$0.00	(\$2,575,519.00)	63.26%	Table 7.1 Row C
AG	Rate Reduction to Specialty Drug Carveout Program	(\$86,155.00)	0.0	(\$32,238.00)	(\$4,135.00)	\$0.00	(\$49,782.00)	57.78%	Table 7.1 Row D
AH	Dispensing Fee Reduction	(\$281,817.00)	0.0	(\$84,918.00)	(\$18,616.00)	\$0.00	(\$178,283.00)	63.26%	Table 7.1 Row E
AI	Delaying Long Term Services and Supports Presumptive Eligibility	(\$1,303,093.00)	0.0	(\$690,802.00)	\$0.00	\$0.00	(\$612,291.00)	N/A	FY 2023-24 BA-07 Community Based Access to Services Appendix JBC Action
AJ	Implement a Soft Cap on Certain HCB Services	(\$2,321,008.00)	1.5	(\$1,160,504.00)	\$0.00	\$0.00	(\$1,160,504.00)	N/A	Table 9.1 Row G through Row L
AK	Implement a Soft Cap on Weekly Caregiving Hours	(\$335,604.00)	0.5	(\$167,802.00)	\$0.00	\$0.00	(\$167,802.00)	N/A	Table 9.1 Row R through Row W
AL	Implement a Soft Cap on Weekly Homemaker Hours for Legally Responsible Individuals	(\$74,350.00)	0.0	(\$37,175.00)	\$0.00	\$0.00	(\$37,175.00)	N/A	Table 9.1 Row AG
AM	Align Community Connector Rate with Supported Community Connections	(\$3,055,311.00)	0.0	(\$1,527,656.00)	\$0.00	\$0.00	(\$1,527,655.00)	50%	Table 10.1 Row H
AN	Implement New Service Unit Limitations for Community Connector	(\$2,473,183.00)	0.0	(\$1,236,592.00)	\$0.00	\$0.00	(\$1,236,591.00)	50%	Table 10.2 Row M
AO	Reduce Movement Therapy Services to Align with Rate Methodology	(\$119,412.00)	0.0	(\$59,706.00)	\$0.00	\$0.00	(\$59,706.00)	50%	Table 10.3 Row Y
AP	Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	50.00%	Table 10.4 Row H through Row K
AQ	Executive Order Reductions Announced October 31, 2025	(\$41,057,606.00)	2.0	(\$13,218,648.00)	(\$2,255,306.00)	\$0.00	(\$25,583,652.00)		Sum of Row Y through Row AP
Additional Reductions Package Budget Amendment									
AR	Additional Reductions Package Budget Amendment	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	See Narrative
AS	Total Additional Supplemental Reductions Package	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00		Row AQ
AT	Total Request	(\$262,417,204.00)	3.0	(\$92,317,713.00)	(\$15,635,570.00)	\$0.00	(\$154,463,921.00)	N/A	Row D + Row J + Row N + Row U + Row X + Row AQ + Row AS

Table 2.1 Summary by Initiative FY 2026-27									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Reducing Incentive Programs									
A	Reduce the ACC Incentive Program	(\$2,325,290.00)	0.0	(\$750,000.00)	(\$412,645.00)	\$0.00	(\$1,162,645.00)	N/A	Table 3.1 Row A
B	Reduce the Behavioral Health Incentive Program	(\$12,644,332.00)	0.0	(\$3,000,000.00)	(\$3,322,166.00)	\$0.00	(\$6,322,166.00)	N/A	Table 3.1 Row B
C	Reductions to Access Stabilization Payments	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	Table 3.1 Row C
D	Total Reduction in Incentive Programs	(\$14,969,622.00)	0.0	(\$3,750,000.00)	(\$3,734,811.00)	\$0.00	(\$7,484,811.00)	N/A	Sum of Row A through Row C
Reduction in Programs									
E	Ending Continuous Coverage	(\$27,209,010.00)	0.0	(\$11,226,343.00)	(\$716,877.00)	\$0.00	(\$15,265,790.00)	N/A	Table 4.1 Row A
F	Reduction in Immigrant Family Planning Reduction	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	0.00%	Table 4.1 Row C
G	Reduction in SBIRT Training Grants	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00	0.00%	Table 4.1 Row D
H	General Fund Offset from SBIRT Grants	\$0.00	0.0	(\$500,000.00)	\$500,000.00	\$0.00	\$0.00		Table 4.1 Row E
I	Eliminate Outreach for Cover All Coloradans	(\$750,000.00)	0.0	(\$262,500.00)	\$0.00	\$0.00	(\$487,500.00)		Table 4.1 Row F
J	Total Reduction in Programs	(\$28,959,010.00)	0.0	(\$12,488,843.00)	(\$716,877.00)	\$0.00	(\$15,753,290.00)	N/A	Sum of Row E through Row I
Cost Controls									
K	Definitive Drug Testing	(\$14,106,232.00)	0.0	(\$1,876,129.00)	(\$1,035,397.00)	\$0.00	(\$11,194,706.00)	N/A	Table 5.1 Row A
L	Amend state statute to reinstate Medicaid prior authorization of outpatient psychotherapy	(\$31,330,942.00)	0.0	(\$12,241,619.00)	(\$959,135.00)	\$0.00	(\$18,130,188.00)		Table 5.1 Row B
M	Implement pre- and post- claim review of all pediatric autism behavioral therapy	(\$20,000,000.00)	0.0	(\$10,000,000.00)	\$0.00	\$0.00	(\$10,000,000.00)	50.00%	Table 5.1 Row C
N	Total Cost Controls	(\$65,437,174.00)	0.0	(\$24,117,748.00)	(\$1,994,532.00)	\$0.00	(\$39,324,894.00)	N/A	Sum of Row K through Row M
Reduction in Rates									
O	Rollback the FY25-26 1.6% provider rate increase	(\$160,972,816.00)	0.0	(\$56,992,200.00)	(\$8,810,550.00)	\$0.00	(\$95,170,066.00)	N/A	Table 6.1 Row A
P	Community Connector Rate Decrease	(\$12,052,939.00)	0.0	(\$6,026,469.00)	\$0.00	\$0.00	(\$6,026,470.00)	50%	Table 6.1 Row B
Q	Eliminate the nursing facility minimum wage payment supplemental payment	(\$8,719,922.00)	0.0	(\$4,359,961.00)	\$0.00	\$0.00	(\$4,359,961.00)	50%	Table 6.1 Row C
R	Reduce Individual Residential Services and Supports	(\$5,801,116.00)	0.0	(\$2,284,479.00)	(\$616,079.00)	\$0.00	(\$2,900,558.00)	50.00%	Table 6.1 Row E
S	Reduce Pediatric Behavioral Therapy Rates to 95% of the Benchmark	(\$13,057,068.00)	0.0	(\$6,528,534.00)	\$0.00	\$0.00	(\$6,528,534.00)	50%	Table 6.1 Row F
T	Decrease Dental Reimbursement Rates	(\$20,668,949.00)	0.0	(\$3,774,150.00)	(\$3,121,011.00)	\$0.00	(\$13,773,788.00)	N/A	Table 6.1 Row G
U	Total Reduction in Rates	(\$221,272,810.00)	0.0	(\$79,965,793.00)	(\$12,547,640.00)	\$0.00	(\$128,759,377.00)	N/A	Sum of Row O through Row T
Enrollment Changes for the Developmental Disabilities Waiver									
V	Auto Enrollment Changes for Certain Youth Transitions in DD Waiver	(\$15,261,376.00)	1.0	(\$7,630,688.00)	\$0.00	\$0.00	(\$7,630,688.00)		Table 8.2 Row C
W	Reduce DD Waiver Churn Enrollments	(\$6,497,170.00)	1.0	(\$3,248,585.00)	\$0.00	\$0.00	(\$3,248,585.00)		Table 8.2 Row F
X	Total Enrollment Changes for the Developmental Disabilities Waiver	(\$21,758,546.00)	2.0	(\$10,879,273.00)	\$0.00	\$0.00	(\$10,879,273.00)	50.00%	Row V + Row W
October 31, 2025 Executive Orders									
Y	Reduce Senior Dental Grants	(\$2,000,000.00)	0.0	(\$2,000,000.00)	\$0.00	\$0.00	\$0.00		Table 4.1 Row B
Z	Delay implementation of Community Health Workers	(\$13,385,549.00)	0.0	(\$3,196,962.00)	(\$803,013.00)	\$0.00	(\$9,385,574.00)	70%	SB 25-Z29 Reimbursement for Community Health Workers
AA	Realigning Children in Rocky Mountain Health PRIME	(\$3,476,470.00)	0.0	(\$1,738,235.00)	\$0.00	\$0.00	(\$1,738,235.00)	50%	Removal of Rocky Mountain Children Costs from FY 2026 R-6 Accountable Care Collaborative Phase III
AB	Removing ACC credentialing component from FY 2026 R-6 Accountable Care Collaborative Phase III	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	Removal of Systems Cost from FY 2026 R-6 Accountable Care Collaborative Phase III
AC	Reducing Certain Rates to 85% of Medicare Benchmark	(\$53,241,533.00)	0.0	(\$15,046,057.00)	(\$3,780,149.00)	\$0.00	(\$34,415,327.00)		Table 6.6 Row AI
AD	Outpatient Drug Rate Reduction	(\$15,805,934.00)	0.0	(\$3,772,279.00)	(\$1,178,513.00)	\$0.00	(\$10,855,142.00)	68.68%	Table 7.1 Row A
AE	Shifting Utilization to Cost-Effective Biosimilars and Other Agents	(\$12,316,324.00)	0.0	(\$2,357,591.00)	(\$1,240,468.00)	\$0.00	(\$8,718,265.00)	70.79%	Table 7.1 Row B
AF	Third Party Liability Secondary Payer Shift	(\$9,770,846.00)	0.0	(\$2,944,176.00)	(\$645,423.00)	\$0.00	(\$6,181,247.00)	63.26%	Table 7.1 Row C
AG	Rate Reduction to Specialty Drug Carveout Program	(\$516,928.00)	0.0	(\$193,431.00)	(\$24,809.00)	\$0.00	(\$298,688.00)	57.78%	Table 7.1 Row D
AH	Dispensing Fee Reduction	(\$1,690,905.00)	0.0	(\$509,509.00)	(\$111,694.00)	\$0.00	(\$1,069,702.00)	63.26%	Table 7.1 Row E
AI	Delaying Long Term Services and Supports Presumptive Eligibility	(\$2,775,871.00)	0.0	(\$1,471,558.00)	\$0.00	\$0.00	(\$1,304,313.00)	N/A	FY 2023-24 BA-07 Community Based Access to Services Appendix JBC Action
AJ	Implement a Soft Cap on Certain HCBS Services	(\$13,891,297.00)	3.0	(\$6,945,648.00)	\$0.00	\$0.00	(\$6,945,649.00)		Table 9.1 Row G through Row L
AK	Implement a Soft Cap on Weekly Caregiving Hours	(\$2,266,749.00)	1.0	(\$1,133,374.00)	\$0.00	\$0.00	(\$1,133,375.00)		Table 9.1 Row R through Row W
AL	Implement a Soft Cap on Weekly Homemaker Hours for Legally Responsible Individuals	(\$446,102.00)	0.0	(\$223,051.00)	\$0.00	\$0.00	(\$223,051.00)		Table 9.1 Row AG
AM	Align Community Connector Rate with Supported Community Connections	(\$18,331,864.00)	0.0	(\$9,165,932.00)	\$0.00	\$0.00	(\$9,165,932.00)	50%	Table 10.1 Row H
AN	Implement New Service Unit Limitations for Community Connector	(\$15,092,223.00)	1.0	(\$7,546,112.00)	\$0.00	\$0.00	(\$7,546,111.00)	50%	Table 10.2 Row M
AO	Reduce Movement Therapy Services to Align with Rate Methodology	(\$716,467.00)	0.0	(\$358,234.00)	\$0.00	\$0.00	(\$358,233.00)	50%	Table 10.3 Row Y
AP	Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services	(\$12,641,817.00)	0.0	(\$6,320,909.00)	\$0.00	\$0.00	(\$6,320,908.00)	50.00%	Table 10.4 Row H through Row K
AQ	Executive Order Reductions Announced October 31, 2025	(\$178,366,879.00)	5.0	(\$64,923,058.00)	(\$7,784,069.00)	\$0.00	(\$105,659,752.00)		Sum of Row Y through Row AP
Additional Reductions Package Budget Amendment									
AR	Additional Reductions Package Budget Amendment	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00		See Narrative
AS	Total Additional Supplemental Reductions Package	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00		Row AQ
AT	Total Request	(\$530,764,041.00)	7.0	(\$196,124,715.00)	(\$26,777,929.00)	\$0.00	(\$307,861,397.00)	N/A	Row D + Row J + Row N + Row U + Row X + Row AQ + Row AS

