FY 2026-27 Budget Briefing Summary

Health Care Policy and Financing

The Department helps cover health and long-term care costs for low-income and vulnerable people. Federal matching funds assist with most of these costs. In return for the federal funds, the Department must follow federal rules governing eligibility, benefits, and other features.

Summary of Request

Department of Health Care Policy and Financing

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Total	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
FY 2026-27 Requested Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Medical forecast [1]	2,841,332,450	630,860,236	477,749,914	0	1,732,722,300	0.0
Eligibility & benefit changes [1]	-203,585,062	-82,866,991	-5,345,281	0	-115,372,790	7.0
Provider rates [1]	-341,182,268	-126,227,926	-17,665,178	0	-197,289,164	1.0
Administration [1]	8,655,095	-7,133,048	2,291,649	2,455,447	11,041,047	11.3
Prior year actions [1]	37,382,050	15,219,353	-4,075,326	-1,652,006	27,890,029	-2.6
Employee compensation common policies	8,693,320	2,544,524	1,436,917	0	4,711,879	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0
Impacts driven by other agencies	1,890,335	852,076	93,091	0	945,168	1.8
Total	$20,574,754,164	$5,988,845,075	$2,485,238,785	$144,810,897	$11,955,859,407	861.7
Increase/-Decrease	$2,357,463,218	$434,529,053	$454,959,208	$790,014	$1,467,184,943	18.5
Percentage Change	12.9%	7.8%	22.4%	0.5%	14.0%	2.2%

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

Medical forecast

The Department requests an increase for projected expenditures for Home- and Community-Based Services waivers for individuals with development disabilities under current law and policy. The cost is $136.9 million total funds in FY 2026-27, including $72.9 million General Fund.

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R1 Medical Services Premiums	$2,282,305,964	$431,286,496	$443,437,319	$0	$1,407,582,149	0.0	EK
R2 Behavioral health	343,831,232	68,242,986	30,852,643	0	244,735,603	0.0	EP
R5 Office of Community Living [1]	136,855,181	72,893,346	-1,713,868	0	65,675,703	0.0	TD
R4 Other programs & services	56,180,311	56,180,311	0	0	0	0.0	EK
R3 Child Health Plan Plus	22,659,762	2,757,097	5,173,820	0	14,728,845	0.0	EK
R6.05 Immigrant family planning	-500,000	-500,000	0	0	0	0.0	EK
Total	$2,841,332,450	$630,860,236	$477,749,914	$0	$1,732,722,300	0.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

The forecasts do not account for the impacts from the Governor's August 28, 2025 Executive Order, or it's October 31st update. Nor do the forecasts account for the impacts of federal H.R. 1. Impacts from the Executive Order are included in R6. The forecast is based on enrollment and expenditure data through June 2025. The Committee will receive an updated based on enrollment and expenditure data through December 2025 in February 2026 for consideration during figure setting.

Eligibility & benefits changes

The Department requests 18 eligibility and benefit changes across 3 prioritized requests. Nine changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Eligibility and benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R18 3D mammograms	$635,758	$128,456	$37,885	$469,417	0.0	EK
R6.09 Outpatient psychotherapy prior auth	-31,330,942	-12,241,619	-959,135	-18,130,188	0.0	EP
R6.04 Continuous coverage	-27,209,010	-11,226,343	-716,877	-15,265,790	0.0	EK
R6.10 Pediatric behavioral therapy reviews	-20,000,000	-10,000,000	0	-10,000,000	0.0	EP
R6.17 IDD youth transitions [1]	-15,261,376	-7,630,688	0	-7,630,688	1.0	TD
R6.34 Community connector units [1]	-15,092,224	-7,546,112	0	-7,546,112	1.0	TD
R6.08 Tests for specific drugs	-14,106,232	-1,876,129	-1,035,397	-11,194,706	0.0	EK
R6.30 HCBS hours soft cap [1]	-13,891,297	-6,945,648	0	-6,945,649	3.0	TD
R6.20 Community health workers	-13,385,549	-3,196,962	-803,013	-9,385,574	0.0	EK
R6.36 IDD cost share [1]	-12,641,818	-6,320,909	0	-6,320,909	0.0	TD
R6.25 Biosimilars	-12,316,324	-2,357,591	-1,240,468	-8,718,265	0.0	EK
R6.26 3rd party pay for drugs	-9,770,846	-2,944,176	-645,423	-6,181,247	0.0	EK
R6.18 IDD waitlist [1]	-6,497,170	-3,248,585	0	-3,248,585	1.0	TD
R17 Community connector age limit [1]	-5,229,310	-2,632,702	17,147	-2,613,755	0.0	TD
R6.29 LTSS presumptive eligibility [1]	-2,775,871	-1,471,558	0	-1,304,313	0.0	TD
R6.31 Caregiving hours soft cap [1]	-2,266,749	-1,133,374	0	-1,133,375	1.0	TD
R6.19 Senior dental grants	-2,000,000	-2,000,000	0	0	0.0	EK

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R6.32 Homemaker hours soft cap [1]	-446,102	-223,051	0	-223,051	0.0	TD
Total	-$203,585,062	-$82,866,991	-$5,345,281	-$115,372,790	7.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R6.17 IDD youth transitions: The Department asks to reduce funding for the automatic enrollment to the DD waiver of youth who age out of the CES waiver.

The Department anticipates implementing this change July 1, 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: An increase of $72,922 total funds, including $36,461 General Fund, and 0.5 FTE.
- Year 1: A net reduction of $15.3 million total funds, including $7.6 million General Fund, and an increase of 1.0 FTE.
- Year 2: A net reduction is $43.7 million total funds, including $21.8 million General Fund, and an increase of 1.0 FTE.

The Department proposed ending the practice of automatically enrolling into the DD waiver youth who age out of the CES and CHRP waivers. The Department is required by statute to enroll youth who are served through child welfare services and turning 18 years old into the DD waiver without being placed on the waitlist. The proposal does not change this policy. The change will necessitate non-exempt individuals aging out of the CES and CHRP waivers to seek services through other waivers. These individuals are eligible to be placed on the DD wavier waitlist.

The Department requests an additional staff position to train and support case management agencies, to assist with emergency enrollment authorizations review, and to review appeals decisions. The proposal also requires changes to the Care and Case Management system to track emergency requests and denials.

R6.34 Community connector units: The Department asks to reduce funding for the community connector rate for implementing a lower annual cap on the number of units covered.

The Department anticipates implementing this change in the Spring of 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: A net reduction of $2.5 million total funds, including $1.2 million General Fund, and an increase of 0.5 FTE.
- Year 1 and ongoing: A net reduction of $15.1 million total funds, including $7.5 million General Fund, and an increase of 1.0 FTE.

Community connector services help individuals enrolled in the CES and CHRP waivers participate in typical childhood activities and to become more fully integrate into their communities. These services help members develop skills and abilities to be active participants in their communities, build relationships and natural supports, and interact one-on-one with non-familial persons without disabilities. Examples of engagement supported by this benefit are volunteering, attending enrichment classes, and going to the library alongside peers without disabilities.

The Department is planning a 50.0 percent reduction to the annual cap for community connector services to 1,040 units. Community connector services are billed in 15-minute increments, so the new cap equates to 260

hours per year per member. The Department anticipates hundreds of exception requests and requests an addition staff position to support the review process for this change to the community connector benefit.

R6.30 HCBS hours soft cap: The Department asks to reduce