Table 2.2 Summary by Initiative Item FY 2027-28									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Reducing Incentive Programs									
A	Reduce the ACC Incentive Program	(\$2,325,290.00)	0.0	(\$750,000.00)	(\$412,645.00)	\$0.00	(\$1,162,645.00)	N/A	Table 3.1 Row A
B	Reduce the Behavioral Health Incentive Program	(\$12,644,332.00)	0.0	(\$3,000,000.00)	(\$3,322,166.00)	\$0.00	(\$6,322,166.00)	N/A	Table 3.1 Row B
C	Reductions to Access Stabilization Payments	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	Table 3.1 Row C
D	Total Reduction in Incentive Programs	(\$14,969,622.00)	0.0	(\$3,750,000.00)	(\$3,734,811.00)	\$0.00	(\$7,484,811.00)	N/A	Row A + Row B + Row C
Reduction in Programs									
E	Ending Continuous Coverage	(\$27,209,010.00)	0.0	(\$11,226,343.00)	(\$716,877.00)	\$0.00	(\$15,265,790.00)	N/A	Table 4.1 Row A
F	Reduction in Immigrant Family Planning Reduction	(\$500,000.00)	0.0	(\$500,000.00)	\$0.00	\$0.00	\$0.00	0.00%	Table 4.1 Row C
G	Reduction in SBIRT Trainee Grants	(\$500,000.00)	0.0	\$0.00	(\$500,000.00)	\$0.00	\$0.00	0.00%	Table 4.1 Row D
H	General Fund Offset from SBIRT Grants	\$0.00	0.0	(\$500,000.00)	\$500,000.00	\$0.00	\$0.00		Table 4.1 Row E
I	Eliminate Outreach for Cover All Coloradans	(\$750,000.00)	0.0	(\$262,500.00)	\$0.00	\$0.00	(\$487,500.00)	0.00%	Table 4.1 Row F
J	Total Reduction in Programs	(\$28,959,010.00)	0.0	(\$12,488,843.00)	(\$716,877.00)	\$0.00	(\$15,753,290.00)	N/A	Sum of Row E through Row I
Cost Controls									
K	Definitive Drug Testing	(\$14,106,232.00)	0.0	(\$1,876,129.00)	(\$1,035,397.00)	\$0.00	(\$11,194,706.00)	N/A	Table 5.1 Row A
L	Amend state statute to reinstate Medicaid prior authorization of outpatient psychotherapy	(\$31,330,942.00)	0.0	(\$12,241,619.00)	(\$959,135.00)	\$0.00	(\$18,130,188.00)		Table 5.1 Row B
M	Implement pre- and post- claim review of all pediatric autism behavioral therapy	(\$20,000,000.00)	0.0	(\$10,000,000.00)	\$0.00	\$0.00	(\$10,000,000.00)	50.00%	Table 5.1 Row C
N	Total Cost Controls	(\$65,437,174.00)	0.0	(\$24,117,748.00)	(\$1,994,532.00)	\$0.00	(\$39,324,894.00)	N/A	Sum of Row K through Row M
Reduction in Rates									
O	Rollback the FY25-26 1.6% provider rate increase	(\$160,972,816.00)	0.0	(\$56,992,200.00)	(\$8,810,550.00)	\$0.00	(\$95,170,066.00)	N/A	Table 6.1 Row A
P	Community Connector Rate Decrease	(\$12,052,940.00)	0.0	(\$6,026,470.00)	\$0.00	\$0.00	(\$6,026,470.00)	50%	Table 6.1 Row B
Q	Eliminate the nursing facility minimum wage payment supplemental payment	(\$8,719,922.00)	0.0	(\$4,359,961.00)	\$0.00	\$0.00	(\$4,359,961.00)	50%	Table 6.1 Row C
R	Reduce Individual Residential Services and Supports	(\$5,801,116.00)	0.0	(\$2,284,479.00)	(\$616,079.00)	\$0.00	(\$2,900,558.00)	50%	Table 6.1 Row E
S	Reduce Pediatric Behavioral Therapy Rates to 95% of the Benchmark	(\$13,057,068.00)	0.0	(\$6,528,534.00)	\$0.00	\$0.00	(\$6,528,534.00)	0.5	Table 6.1 Row F
T	Decrease Dental Reimbursement Rates	(\$20,668,949.00)	0.0	(\$3,774,150.00)	(\$3,121,011.00)	\$0.00	(\$13,773,788.00)	N/A	Table 6.1 Row G
U	Total Reduction in Rates	(\$221,272,811.00)	0.0	(\$79,965,794.00)	(\$12,547,640.00)	\$0.00	(\$128,759,377.00)	N/A	Sum of Row O through Row T
Enrollment Changes for the Developmental Disabilities Waiver									
V	Reduce DD Waiver Churn Enrollments	(\$18,742,602.00)	1.0	(\$9,371,301.00)	\$0.00	\$0.00	(\$9,371,301.00)	50%	Table 8.3 Row F
W	Auto Enrollment Changes for Certain Youth Transitions in DD Waiver	(\$43,686,880.00)	1.0	(\$21,843,440.00)	\$0.00	\$0.00	(\$21,843,440.00)		Table 8.3 Row C
X	Total Enrollment Changes for the Developmental Disabilities Waiver	(\$62,429,482.00)	2.0	(\$31,214,741.00)	\$0.00	\$0.00	(\$31,214,741.00)	50.00%	Row V + Row W
October 31, 2025 Executive Orders									
Y	Reduce Senior Dental Grants	(\$2,000,000.00)	0.0	(\$2,000,000.00)	\$0.00	\$0.00	\$0.00		Table 4.1 Row B
Z	Delay implementation of Community Health Workers	(\$7,672,204.00)	0.0	(\$1,832,405.00)	(\$460,263.00)	\$0.00	(\$5,379,536.00)	70%	SB 25-229 Reimbursement for Community Health Workers
AA	Realigning Children in Rocky Mountain Health PRIME	(\$3,476,470.00)	0.0	(\$1,738,235.00)	\$0.00	\$0.00	(\$1,738,235.00)	50%	Removal of Rocky Mountain Children Costs from FY 2026 R-6 Accountable Care Collaborative Phase III
AB	Removing ACC credentialing component from FY 2026 R-6 Accountable Care Collaborative Phase III	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	N/A	Removal of Systems Cost from FY 2026 R-6 Accountable Care Collaborative Phase III
AC	Reducing Certain Rates to 85% of Medicare Benchmark	(\$57,582,208.00)	0.0	(\$16,272,732.00)	(\$4,088,337.00)	\$0.00	(\$37,221,139.00)		Table 6.6 Row AJ
AD	Outpatient Drug Rate Reduction	(\$15,805,934.00)	0.0	(\$3,772,279.00)	(\$1,178,513.00)	\$0.00	(\$10,855,142.00)	68.68%	Table 7.1 Row A
AE	Shifting Utilization to Cost-Effective Biosimilars and Other Agents	(\$12,316,324.00)	0.0	(\$2,357,591.00)	(\$1,240,468.00)	\$0.00	(\$8,718,265.00)	70.79%	Table 7.1 Row B
AF	Third Party Liability Secondary Payer Shift	(\$9,770,846.00)	0.0	(\$2,944,176.00)	(\$645,423.00)	\$0.00	(\$6,181,247.00)	63.26%	Table 7.1 Row C
AG	Rate Reduction to Specialty Drug Carveout Program	(\$516,928.00)	0.0	(\$193,431.00)	(\$24,809.00)	\$0.00	(\$298,688.00)	57.78%	Table 7.1 Row D
AH	Dispensing Fee Reduction	(\$1,690,905.00)	0.0	(\$509,509.00)	(\$111,694.00)	\$0.00	(\$1,069,702.00)	63.26%	Table 7.1 Row E
AI	Delaying Long Term Services and Supports Presumptive Eligibility	(\$1,387,936.00)	0.0	(\$735,779.00)	\$0.00	\$0.00	(\$652,157.00)	N/A	FY 2023-24 BA-07 Community Based Access to Services Appendix JBC Action
AJ	Implement a Soft Cap on Certain HCBs Services	(\$13,886,452.00)	3.0	(\$6,943,226.00)	\$0.00	\$0.00	(\$6,943,226.00)	50.00%	Table 9.1 Row G through Row L
AK	Implement a Soft Cap on Weekly Caregiving Hours	(\$2,265,134.00)	1.0	(\$1,132,567.00)	\$0.00	\$0.00	(\$1,132,567.00)		Table 9.1 Row R through Row W
AL	Implement a Soft Cap on Weekly Homemaker Hours for Legally Responsible Individuals	(\$446,102.00)	0.0	(\$223,051.00)	\$0.00	\$0.00	(\$223,051.00)		Table 9.1 Row AG
AM	Align Community Connector Rate with Supported Community Connections	(\$18,331,864.00)	0.0	(\$9,165,932.00)	\$0.00	\$0.00	(\$9,165,932.00)		Table 10.1 Row H
AN	Implement New Service Unit Limitations for Community Connector	(\$15,092,223.00)	1.0	(\$7,546,112.00)	\$0.00	\$0.00	(\$7,546,111.00)		Table 10.2 Row M
AO	Reduce Movement Therapy Services to Align with Rate Methodology	(\$716,467.00)	0.0	(\$358,234.00)	\$0.00	\$0.00	(\$358,233.00)		Table 10.3 Row Y
AP	Align Member Cost of Care Contribution in the DD Waiver with other Residential Waiver Services	(\$26,267,767.00)	0.0	(\$13,133,884.00)	\$0.00	\$0.00	(\$13,133,883.00)	50.00%	Table 10.4 Row H through Row K
AQ	Executive Order Reductions Announced October 31, 2025	(\$189,225,764.00)	5.0	(\$70,859,143.00)	(\$7,749,507.00)	\$0.00	(\$110,617,114.00)		Sum of Row Y through Row AP
Additional Reductions Package Budget Amendment									
AR	Additional Reductions Package Budget Amendment	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00		See Narrative
AS	Total Additional Supplemental Reductions Package	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00		Row AR
AT	Total Request	(\$582,293,863.00)	7.0	(\$222,396,269.00)	(\$26,743,367.00)	\$0.00	(\$333,154,227.00)	N/A	Row D + Row J + Row N + Row U + Row X + Row AQ + Row AS

Table 3.1 Reductions in Incentive Payment Programs						
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29 Ongoing	Notes
A	Reduce the ACC Incentive Program	(\$2,317,086.00)	(\$2,325,290.00)	(\$2,325,290.00)	(\$2,347,118.00)	Proposed Reduction to ACC Incentive Payments
B	Reduce the Behavioral Health Incentive Program	(\$11,993,686.00)	(\$12,644,332.00)	(\$12,644,332.00)	(\$12,617,450.00)	Proposed Reduction to Behavioral Health Incentive Payments
C	Reductions to Access Stabilization Payments	(\$4,585,035.00)	\$0.00	\$0.00	\$0.00	Reduction to Access in Stabilization Payments, FY 23-24 R-6 request
D	Total Reduction in Incentive Programs	(\$18,895,807.00)	(\$14,969,622.00)	(\$14,969,622.00)	(\$14,964,568.00)	Row A + Row B + Row C

Table 4.1 Reduction in Programs						
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29 Ongoing	Notes
A	Ending Continuous Coverage	(\$13,604,504.00)	(\$27,209,010.00)	(\$27,209,010.00)	(\$27,209,010.00)	Removing HB 23-1300 Impact
B	Reduce Senior Dental Grants	(\$500,000.00)	(\$2,000,000.00)	(\$2,000,000.00)	(\$2,000,000.00)	SB 24-168 Reconciled Fiscal Note
C	Reduction in Immigrant Family Planning Reduction	(\$500,000.00)	(\$500,000.00)	(\$500,000.00)	(\$500,000.00)	Reduction in Family Planning Grant
D	Reduction in SBIRT Training Grants	(\$500,000.00)	(\$500,000.00)	(\$500,000.00)	(\$500,000.00)	Reduction in SBIRT Training Grant
E	General Fund Offset from SBIRT Training Grants	\$0.00	\$0.00	\$0.00	\$0.00	Savings from Reducing SBIRT Training Grants will be transferred to General Fund
F	Eliminate Outreach for Cover All Coloradans	(\$375,000.00)	(\$750,000.00)	(\$750,000.00)	(\$750,000.00)	HB 22-1289 Outreach Impact Removed Effective January 1, 2026
G	Total Reduction in Programs	(\$15,479,504.00)	(\$30,959,010.00)	(\$30,959,010.00)	(\$30,959,010.00)	Sum of Row A through Row F

Table 5.1 Reducing Costs through Cost Controls					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28 Ongoing	Notes
A	Definitive Drug Testing	(\$12,930,713.00)	(\$14,106,232.00)	(\$14,106,232.00)	Table 5.2 Row E
C	Amend state statute to reinstate prior authorization requirements (PARs) for antipsychotic drugs	\$0.00	\$0.00	\$0.00	SB 24-110 Same assumptions as FN
B	Amend state statute to reinstate Medicaid prior authorization of outpatient psychotherapy	(\$15,665,471.00)	(\$31,330,942.00)	(\$31,330,942.00)	Department data show that utilization grew exponentially after the passage of 22 156
C	Implement pre- and post-claim review of all pediatric autism behavioral therapy	(\$14,000,000.00)	(\$20,000,000.00)	(\$20,000,000.00)	Savings assumption based on OIG audit findings assuming approximately a 5% reduction in annual expenditure
D	Total Cost Controls	(\$42,596,184.00)	(\$65,437,174.00)	(\$65,437,174.00)	Row A + Row B + Row C

Table 5.2 Limit Definitive Drug Testing					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28 Ongoing	Notes
A	Annual cost of drug test after PARs	\$60,760,543.00	\$60,760,543.00	\$60,760,543.00	Source: Claims Data
B	Annual cost of drug test after PARs	\$46,654,311.00	\$46,654,311.00	\$46,654,311.00	Source: Claims Data with PARs applied
C	Projected Full Year Savings	(\$14,106,232.00)	(\$14,106,232.00)	(\$14,106,232.00)	Row B - Row A
D	Implementation Adjustment	91.67%	100%	\$1.00	Implementation in August 2025
E	Final Projected Savings from Limiting Definitive Drug Testing	(\$12,930,713.00)	(\$14,106,232.00)	(\$14,106,232.00)	Row C * Row D

Table 6.1 Reduction in Provider Rates and Payments						
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29 Ongoing	Notes
A	Rollback the FY25-26 1.6% provider rate increase	(\$108,167,255.00)	(\$160,972,816.00)	(\$160,972,816.00)	(\$160,972,816.00)	FY 2025-26 JBC Action Medicaid Provider Rate Adjustment 1.6% Adjusted for October 1, 2025 Implementation Date
B	Community Connector Rate Decrease	(\$6,026,470.00)	(\$12,052,939.00)	(\$12,052,939.00)	(\$12,052,939.00)	Table 6.2 Row F
C	Eliminate the nursing facility minimum wage payment supplemental payment	(\$8,719,922.00)	(\$8,719,922.00)	(\$8,719,922.00)	(\$8,719,922.00)	Current Supplemental Payment included in Department's R-1 Medical Services Premiums Forecast
D	Reduce Individual Residential Services and Supports	(\$2,900,558.00)	(\$5,801,116.00)	(\$5,801,116.00)	(\$5,801,116.00)	Table 6.5 Row AA
E	Reduce Pediatric Behavioral Therapy Rates to 95% of the Benchmark	(\$5,440,445.00)	(\$13,057,068.00)	(\$13,057,068.00)	(\$13,057,068.00)	Table 6.3 Row F and Row G
F	Decrease Dental Reimbursement Rates	(\$13,779,299.00)	(\$20,668,949.00)	(\$20,668,949.00)	(\$20,668,949.00)	Table 6.4 Row Z and AA
G	Total Reduction in Rates	(\$131,254,650.00)	(\$186,082,823.00)	(\$186,082,823.00)	(\$186,082,823.00)	Sum of Row A through Row F

Table 6.2 Community Connector Rate						
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29 Ongoing	Notes
A	Current Total Expenditure	\$65,329,852	\$65,329,852	\$65,329,852	\$65,329,852	N/A
B	Projected FY 25-26 growth on the CES and CHRP waiver	23.17%	23.17%	23.17%	23.17%	N/A
C	Percentage Rate Reduction	-14.98%	-14.98%	-14.98%	-14.98%	N/A
D	Estimated Impact	-\$12,052,939	-\$12,052,939	-\$12,052,939	-\$12,052,939	Row A * (1 + Row B) * Row C
E	Implementation Adjustment	50.00%	100%	100%	100%	Assuming January 1, 2026 implementation date
F	Total Adjusted Impact	(\$6,026,470)	(\$12,052,939)	(\$12,052,939)	(\$12,052,939)	Row D * Row E

Table 6.3 Pediatric Behavioral Therapy Rate Cuts						
Row	Item	Current Expenditure	Current Rate	Proposed Rate (Benchmark @ 95%)	Total Impact of Rate Cut	Notes
A	97151 - BHV ID ASSMT BY PHYS/QHP	\$4,156,139	\$27.59	\$27.12	-\$70,800	N/A
B	97153 - ADAPTIVE BEHAVIOR TX BY TECH	\$217,335,167	\$18.17	\$17.22	-\$11,363,149	N/A
C	97154 - GRP ADAPT BHV TX BY TECH	\$238,984	\$11.51	\$8.81	-\$56,061	N/A
D	97155 - ADAPT BEHAVIOR TX PHYS/QHP	\$52,469,960	\$26.62	\$25.84	-\$1,537,437	N/A
E	97158 - GRP ADAPT BHV TX BY PHY/QHP	\$62,209	\$17.83	\$9.34	-\$29,622	N/A
F	Total PBT	\$274,262,460			(\$13,057,068)	
					Total Funds	General Fund
G	FY 2025-26 Impact (1/1/2026 Implementation)				(\$5,440,445)	(\$2,720,223)
H	FY 2026-27 Ongoing Impact				(\$13,057,068)	(\$6,528,534)

Table 6.4 Dental Provider Rate Cuts						
Row	Item	Procedure Code	Estimated Expenditure	July 2024 Rates	Proposed Rate (Benchmark at 95%)	Total Impact of Rate Cut
A	Periodic oral evaluation	D0120	\$13,282,199	\$38.35	\$32.41	-\$2,057,269
B	Limited Oral Evaluation Problem Focused	D0140	\$4,921,585	\$53.14	\$44.90	-\$763,151
C	Comprehensive Oral Evaluation	D0150	\$7,696,701	\$61.03	\$51.57	-\$1,193,033
D	Prophylaxis Adult	D1110	\$14,157,549	\$97.50	\$82.39	-\$2,194,057
E	Prophylaxis Child	D1120	\$10,709,631	\$73.04	\$61.72	-\$1,659,817
F	Topical fluoride varnish	D1206	\$8,483,748	\$41.96	\$35.46	-\$1,314,213
G	Sealant Per Tooth	D1351	\$5,974,526	\$57.10	\$48.25	-\$925,999
H	Prev resin rest, perm tooth	D1352	\$51,404	\$99.32	\$83.93	-\$7,965
I	Interim Caries Arresting Medicament Application,	D1354	\$166,311	\$54.53	\$46.08	-\$25,772
J	Crown, Porcelain/Ceramic substrate	D2740	\$22,766,526	\$849.16	\$717.54	-\$3,528,817
K	Crown Porcelain High Noble Metal	D2750	\$1,662,728	\$841.06	\$710.70	-\$257,714
L	Crown Porcelain Base Metal	D2751	\$1,023,417	\$767.03	\$648.14	-\$158,630
M	Crown Porcelain Noble Metal	D2752	\$468,522	\$798.29	\$674.56	-\$72,618
N	Crown Full Cast High Noble Metal	D2790	\$24,100	\$868.62	\$733.98	-\$3,736
O	Crown Titanium	D2794	\$0	\$836.88	\$707.16	\$0
P	Prefab Stainless Steel Crown Primary	D2930	\$13,217,544	\$198.49	\$167.72	-\$2,048,989
Q	End thxpy, anterior tooth	D3310	\$2,897,685	\$799.76	\$675.80	-\$449,131
R	End thxpy, bicuspid tooth	D3320	\$4,987,749	\$917.71	\$775.46	-\$773,128
S	End thxpy, molar	D3330	\$5,784,941	\$1,109.31	\$937.37	-\$896,650
T	Retreatment Root Canal Anterior	D3346	\$104,220	\$911.61	\$770.31	-\$16,154
U	Retreatment Root Canal Bicuspid	D3347	\$142,963	\$1,044.12	\$882.28	-\$22,159
V	Retreatment Root Canal Molar	D3348	\$303,339	\$1,246.06	\$1,052.92	-\$47,018
W	Periodontal Scaling & Root Planing	D4341	\$2,859,762	\$266.51	\$225.20	-\$443,273
X	Periodontal Scaling 1 to 3 Teeth	D4342	\$9,045,977	\$189.68	\$160.28	-\$1,402,107
Y	Periodontal Maintenance	D4910	\$2,628,950	\$149.01	\$125.91	-\$407,548
Z	Full Year Impact		\$133,362,077			-\$20,668,949
AA	FY 2025-26 Impact (Assuming October 1, 2025 Implementation)					-\$13,779,299

Table 6.5: IRSS Rate Revamp Calculations					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
Current Billing Practices - Denver					
A	Higher Rate	\$225.96	\$225.96	\$225.96	From FY 2024-25 Fee Schedule
B	Lower Rate	\$207.73	\$207.73	\$207.73	From FY 2024-25 Fee Schedule
C	Total Number of Members (FY 2023-24)	130,198	130,198	130,198	Total number of members receiving IRSS services in Denver County in FY 2023-24
D	Percentage of Billing at Higher Rate	52.55%	52.55%	52.55%	Percentage based on total IRSS expenditure in Denver County
E	Percentage of Billing at Lower Rate	47.45%	47.45%	47.45%	Percentage based on total IRSS expenditure in Denver County
F	Current Expenditure	\$28,293,309.80	\$28,293,309.80	\$28,293,309.80	Row A * Row D * Row C + Row B * Row E * Row C
Current Billing Practices - Outside Denver					
G	Higher Rate	\$206.95	\$206.95	\$206.95	From FY 2024-25 Fee Schedule
H	Lower Rate	\$190.65	\$190.65	\$190.65	From FY 2024-25 Fee Schedule
I	Total Number of Members (FY 2023-24)	1,204,561	1,204,561	1,204,561	Total number of members receiving IRSS services outside of Denver County in FY 2023-24
J	Percentage of Billing at Higher Rate	51.21%	51.21%	51.21%	Percentage based on total IRSS expenditure outside Denver County
K	Percentage of Billing at Lower Rate	48.79%	48.79%	48.79%	Percentage based on total IRSS expenditure outside Denver County
L	Current Expenditure	\$239,704,302.37	\$239,704,302.37	\$239,704,302.37	Row I * Row J * Row G + Row H * Row K * Row I
Proposed Billing Practices - Denver					
M	Higher Rate	\$225.96	\$225.96	\$225.96	From FY 2024-25 Fee Schedule
N	Lower Rate	\$207.73	\$207.73	\$207.73	From FY 2024-25 Fee Schedule
O	Total Number of Members	130,198	130,198	130,198	Total number of members receiving IRSS services in Denver County in FY 2023-24
P	Percentage Billing at Higher Rate	25%	25%	25%	Percentage based on total IRSS expenditure in Denver County
Q	Percentage Billing at Lower Rate	75%	75%	75%	Percentage based on total IRSS expenditure in Denver County
R	Proposed Expenditure	\$27,639,407.93	\$27,639,407.93	\$27,639,407.93	Row O * Row Q * Row N + Row O * Row P * Row M
Proposed Billing Practices - Outside Denver					
S	Higher Rate	\$206.95	\$206.95	\$206.95	From FY 2024-25 Fee Schedule
T	Lower Rate	\$190.65	\$190.65	\$190.65	From FY 2024-25 Fee Schedule
U	Total Number of Members	1,204,561	1,204,561	1,204,561	Total number of members receiving IRSS services outside of Denver County in FY 2023-24
V	Percentage Billing at Higher Rate	25%	25%	25%	Percentage based on total IRSS expenditure outside Denver County
W	Percentage Billing at Lower Rate	75%	75%	75%	Percentage based on total IRSS expenditure outside Denver County
X	Proposed Expenditure	\$234,558,140.73	\$234,558,140.73	\$234,558,140.73	Row U * Row V * Row S + Row U * Row W * Row T
Y	Difference	(\$5,800,064.00)	(\$5,800,064.00)	(\$5,800,064.00)	Sum of Rows X and R - Sum of Rows L and F
Z	Percentage of the Year Affected	50%	100%	100%	Assuming January 1, 2026 Implementation Date
AA	Final Projected Impact of IRSS Rates	(\$2,900,032.00)	(\$5,800,064.00)	(\$5,800,064.00)	Row Y * Row Z

Table 6.6: Reduce Rates to no More than 85% of Medicare Benchmark

Row	Item	Estimated Costs Under Current Rates	Estimated Costs Under Proposed Rates (85% of the Medicare Benchmark)	Estimated Savings	Notes
A	Dialysis	\$257,871.14	\$220,033.32	-\$37,837.82	From FY 2024-25 Fee Schedule
B	DMEPOS	\$2,873,047.11	\$2,097,902.22	-\$775,144.89	From FY 2024-25 Fee Schedule
C	EEG Ambulatory Monitoring	\$1,430,511.28	\$1,044,684.04	-\$385,827.24	From FY 2024-25 Fee Schedule
D	Eyeglasses & Vision	\$27,037,366.57	\$25,111,858.12	-\$1,925,508.45	From FY 2024-25 Fee Schedule
E	FFS Behavioral Health	\$11,534,029.34	\$8,180,357.09	-\$3,353,672.25	From FY 2024-25 Fee Schedule
F	Laboratory and Pathology	\$12,010,126.73	\$10,454,376.29	-\$1,555,750.44	From FY 2024-25 Fee Schedule
G	Maternity	\$27,012,675.57	\$22,154,099.94	-\$4,858,575.63	From FY 2024-25 Fee Schedule
H	Neuro, Psych Testing Services	\$2,578,555.11	\$1,078,347.80	-\$1,500,207.31	From FY 2024-25 Fee Schedule
I	Outpatient OT	\$147,121.31	\$146,077.36	-\$1,043.95	From FY 2024-25 Fee Schedule
J	Outpatient PT	\$2,968,420.64	\$2,600,971.83	-\$367,448.81	From FY 2024-25 Fee Schedule
K	Outpatient ST	\$6,259.80	\$5,771.18	-\$488.62	From FY 2024-25 Fee Schedule
L	Physician Services - Cardiology	\$11,637,113.39	\$9,852,058.47	-\$1,785,054.92	From FY 2024-25 Fee Schedule
M	Physician Services - Ear, Nose, and Throat	\$2,157,778.92	\$1,970,649.35	-\$187,129.57	From FY 2024-25 Fee Schedule
N	Physician Services - EEG Ambulatory Monitoring	\$337.52	\$243.91	-\$93.61	From FY 2024-25 Fee Schedule
O	Physician Services - Gastroenterology	\$295,911.34	\$273,022.58	-\$22,888.76	From FY 2024-25 Fee Schedule
P	Physician Services - Health Education	\$257,049.45	\$194,243.57	-\$62,805.88	From FY 2024-25 Fee Schedule
Q	Physician Services - Ophthalmology	\$2,679,549.60	\$2,123,130.17	-\$556,419.43	From FY 2024-25 Fee Schedule
R	Physician Services - Other Physician Services	\$56,340,590.68	\$47,872,854.29	-\$8,467,736.39	From FY 2024-25 Fee Schedule
S	Physician Services - Radiology	\$107,355,760.00	\$91,494,914.17	-\$15,860,845.83	From FY 2024-25 Fee Schedule
T	Physician Services - Respiratory	\$1,124,262.45	\$824,071.72	-\$300,190.73	From FY 2024-25 Fee Schedule
U	Physician Services - Sleep Studies	\$7,427,850.50	\$5,406,079.33	-\$2,021,771.17	From FY 2024-25 Fee Schedule
V	Physician Services - Vascular	\$1,557,668.59	\$1,424,345.86	-\$133,322.73	From FY 2024-25 Fee Schedule
W	Physician Services - Women's Health and Family P	\$14,149,860.02	\$13,013,314.53	-\$1,136,545.49	From FY 2024-25 Fee Schedule
X	Primary Care and Evaluation & Management Services	\$135,248,442.72	\$135,248,442.72	\$0.00	From FY 2024-25 Fee Schedule
Y	Surgery - Cardiovascular System	\$1,944,904.22	\$1,717,553.85	-\$227,350.37	From FY 2024-25 Fee Schedule
Z	Surgery - Digestive System	\$892,047.03	\$864,594.35	-\$27,452.68	From FY 2024-25 Fee Schedule
AA	Surgery - Eye & Auditory System	\$1,459,201.85	\$1,254,732.99	-\$204,468.86	From FY 2024-25 Fee Schedule
AB	Surgery - Integumentary System	\$396,812.14	\$359,022.69	-\$37,789.45	From FY 2024-25 Fee Schedule
AC	Surgery - Musculoskeletal System	\$175,241.54	\$165,036.55	-\$10,204.99	From FY 2024-25 Fee Schedule
AD	Surgery - Other Surgeries	\$2,793,799.24	\$2,492,172.16	-\$301,627.08	From FY 2024-25 Fee Schedule
AE	Surgery - Respiratory System	\$552,668.82	\$491,123.95	-\$61,544.87	From FY 2024-25 Fee Schedule
AF	Anesthesia	13293246.21	10231927.64	-\$3,061,318.57	From FY 2024-25 Fee Schedule
AG	Total	\$449,596,081.00	\$400,368,014.00	-\$49,228,067.00	Sum of Row A through Row AF
AH	Total Estimated Impact in FY 2025-26			-\$12,307,017.00	Assuming an April 1, 2026 Implementation Date
AI	Total Estimated Impact in FY 2026-27			-\$53,241,533.00	Row AG * (1+ Table 6.7 Row C)
AJ	Total Estimated Impact in FY 2027-28			-\$57,582,208.00	Row AH * (1+ Table 6.7 Row F)

Table 6.7 General Fund Growth Trend Based on R-1 Medical Services Premiums Forecast

Row	Item	Estimate
A	FY 2025-26 Medical Services Premiums Expenditure excluding special financing	\$4,192,003,802
B	FY 2026-27 Medical Services Premiums Expenditure excluding special financing	\$4,462,952,313
C	Percentage Growth Trend Into FY 2026-27	6.46%
D	FY 2026-27 Medical Services Premiums Expenditure excluding special financing	\$4,462,952,313
E	FY 2027-28 Medical Services Premiums Expenditure excluding special financing	\$4,826,807,864
F	Percentage Growth Trend Into FY 2027-28	8.15%

Table 7.1 Total Pharmacy Reduction Savings					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Outpatient Drug Rate Reduction	(\$2,634,322.00)	(\$15,805,934.00)	(\$15,805,934.00)	Table 7.2 Row K
B	Shifting Utilization to Biosimilars	(\$5,131,802.00)	(\$12,316,324.00)	(\$12,316,324.00)	Table 7.3 Row E
C	TPL secondary payer cost shift	(\$4,071,186.00)	(\$9,770,846.00)	(\$9,770,846.00)	Table 7.6 Row I
D	Specialty Drug Carve Rate Reduction	(\$86,155.00)	(\$516,928.00)	(\$516,928.00)	Table 7.7 Row E
E	Dispensing Fee Rate Reduction	(\$281,817.00)	(\$1,690,905.00)	(\$1,690,905.00)	Table 7.8 Row C
F	Total Estimated Pharmacy Reductions	(\$12,205,282.00)	(\$40,100,937.00)	(\$40,100,937.00)	Sum of Row A through Row E

Table 7.2 Outpatient Drug Rate Reduction					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Current Expenditure Based on Existing WAC Discount Brand	\$1,654,642,804.00	\$1,654,642,804.00	\$1,654,642,804.00	N/A
B	Projected Expenditure based on potential increased WAC discount Brand	\$1,643,969,304.00	\$1,643,969,304.00	\$1,643,969,304.00	N/A
C	Estimated Reduction	(\$10,673,500.00)	(\$10,673,500.00)	(\$10,673,500.00)	Row B - Row A
D	Current Expenditure Based on Existing WAC Discount Generic	\$103,683,006.00	\$103,683,006.00	\$103,683,006.00	N/A
E	Projected Expenditure based on potential increased WAC discount Generic	\$98,550,572.00	\$98,550,572.00	\$98,550,572.00	N/A
F	Estimated Reduction	(\$5,132,434.00)	(\$5,132,434.00)	(\$5,132,434.00)	Row E - Row D
G	Current Expenditure Based on Existing WAC Discount Generic	\$1,758,325,810.00	\$1,758,325,810.00	\$1,758,325,810.00	Row A + Row D
H	Projected Expenditure based on potential increased WAC discount Generic	\$1,742,519,876.00	\$1,742,519,876.00	\$1,742,519,876.00	Row B + Row E
I	Total Estimated Reduction	(\$15,805,934.00)	(\$15,805,934.00)	(\$15,805,934.00)	Row H - Row G
J	Implementation Adjustment	16.67%	100%	100%	April 1, 2026 Implementation Date
K	Total Adjusted Reduction	(\$2,634,322.33)	(\$15,805,934.00)	(\$15,805,934.00)	Row I * Row J

Table 7.3 Shifting Utilization to Lower Cost drugs					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Brand Specialty Drugs to Biosimilars	(\$9,991,534.00)	(\$9,991,534.00)	(\$9,991,534.00)	Table 7.4 Row E
B	GLP1's	(\$2,324,790.00)	(\$2,324,790.00)	(\$2,324,790.00)	Table 7.5 Row A
C	Estimated Savings	(\$12,316,324.00)	(\$12,316,324.00)	(\$12,316,324.00)	Row A + Row B
D	Implementation Adjustment	41.67%	100.00%	100.00%	Assuming January 1, 2026 Start Date
E	Total Adjusted Savings	(\$5,131,801.67)	(\$12,316,324.00)	(\$12,316,324.00)	Row C * Row D

Table 7.4 Shifting Utilization to Cost Effective Drugs -From Brand Specialty Drugs to Biosimilars			
Row	Item	Total	Notes
A	Cost Per Unit Net of (average) Rebate	\$14,900.97	N/A
B	Cost Per Unit of Biosimilar	\$14,063.60	N/A
C	Difference	(\$837.37)	Row B - Row A
D	FY 2024-25 utilization	11,932	N/A
E	Total Estimated Savings	(\$9,991,534.00)	Row C * Row D

Table 7.5 Shifting Utilization to Cost Effective Drugs - GLP1s			
Row	Drug Type	Amount	Notes
A	Total Savings	(\$2,324,790.00)	See Narrative

Table 7.6 Third Party Liability Enforcement Savings					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	FY 2024-25 Expenditure on all COB3 bypass codes	\$20,625,427.00	\$20,625,427.00	\$20,625,427.00	Total Expend associated with COB3 Bypass codes
B	FY 2024-25 Expenditure on allowable COB3 bypass codes	\$9,768,931.00	\$9,768,931.00	\$9,768,931.00	Total Expend with updated allowable COB3 bypass codes
C	Estimated Reduction	(\$10,856,496.00)	(\$10,856,496.00)	(\$10,856,496.00)	Row B- Row A
D	Estimated Percentage of Claim for which HCPF will have liability as secondary payer	10.00%	10.00%	10.00%	N/A
E	FY 2026-27 Estimated Bypass Expenditure	\$1,085,650	\$1,085,650	\$1,085,650	Row C * Row D * -1
F	Total FY 2026-27 TPL Bypass Expenditure	\$10,854,581	\$10,854,581	\$10,854,581	Row B + Row E
G	Total Reduction	(\$9,770,846.40)	(\$9,770,846.40)	(\$9,770,846.40)	Row F - Row A
H	Implementation Adjustment	41.67%	100.00%	100.00%	Assuming January 1, 2026 Start Date
I	Total Adjusted Savings	(\$4,071,186.00)	(\$9,770,846.40)	(\$9,770,846.40)	Row G * Row H

Table 7.7 Specialty Drug Carve Out					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	FY 2024-25 Expenditure on Specialty Drugs at current reimburse	\$13,365,694.65	\$13,365,694.65	\$13,365,694.65	Total Expend for EAPG outpatient Specailty Drugs
B	FY 2024-25 Expenditure on Specialty Drugs at New 92% reimburs	\$12,848,766.62	\$12,848,766.62	\$12,848,766.62	Row A Applying a 92% reimbursement
C	Estimated Savings	(\$516,928.03)	(\$516,928.03)	(\$516,928.03)	Row B- Row A
D	Implementation Adjustment	16.67%	100.00%	100.00%	Assuming April 1, 2026 Start Date
E	Total Adjusted Savings	(\$86,154.67)	(\$516,928.03)	(\$516,928.03)	Row C * Row D

Table 7.8 Savings for Dispensing Fees Reduction					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Reducing Tier 1 Dispensing Fee	(\$234,023.83)	(\$1,404,143.00)	(\$1,404,143.00)	Table 7.10 Row H
B	Reducing Tier 2 Dispensing Fee	(\$47,793.65)	(\$286,761.88)	(\$286,761.88)	Table 7.9 Row H
C	Total Projected Savings	(\$281,817.00)	(\$1,690,905.00)	(\$1,690,905.00)	Row A + Row B

Table 7.9 Reducing tier 2 Dispensing fee Rate from \$10.25 to \$9.93					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Non Compound Pharmacy Claims	83,967,302	83,967,302	83,967,302	Total Cost of Non Compound Pharmacy Claims where the dispensing fee is changed from \$10.25 to \$9.93, using FY 2023-24 Claims
B	Non Infusion Compounds Calims	\$201,361	\$201,361	\$201,361	Total Cost of Non Infusion Compound Pharmacy Claims where the dispensing fee is changed from \$10.25 to \$9.93, using FY 2023-24 Claims
C	Infusion Compounds Claims	\$89,768	\$89,768	\$89,768	Total Cost of Infusion Compound Claims where the Dispensing Fee is changed for \$10.25 to \$9.93, using FY 2023-24 Claims
D	Projected Total Dispensing Fees	\$84,258,430	\$84,258,430	\$84,258,430	Sum Row A thru C
E	Current Total Dispensing Fees	\$84,545,192	\$84,545,192	\$84,545,192	Total Dispensing Fees in FY 2023-24
F	Projected Savings	(\$286,762)	(\$286,762)	(\$286,762)	Row D - Row E
G	Implementation Adjustment	16.67%	100.00%	100.00%	Assuming April 1, 2026 Start Date
H	Total Adjusted Savings	(\$47,793.65)	(\$286,761.88)	(\$286,761.88)	Row G * Row H

Table 7.10 Reducing tier 1 Dispensing fee Rate from \$9.31 to \$8.72					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Non Compound Pharmacy Claims	82,852,660	82,852,660	82,852,660	Total Cost of Non Compound Pharmacy Claims where the dispensing fee is changed from \$9.31 to \$8.72, using FY 2023-24 Claims
B	Non Infusion Compounds Calims	\$200,136	\$200,136	\$200,136	Total Cost of Non Infusion Compound Pharmacy Claims where the dispensing fee is changed from \$9.31 to \$8.72, using FY 2023-24 Claims
C	Infusion Compounds Claims	\$88,253	\$88,253	\$88,253	Total Cost of Infusion Compound Claims where the Dispensing Fee is changed for \$9.31 to \$8.72, using FY 2023-24 Claims
D	Projected Total Dispensing Fees	\$83,141,049	\$83,141,049	\$83,141,049	Sum Row A thru C
E	Current Total Dispensing Fees	\$84,545,192	\$84,545,192	\$84,545,192	Total Dispensing Fees in FY 2023-24
F	Projected Savings	(\$1,404,143)	(\$1,404,143)	(\$1,404,143)	Row D - Row E
G	Implementation Adjustment	16.67%	100.00%	100.00%	Assuming April 1, 2026 Start Date
H	Total Adjusted Savings	(\$234,023.83)	(\$1,404,143.00)	(\$1,404,143.00)	Row G * Row H

Table 7.11 Proposed WAC Discounts				
Row	Item	Current WAC Discount	Proposed WAC Discount	Change in Discount off WAC
A	Brand WAC Discount	-3%	-4%	-1%
B	Generic WAC Discount	-10%	-22%	-12%

Table 8.1 FY 2025-26 DD Enrollment Reductions									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Stopping Automatic Youth Enrollments in DD Waiver									
A	Projected Savings	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	50%	Table 8.5A Row M
B	FTE Costs	\$72,922	0.5	\$36,461	\$0.00	\$0.00	\$36,461	50%	Table 11 DD Waiver
C	Total Projected Savings	\$72,922.00	0.5	\$36,461.00	\$0.00	\$0.00	\$36,461.00		Row A + Row B
Pausing 50% of Developmental Disability Waiver Churn Enrollments									
D	Projected Savings	\$0.00	0.0	\$0.00	\$0.00	\$0.00	\$0.00	50%	Table 8.5B Row M
E	FTE Costs	\$72,922	0.5	\$36,461	\$0.00	\$0.00	\$36,461	50%	FTE Calculations
F	Systems Costs	\$0	0.0	\$0	\$0.00	\$0.00	\$0	50%	
G	Total Projected Savings	\$72,922.00	0.5	\$36,461.00	\$0.00	\$0.00	\$36,461.00		Row D + Row E

Table 8.2 FY 2026-27 DD Enrollment Reductions									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Stopping Automatic Youth Enrollments in DD Waiver									
A	Projected Savings	(\$15,398,023.00)	0.0	(\$7,699,012.00)	\$0.00	\$0.00	(\$7,699,011.00)	50%	Table 8.5A Row Z
B	FTE Costs	\$136,647	1.0	\$68,324	\$0.00	\$0.00	\$68,323	50%	Table 11 DD Waiver
C	Total Projected Savings	(\$15,261,376.00)	1.0	(\$7,630,688.00)	\$0.00	\$0.00	(\$7,630,688.00)		Row A + Row B
Pausing 50% of Developmental Disability Waiver Churn Enrollments									
D	Projected Savings	(\$6,633,817.00)	0.0	(\$3,316,909.00)	\$0.00	\$0.00	(\$3,316,908.00)	50%	Table 8.5B Row Z
E	FTE Costs	\$136,647	1.0	\$68,324	\$0.00	\$0.00	\$68,323	50%	Table 11 DD Waiver
F	Systems Costs	\$0	0.0	\$0	\$0.00	\$0.00	\$0	50%	
G	Total Projected Savings	(\$6,497,170.00)	1.0	(\$3,248,585.00)	\$0.00	\$0.00	(\$3,248,585.00)		Row D + Row E

Table 8.3 FY 2027-28 DD Enrollment Reductions									
Row	Item	Total Funds	FTE	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FFP Rate	Notes/Calculations
Stopping Automatic Youth Enrollments in DD Waiver									
A	Projected Savings	(\$43,825,142.00)	0.0	(\$21,912,571.00)	\$0.00	\$0.00	(\$21,912,571.00)	50%	Table 8.5A Row AM
B	FTE Costs	\$138,262	1.0	\$69,131	\$0.00	\$0.00	\$69,131	50%	Table 11 DD Waiver
C	Total Projected Savings	(\$43,686,880.00)	1.0	(\$21,843,440.00)	\$0.00	\$0.00	(\$21,843,440.00)		Row A + Row B
Pausing 50% of Developmental Disability Waiver Churn Enrollments									
D	Projected Savings	(\$18,880,864.00)	0.0	(\$9,440,432.00)	\$0.00	\$0.00	(\$9,440,432.00)	50%	Table 8.5B Row AM
E	FTE Costs	\$138,262	1.0	\$69,131	\$0.00	\$0.00	\$69,131	50%	Table 11 DD Waiver
F	Systems Costs	\$0	0.0	\$0	\$0.00	\$0.00	\$0	50%	
G	Total Projected Savings	(\$18,742,602.00)	1.0	(\$9,371,301.00)	\$0.00	\$0.00	(\$9,371,301.00)		Row D + Row E

Table 8.4A Savings from Stopping Automatic Youth Enrollments in DD Waiver			
Row	Item	Amount	Notes
DD Cost Avoided			
A	Average Monthly DD Enrollments	65	FY 2024-25 Average Increase in DD Enrollment
B	Average Monthly Emergency Enrollments	14	FY 2024-25 Data
C	Average Monthly Transitions from Insititutions	3	FY 2024-25 Data
D	Increase in Monthly Emergency Enrollments if automatic Enrollments is no longer an option	7	Assumed 50% increase in current Emergency Authorizations
E	Average Monthly 129 Enrollments	11	FY 2024-25 JBC Action-129 New DD Waiver Enrollments/ 12
F	Average Monthly Children Transitions	30	Row A - Sum of Row B through Row E
G	Average Monthly DD Costs	\$8,876.91	R-5 Forecast
H	Total DD Cost per Month Avoided	\$266,307.35	Row F * Row G
Increase in Other Waiver Costs			
I	Members Transitioning to SLS	24	Assumed 80%
J	Average Monthly Cost of SLS Waiver	\$2,048.74	R-5 Forecast
K	Total Increase in Cost to SLS Waiver	\$49,169.84	Row I * Row J
L	Members Transitioning to EBD	6	Assumed 20%
M	Average Monthly Cost of EBD Waiver	\$3,287.83	R-1 Forecast
N	Total Increase in Cost to EBD Waiver	\$19,726.96	Row L * Row M
O	Monthly Change in Costs	(\$197,410.55)	Row K + Row M - Row H

Table 8.4B Savings from Pausing Developmental Disability Waiver Churn Enrollments			
Row	Item	Amount	Notes
DD Cost Avoided			
A	Number of Members Disenrolled by month	25	N/A
B	Number of Members assumed to still enroll in DD Waiver	12	See Narrative
C	Adjusted Monthly Decrease in DD Enrollment	13	Row A - Row B
D	Average Monthly DD Costs	\$8,876.91	R-5 Forecast
E	Total DD Cost per Month Avoided	\$115,399.85	Row C * Row D
Increase in Other Waiver Costs			
F	Members Transitioning to SLS	10	Assumed 80%
G	Average Monthly Cost of SLS Waiver	\$2,048.74	R-5 Forecast
H	Total Increase in Cost to SLS Waiver	\$20,487.43	RowF * Row G
I	Members Transitioning to EBD	3	Assumed 20%
J	Average Monthly Cost of EBD Waiver	\$3,287.83	R-1 Forecast
K	Total Increase in Cost to EBD Waiver	\$9,863.48	Row I * Row J
L	Monthly Change in Costs	(\$85,048.94)	Row H + Row K - Row E

Table 8.5A Monthly Savings from Stopping Automatic Youth Enrollments in DD Waiver			
Row	Cost over time of Pause	Total Fund Savings	General Fund Savings
FY 2025-26 Savings			
A	0 Month	\$0.00	\$0.00
B	0 Month	\$0.00	\$0.00
C	0 Month	\$0.00	\$0.00
D	0 Month	\$0.00	\$0.00
E	0 Month	\$0.00	\$0.00
F	0 Month	\$0.00	\$0.00
G	0 Month	\$0.00	\$0.00
H	0 Month	\$0.00	\$0.00
I	0 Month	\$0.00	\$0.00
J	0 Month	\$0.00	\$0.00
K	0 Month	\$0.00	\$0.00
L	0 Month	\$0.00	\$0.00
M	FY 2025-26	\$0.00	\$0.00
FY 2026-27 Savings			
N	1 Month	(\$197,410.55)	(\$98,705.28)
O	2 Month	(\$394,821.10)	(\$197,410.55)
P	3 Month	(\$592,231.65)	(\$296,115.83)
Q	4 Month	(\$789,642.20)	(\$394,821.10)
R	5 Month	(\$987,052.75)	(\$493,526.38)
S	6 Month	(\$1,184,463.30)	(\$592,231.65)
T	7 Month	(\$1,381,873.85)	(\$690,936.93)
U	8 Month	(\$1,579,284.40)	(\$789,642.20)
V	9 Month	(\$1,776,694.95)	(\$888,347.48)
W	10 Month	(\$1,974,105.50)	(\$987,052.75)
X	11 Month	(\$2,171,516.05)	(\$1,085,758.03)
Y	12 Month	(\$2,368,926.60)	(\$1,184,463.30)
Z	FY 2026-27	(\$15,398,022.90)	(\$7,699,011.45)
FY 2027-28 Savings			
AA	13 Month	(\$2,566,337.15)	(\$1,283,168.58)
AB	14 Month	(\$2,763,747.70)	(\$1,381,873.85)
AC	15 Month	(\$2,961,158.25)	(\$1,480,579.13)
AD	16 Month	(\$3,158,568.80)	(\$1,579,284.40)
AE	17 Month	(\$3,355,979.35)	(\$1,677,989.68)
AF	18 Month	(\$3,553,389.90)	(\$1,776,694.95)
AG	19 Month	(\$3,750,800.45)	(\$1,875,400.23)
AH	20 Month	(\$3,948,211.00)	(\$1,974,105.50)
AI	21 Month	(\$4,145,621.55)	(\$2,072,810.78)
AJ	22 Month	(\$4,343,032.10)	(\$2,171,516.05)
AK	23 Month	(\$4,540,442.65)	(\$2,270,221.33)
AL	24 Month	(\$4,737,853.20)	(\$2,368,926.60)
AM	FY 2027-28	(\$43,825,142.10)	(\$21,912,571.05)

Table 8.5B Monthly Savings from Pausing Developmental Disability Waiver Churn Enrollments			
Row	Cost over time of Pause	Total Fund Savings	General Fund Savings
FY 2025-26 Savings			
A	0 Month	\$0.00	\$0.00
B	0 Month	\$0.00	\$0.00
C	0 Month	\$0.00	\$0.00
D	0 Month	\$0.00	\$0.00
E	0 Month	\$0.00	\$0.00
F	0 Month	\$0.00	\$0.00
G	0 Month	\$0.00	\$0.00
H	0 Month	\$0.00	\$0.00
I	0 Month	\$0.00	\$0.00
J	0 Month	\$0.00	\$0.00
K	0 Month	\$0.00	\$0.00
L	0 Month	\$0.00	\$0.00
M	FY 2025-26	\$0.00	\$0.00
FY 2026-27 Savings			
N	1 Month	(\$85,048.94)	(\$42,524.47)
O	2 Month	(\$170,097.88)	(\$85,048.94)
P	3 Month	(\$255,146.82)	(\$127,573.41)
Q	4 Month	(\$340,195.75)	(\$170,097.88)
R	5 Month	(\$425,244.69)	(\$212,622.35)
S	6 Month	(\$510,293.63)	(\$255,146.82)
T	7 Month	(\$595,342.57)	(\$297,671.28)
U	8 Month	(\$680,391.51)	(\$340,195.75)
V	9 Month	(\$765,440.45)	(\$382,720.22)
W	10 Month	(\$850,489.38)	(\$425,244.69)
X	11 Month	(\$935,538.32)	(\$467,769.16)
Y	12 Month	(\$1,020,587.26)	(\$510,293.63)
Z	FY 2026-27	(\$6,633,817.19)	(\$3,316,908.60)
FY 2027-28 Savings			
AA	13 Month	(\$1,105,636.20)	(\$552,818.10)
AB	14 Month	(\$1,190,685.14)	(\$595,342.57)
AC	15 Month	(\$1,275,734.08)	(\$637,867.04)
AD	16 Month	(\$1,360,783.01)	(\$680,391.51)
AE	17 Month	(\$1,445,831.95)	(\$722,915.98)
AF	18 Month	(\$1,530,880.89)	(\$765,440.45)
AG	19 Month	(\$1,615,929.83)	(\$807,964.91)
AH	20 Month	(\$1,700,978.77)	(\$850,489.38)
AI	21 Month	(\$1,786,027.71)	(\$893,013.85)
AJ	22 Month	(\$1,871,076.64)	(\$935,538.32)
AK	23 Month	(\$1,956,125.58)	(\$978,062.79)
AL	24 Month	(\$2,041,174.52)	(\$1,020,587.26)
AM	FY 2027-28	(\$18,880,864.31)	(\$9,440,432.16)

Table 9.1 Summary of All Unit Cap Savings					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
Savings from Standard Deviation Cap					
A	Savings from Personal Care	(\$768,333.00)	(\$4,609,996.00)	(\$4,609,996.00)	Table 9.2 Row B
B	Savings from Health Maintenance Activity (HMA)	(\$1,133,227.00)	(\$6,799,364.00)	(\$6,799,364.00)	Table 9.2 Row C
C	Savings from Homemaker	(\$601,881.00)	(\$2,817,163.00)	(\$2,817,163.00)	Table 9.2 Row A
D	Savings From Combined Services	(\$2,503,441.00)	(\$14,226,523.00)	(\$14,226,523.00)	Row A + Row B + Row C
E	Associated Systems Cost	\$0.00	\$0.00	\$0.00	Table 9.2 Row D
F	Associated FTE	\$182,433.00	\$335,226	\$340,071	Table 9.2 Row E
G	Total Savings (Service Savings - FTE and Systems Costs)	(\$2,321,008.00)	(\$13,891,297.00)	(\$13,886,452.00)	Row D + Row E + Row F
H	FTE Count	1.50	3.00	3.00	Table 9.2 Row G
I	General Fund	(\$1,160,504.00)	(\$6,945,648.00)	(\$6,943,226.00)	Row G - Row L
J	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
K	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
L	Federal Funds	(\$1,160,504.00)	(\$6,945,649.00)	(\$6,943,226.00)	Row G * 50%
Savings from Caregiver 56 Hours Per Week Cap					
M	Savings from Home Health Aide	(\$37,562.00)	(\$225,373.00)	(\$225,373.00)	Table 9.7 Row A
N	Savings from Personal Care, Homemaker, and HMA	(\$358,853.00)	(\$2,153,118.00)	(\$2,153,118.00)	Table 9.7 Row B
O	Savings from Nursing	\$0.00	\$0.00	\$0.00	Table 9.7 Row C
P	Savings From Combined Services	(\$396,415.00)	(\$2,378,491.00)	(\$2,378,491.00)	Row M + Row N + Row O
Q	Associated Systems Cost	\$0.00	\$0.00	\$0.00	Table 9.7 Row D
Q	Associated FTE	\$60,811.00	\$111,742.00	\$113,357.00	Table 9.7 Row D
R	Total Savings (Service Savings - FTE and Systems Costs)	(\$335,604.00)	(\$2,266,749.00)	(\$2,265,134.00)	Row P + Row Q
S	FTE Count	0.50	1.00	1.00	Table 9.7 Row F
T	General Fund	(\$167,802.00)	(\$1,133,374.00)	(\$1,132,567.00)	Row R - Row W
U	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
V	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
W	Federal Funds	(\$167,802.00)	(\$1,133,375.00)	(\$1,132,567.00)	Row R * 50%
Savings from Homemaker 5 Hour Cap					
X	Savings from Homemaker Cap - Moving from 10 to 5 Hours per Day	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	Table 9.11 Row A
Y	Associated Systems Cost	\$0.00	\$0.00	\$0.00	Table 9.11 Row B
Z	Total Savings (Service Savings - FTE and Systems Costs)	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	Row X + Row Y
AB	FTE Count	0.0	0.0	0.0	
AA	General Fund	(\$37,175.00)	(\$223,051.00)	(\$223,051.00)	Row Z - Row AD
AB	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
AC	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
AD	Federal Funds	(\$37,175.00)	(\$223,051.00)	(\$223,051.00)	Row Z * 50%
Total Savings from All Initiatives					
AE	Savings from Standard Deviation Cap	(\$2,321,008.00)	(\$13,891,297.00)	(\$13,886,452.00)	Row G
AF	Savings from 56 Hours Per Week Cap	(\$335,604.00)	(\$2,266,749.00)	(\$2,265,134.00)	Row R
AG	Savings From Homemaker 5 Hour Cap	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	Row Z
AH	Total Savings for All Initiatives (Including Overlap Factor Calculated Individually)	(\$2,730,962.00)	(\$16,604,148.00)	(\$16,597,688.00)	Row AE + Row AF + Row AG
AI	FTE Count	2.00	4.00	4.00	Row H + Row S
AJ	General Fund	(\$1,365,481.00)	(\$8,302,073.00)	(\$8,298,844.00)	Row I + Row T + Row AA
AK	Cash Funds	\$0.00	\$0.00	\$0.00	Row J + Row U + Row AB
AL	Reappropriated Funds	\$0.00	\$0.00	\$0.00	Row K + Row V + Row AC
AM	Federal Funds	(\$1,365,481.00)	(\$8,302,075.00)	(\$8,298,844.00)	Row L + Row W + Row AD

Table 9.2 Summary of Standard Deviation Unit Cap Savings					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Savings from Homemaker (including overlap factor)	(\$601,881.00)	(\$2,817,163.00)	(\$2,817,163.00)	Table 9.3 Row H
B	Savings from Personal Care (including overlap factor)	(\$768,333.00)	(\$4,609,996.00)	(\$4,609,996.00)	Table 9.4 Row H
C	Savings from HMA (including overlap factor and LTHH expend)	(\$1,133,227.00)	(\$6,799,364.00)	(\$6,799,364.00)	Table 9.5 Row M
D	Expenditure for System Changes	\$0.00	\$0.00	\$0.00	Table 9.6 Row C
E	FTE Expenditure	\$182,433	\$335,226	\$340,071	Table 11 Capping CFC FTE
F	Total Expenditure	(\$2,321,008.00)	(\$13,891,297.00)	(\$13,886,452.00)	Sum of Rows A through D
G	FTE Count	1.50	3.00	3.00	Table 11 Capping CFC FTE
H	General Fund	(\$1,160,504.00)	(\$6,945,649.00)	(\$6,943,226.00)	Row E * 50%
I	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
J	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
K	Federal Funds	(\$1,160,504.00)	(\$6,945,649.00)	(\$6,943,226.00)	Row E * 50%

Table 9.3 Homemaker Savings - 2 Standard Deviations Above Mean					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members 2 Standard Deviations Above Mean	284.0	284.0	284.0	Average Number of Members 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
B	Average Units Per Week - 2 Standard Deviations Above Mean	5,427	5,427	5,427	Average Number of Units Per Member 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
C	Average Expenditure - 2 Standard Deviations Above Mean	\$9,630,095.00	\$9,630,095.00	\$9,630,095.00	Average of Total Paid Amount 2 SD above mean, annualized from data between 4/1/22 and 3/31/23, 4/1/23 and 3/31/24, and 4/1/24 and 3/31/25
D	Total Potential Savings	\$9,630,095.00	\$7,512,435.87	\$7,512,435.87	Row C
E	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
F	Overlap Factor	75%	75%	75%	See Narrative
G	Patient Behavior Factor	50.00%	50.00%	50.00%	Assuming 50% of members will decrease services in accordance with cap, and not substitute care with another service.
H	Total Savings From Implementing Cap	(\$601,881.00)	(\$2,817,163.00)	(\$2,817,163.00)	Row D * Row E * Row F * Row G

Table 9.4 Personal Care Savings - 2 Standard Deviations Above Mean					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members 2 Standard Deviations Above Mean	353	353	353	Average Number of Members 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
B	Average Units Per Week - 2 Standard Deviations Above Mean	12,517	12,517	12,517	Average Number of Units Per Member 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
C	Average Expenditure - 2 Standard Deviations Above Mean	\$12,293,322.00	\$12,293,322.00	\$12,293,322.00	Average of Total Paid Amount 2 SD above mean, annualized from data between 4/1/22 and 3/31/23, 4/1/23 and 3/31/24, and 4/1/24 and 3/31/25
D	Total Potential Savings	\$12,293,322.00	\$12,293,322.00	\$12,293,322.00	Row C
E	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
F	Overlap Factor	75.00%	75.00%	75.00%	See Narrative
G	Patient Behavior Factor	50.00%	50.00%	50.00%	Assuming 50% of members will decrease services in accordance with cap, and not substitute care with another service.
H	Total Savings From Implementing Cap	(\$768,333.00)	(\$4,609,996.00)	(\$4,609,996.00)	Row D * Row E * Row F * Row G

Table 9.5 Health Maintenance Activities - 2 Standard Deviations Above Mean					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members 2 Standard Deviations Above Mean	329.00	329.00	329.00	Average Number of Members 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
B	Average Units Per Week - 2 Standard Deviations Above Mean	24,568.00	24,568.00	24,568.00	Average Number of Units Per Member 2 SD above mean, annualized from data between 4/1/24 and 3/31/25
C	Average Expenditure - 2 Standard Deviations Above Mean	\$58,017,394.67	\$58,017,394.67	\$58,017,394.67	Average of Total Paid Amount 2 SD above mean, annualized from data between 4/1/22 and 3/31/23, 4/1/23 and 3/31/24, and 4/1/24 and 3/31/25
D	Total Potential Savings	(\$58,017,394.67)	(\$58,017,394.67)	(\$58,017,394.67)	Row C
E	Patient Behavior Factor	50.00%	50.00%	50.00%	Assuming 50% of members will decrease services in accordance with cap, and not substitute care with another service.
F	Overlap Factor	75.00%	75.00%	75.00%	See Narrative
G	Potential Savings Including Overlap Factor	(\$21,756,523.00)	(\$21,756,523.00)	(\$21,756,523.00)	Row D * Row E * Row G (needs to be neg)
H	Percentage of Members Expected to Transition into LTHH	80.00%	80.00%	80.00%	Because this service is deemed medically necessary, if a cap is applied members are likely to substitute this service with another uncapped service, specifically Home Health Aide Basic under Long Term Home Health.
I	Number of Members Expected to Transition into LTHH	263.20	263.20	263.20	Row A * Row I
J	Estimated LTHH Expenditure Per Member	\$56,828.11	\$56,828.11	\$56,828.11	Average cost per member for Home Health Aid Basic
K	Potential LTHH Expenditure	\$14,957,158.88	\$14,957,158.88	\$14,957,158.88	Row J * Row K
L	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
M	Total Savings From Implementing Cap	(\$1,133,227.00)	(\$6,799,364.00)	(\$6,799,364.00)	Row H + Row L * Row M

Table 9.7 Summary of Caregiver Unit Cap					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Total Savings from Home Health Aide	(\$37,562.00)	(\$225,373.00)	(\$225,373.00)	Table 9.8 Row H
B	Savings from Homemaker, Personal Care, HMA	(\$358,853.00)	(\$2,153,118.00)	(\$2,153,118.00)	Table 9.9 Row H
C	Savings from Nursing Services	\$0.00	\$0.00	\$0.00	Table 9.10 Row H
D	FTE Expenditure	\$60,811.00	\$111,742.00	\$113,357.00	Table 11 Caregiver Unit Cap FTE
E	Total Expenditure	(\$335,604.00)	(\$2,266,749.00)	(\$2,265,134.00)	Sum of Rows A through C + Row D
F	FTE Count	0.50	1.00	1.00	Table 11 Caregiver Unit Cap FTE
G	General Fund	(\$167,802.00)	(\$1,133,375.00)	(\$1,132,567.00)	Row E * 50%
H	Federal Funds	(\$167,802.00)	(\$1,133,375.00)	(\$1,132,567.00)	Row E * 50%

Table 9.8 Home Health Aide Savings From Cap					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members Above the Cap	664	664	664	Total number of members receiving Home Health Aide care above the proposed cap during FY 24-25
B	Estimated Percentage of Members Receiving Care from 1 Caregiver	50.00%	50.00%	50.00%	Assuming 50% of members receive care from 1 caregiver
C	Average Hours Per Members Above the Cap	1.67	1.67	1.67	Average number of hours above cap during FY 24-25
D	Total Expenditure Above the Cap	\$7,512,435.87	\$7,512,435.87	\$7,512,435.87	Total expenditure above cap during FY 24-25
E	Patient Behavior Factor	30%	30%	30%	Members that are not decreasing utilization require an exception with additional proof from a Department staff. Many members will not seek an exception due to that requirement, and of those that do, about half will be denied.
F	Overlap Factor	20.00%	20.00%	20.00%	See Narrative
G	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
H	Total Savings From Implementing Cap	(\$37,562.00)	(\$225,373.00)	(\$225,373.00)	(Row D * Row E) * Row B * Row F * Row G

Table 9.9 Homemaker, Personal Care, HMA Savings From Cap					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members Above the Cap	3304	3304	3304	Total number of members receiving Homemaker, Personal Care and HMA above the proposed cap during FY 24-25
B	Estimated Percentage of Members Receiving Care from 1 Caregiver	50.00%	50.00%	50.00%	Assuming 50% of members receive care from 1 caregiver
C	Average Hours Per Members Above the Cap	2.99	2.99	2.99	Average number of hours above cap during FY 24-25
D	Total Expenditure Above the Cap	\$107,655,916.60	\$107,655,916.60	\$107,655,916.60	Total expenditure above cap during FY 24-25
E	Patient Behavior Factor	20.00%	20.00%	20.00%	Members that are not decreasing utilization require an exception with additional proof from a Department staff. Many members will not seek an exception due to that requirement, and of those that do, about half will be denied.
F	Overlap Factor	20.00%	20.00%	20.00%	See Narrative
G	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
H	Total Savings From Implementing Cap	(\$358,853.00)	(\$2,153,118.00)	(\$2,153,118.00)	(Row D * Row E) * Row B * Row F * Row G

Table 9.10 Nursing Savings From Cap					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number of Members Above the Cap	494	494	494	Total number of members receiving nurse care above the proposed cap during FY 24-25
B	Estimated Percentage of Members Recieving Care from 1 Caregiver	50.00%	50.00%	50.00%	Assuming 50% of members receive care from 1 caregiver
C	Average Hours Per Members Above the Cap	6.73	6.73	6.73	Average number of hours above cap during FY 24-25
D	Total Expenditure Above the Cap	\$45,084,954.03	\$45,084,954.03	\$45,084,954.03	Total expenditure above cap during FY 24-25
E	Patient Behavior Factor	0.00%	0.00%	0.00%	This service is medically necessary. Members are likely to seek a secondary caregiver or receive care in a different setting, negating any savings from implementing a cap.
F	Overlap Factor	0%	0%	0%	No other caps apply to this specific service
G	Implementation Adjusment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
H	Total Savings From Implementing Cap	\$0.00	\$0.00	\$0.00	(Row D * Row E) * Row B * Row F * Row G

Table 9.11 Summary of Homemaker Unit Cap Savings					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Savings from Homemaker Hour Cap	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	Table 9.12 Row F
B	Expenditure for System Changes - Homemaker Cap	\$0.00	\$0.00	\$0.00	N/A
C	Total Expenditure	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	Row A
D	General Fund	(\$37,175.00)	(\$223,051.00)	(\$223,051.00)	Row C * 50%
E	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
F	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
G	Federal Funds	(\$37,175.00)	(\$223,051.00)	(\$223,051.00)	Row C * 50%

Table 9.12 Homemaker 5 Hours (35 units) Per Week Savings From Cap					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Number Of Members Above the Cap	94	94	94	Total number of adult members receiving more than 5 hours per week of homemaker services during FY 2024-25.
B	Average Hours Per Members Above the Cap	1.33	1.33	1.33	Average number of hours per week members receive above the cap
C	Total Expenditure Above the Cap	\$2,230,510.84	\$2,230,510.84	\$2,230,510.84	Total expenditure for all hours billed above the cap
D	Implementation Adjustment	16.67%	100.00%	100.00%	April 1, 2026 Implementation Date
E	Overlap Factor	20.00%	20.00%	20.00%	See Narrative
F	Total Savings From Implementing Cap	(\$74,350.00)	(\$446,102.00)	(\$446,102.00)	(Row B * Row D) * Row E * Row F

Table 10.1 Community Connector Rate					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Current Total Expenditure	\$65,329,852	\$65,329,852	\$65,329,852	N/A
B	Projected FY 25-26 growth on the CES and CHRP waiver	23.17%	23.17%	23.17%	N/A
C	Percentage Rate Reduction taken in Executive Order	-14.98%	-14.98%	-14.98%	N/A
D	Estimated Impact	(\$12,052,939)	(\$12,052,939)	(\$12,052,939)	Row A * (1 + Row B) * Row C
E	Proposed Reduction from July 1, 2025 Rates Based on Aligning with Supported Community Connections	-37.76%	-37.76%	-37.76%	N/A
F	Estimated Impact of aligning with Supported Community Connections	(\$30,384,803)	(\$30,384,803)	(\$30,384,803)	Row A * (1 + Row B) * Row E
G	Total Adjusted Impact	(\$18,331,864)	(\$18,331,864)	(\$18,331,864)	Row D - Row F
H	Implementation Adjustment	16.67%	100%	100%	Assuming April 1, 2026 implementation date
I	Total Adjusted Impact	(\$3,055,311)	(\$18,331,864)	(\$18,331,864)	Row H * Row G
J	General Fund	(\$1,527,655)	(\$9,165,932)	(\$9,165,932)	Row H * 50%
K	Cash Funds	\$0	\$0	\$0	N/A
L	Reappropriated Funds	\$0	\$0	\$0	N/A
M	Federal Funds	(\$1,527,655)	(\$9,165,932)	(\$9,165,932)	Row H * 50%

Table 10.2 Community Connector Unit Cap - 50% Decrease					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
A	Percentage of Clients Over 2080 Units	16.30%	16.30%	16.30%	Total Actual Utilizers between April and June of FY 23-24
B	Current Cost of Full Year	\$48,231,605	\$48,231,605	\$48,231,605	Annualized Total Cost from April to June of FY 23-24
C	Annualized Expected Cost	\$40,899,311	\$40,899,311	\$40,899,311	Row B - Row D
D	Difference	\$5,291,548.30	\$5,291,548.30	\$5,291,548.30	Total Expenditure of Units when Cap is Applied
E	Percentage Of Clients Over 1040 Units	47.50%	47.50%	47.50%	Total Actual Utilizers between April and June of FY 23-24
F	Current Cost of Full Year	\$48,231,605.00	\$48,231,605.00	\$48,231,605.00	Annualized Total Cost from April to June of FY 23-24
G	Annualized Expected Cost	\$27,736,092.00	\$27,736,092.00	\$27,736,092.00	Row F - Row H
H	Difference	\$20,495,513.00	\$20,495,513.00	\$20,495,513.00	Total Expenditure of Units when Cap is Applied
I	Difference Between 2080 and 1040 Units	(\$15,203,965.00)	(\$15,203,965.00)	(\$15,203,965.00)	Row H - Row D
J	Implementation Adjustment	16.67%	100.00%	100.00%	Assuming April 1, 2026 implementation date
K	Systems Changes Cost	\$0.00	\$0.00	\$0.00	N/A
L	FTE Costs	\$60,811.00	\$111,742.00	\$113,357.00	Table 11 FTE Calculations
M	Total Adjusted Impact	(\$2,473,183.00)	(\$15,092,223.00)	(\$15,090,608.00)	Row I * Row J + Row L
N	FTE Count	0.5	1.0	1.0	Table 11 FTE Calculations
O	General Fund	(\$1,236,591.50)	(\$7,546,111.50)	(\$7,545,304.00)	Row M * 50%
P	Cash Funds	\$0.00	\$0.00	\$0.00	N/A
Q	Reappropriated Funds	\$0.00	\$0.00	\$0.00	N/A
R	Federal Funds	(\$1,236,591.50)	(\$7,546,111.50)	(\$7,545,304.00)	Row M * 50%

Table 10.3 Movement Therapy Rate to Budget Nuetrality Calculation					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Notes
	<i>Movement Therapy - Bachelors; CES, SLS</i>				
A	Current Rate	\$17.50	\$17.50	\$17.50	N/A
B	Rate at 100% BNF	\$16.11	\$16.11	\$16.11	N/A
C	Percent Reduction	-7.94%	-7.94%	-7.94%	N/A
D	Current Annual Expenditure, Trended Forward	\$1,186,243	\$1,186,243	\$1,186,243	N/A
E	Cash Flow Adjustment	16.67%	100%	100%	Implementing April 1, 2026
F	Estimated Impact of Rate Reduction	(\$15,704)	(\$94,222)	(\$94,222)	Row C * Row D * Row E
	<i>Movement Therapy - Bachelors; CHRP</i>				
G	Current Rate	\$17.68	\$17.68	\$17.68	N/A
H	Rate at 100% BNF	\$16.11	\$16.11	\$16.11	N/A
I	Percent Reduction	-8.88%	-8.88%	-8.88%	N/A
J	Current Annual Expenditure, Trended Forward	\$85,923	\$85,923	\$85,923	N/A
K	Cash Flow Adjustment	16.67%	100%	100%	Implementing April 1, 2026
L	Estimated Impact of Rate Reduction	(\$1,272)	(\$7,630)	(\$7,630)	Row I * Row J * Row K
	<i>Movement Therapy - Masters; CES, SLS</i>				
M	Current Rate	\$25.63	\$25.63	\$25.63	N/A
N	Rate at 100% BNF	\$18.61	\$18.61	\$18.61	N/A
O	Percent Reduction	-27.39%	-27.39%	-27.39%	N/A
P	Current Annual Expenditure, Trended Forward	\$2,155,573	\$2,155,573	\$2,155,573	N/A
Q	Cash Flow Adjustment	16.67%	100%	100%	Implementing April 1, 2026
R	Estimated Impact of Rate Reduction	(\$98,401)	(\$590,407)	(\$590,407)	Row O * Row P * Row Q
	<i>Movement Therapy - Masters; CHRP</i>				
S	Current Rate	\$25.91	\$25.91	\$25.91	N/A
T	Rate at 100% BNF	\$18.61	\$18.61	\$18.61	N/A
U	Percent Reduction	-28.17%	-28.17%	-28.17%	N/A
V	Current Annual Expenditure, Trended Forward	\$85,923	\$85,923	\$85,923	N/A
W	Cash Flow Adjustment	16.67%	100%	100%	Implementing April 1, 2026
X	Estimated Impact of Rate Reduction	(\$4,035)	(\$24,208)	(\$24,208)	Row U * Row V * Row W
Y	Total Impact	(\$119,412)	(\$716,467)	(\$716,467)	Row F + Row L + Row R + Row X
Z	General Fund	(\$59,706)	(\$358,233)	(\$358,233)	Row Y - Row AA
AA	Federal Funds	(\$59,706)	(\$358,234)	(\$358,234)	Row Y * 50%

Table 10.4 PETI Savings Calculation					
Row	Item	FY 2025-26	FY 2026-27	FY 2027-28	Source
A	Estimated DD Enrollment	9,169	9,570	9,942	November 2025 Forecast
B	Estimated Percentage of Members > 300% FPL	40.00%	40.00%	40.00%	Based on eligibility data for members on the DD waiver
C	Estimated DD PETI Contributors	3,668	3,828	3,977	Row A * Row B
D	Estimated Average Monthly PETI Contribution	\$550.41	\$550.41	\$550.41	Average SLP contribution for members on Brain Injury Waiver
E	Implementation Date Adjustment	0%	50%	100%	Implementation on July 1, 2026 based on Member's redetermination date
F	Estimated Annual Savings	\$0	(\$12,641,817)	(\$26,267,767)	Row C * Row D * Row E * 12 * -1
G	Estimated Systems Costs	\$0	\$0	\$0	Systems Costs Absorbable through Pool Hours
H	Total Estimated Impact	\$0	(\$12,641,817)	(\$26,267,767)	Row F + Row G
I	General Fund	\$0	(\$6,320,908)	(\$13,133,883)	Row H - Row K
J	Cash Fund	\$0	\$0	\$0	N/A
K	Federal Funds	\$0	(\$6,320,909)	(\$13,133,884)	50% federal match

Table 11 FTE Calculations Personal Services										
Position Classification	FTE	Start Month	End Month (if Applicable)	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
ADMINISTRATOR V	1.0	Jan 2026	N/A	\$51,205	\$105,313	\$105,313	\$105,313	\$105,313	\$105,313	Stop Automatic Enrollments into the Developmental Disabilities Waiver from Children's Waivers
ADMINISTRATOR V	1.0	Jan 2026	N/A	\$51,205	\$105,313	\$105,313	\$105,313	\$105,313	\$105,313	Reduce Churn Enrollments to the Developmental Disabilities Waivers by 50%
POLICY ADVISOR IV	1.0	Jan 2026	N/A	\$40,125	\$82,528	\$82,528	\$82,528	\$82,528	\$82,528	Capping Community First Choice Services
POLICY ADVISOR IV	1.0	Jan 2026	N/A	\$40,125	\$82,528	\$82,528	\$82,528	\$82,528	\$82,528	Capping Community First Choice Services
POLICY ADVISOR IV	1.0	Jan 2026	N/A	\$40,125	\$82,528	\$82,528	\$82,528	\$82,528	\$82,528	Capping Community First Choice Services
POLICY ADVISOR IV	1.0	Jan 2026	N/A	\$40,125	\$82,528	\$82,528	\$82,528	\$82,528	\$82,528	Capping Caregiver services to 56 Hours per Week
POLICY ADVISOR IV	1.0	Jan 2026	N/A	\$40,125	\$82,528	\$82,528	\$82,528	\$82,528	\$82,528	Cap Community Connector Services to 1040 Units
Total Personal Services (Salary, PERA, FICA)	7.0			\$303,035	\$623,266	\$623,266	\$623,266	\$623,266	\$623,266	

Centrally Appropriated Costs										
Cost Center	FTE Year 1	FTE Year 2+	Cost or Percentage	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Health, Life, and Dental	3.5	7.0	Varies	\$50,974	\$113,064	\$124,369	\$124,369	\$124,369	\$124,369	
Short-term Disability	-	-	0.07%	\$189	\$385	\$385	\$385	\$385	\$385	
Paid Family and Medical Leave Insurance	-	-	0.45%	\$1,208	\$2,478	\$2,478	\$2,478	\$2,478	\$2,478	
Unfunded Liability AED Payments	-	-	10.00%	\$26,796	\$55,116	\$55,116	\$55,116	\$55,116	\$55,116	
Centrally Appropriated Costs Total				\$79,167	\$171,043	\$182,348	\$182,348	\$182,348	\$182,348	

Operating Expenses										
Ongoing Costs	FTE Year 1	FTE Year 2+	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Standard Allowance	3.5	7.0	\$500	\$1,736	\$3,500	\$3,500	\$3,500	\$3,500	\$3,500	
Communications	3.5	7.0	\$235	\$819	\$1,645	\$1,645	\$1,645	\$1,645	\$1,645	
Other	3.5	7.0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	
<i>Subtotal</i>				\$2,555	\$5,145	\$5,145	\$5,145	\$5,145	\$5,145	
One-Time Costs (Capital Outlay)	FTE		Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Cubicle	7.0		\$5,000	\$35,000	\$0	\$0	\$0	\$0	\$0	
PC	7.0		\$2,000	\$14,000	\$0	\$0	\$0	\$0	\$0	
Other	7.0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	
<i>Subtotal</i>				\$49,000	\$0	\$0	\$0	\$0	\$0	
Total Operating				\$51,555	\$5,145	\$5,145	\$5,145	\$5,145	\$5,145	

Leased Space										
	FTE Year 1	FTE Year 2+	Cost	FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29	FY 2029-30	FY 2030-31	Notes
Leased Space	3.5	7.0	\$4,650	\$16,142	\$32,550	\$32,550	\$32,550	\$32,550	\$32,550	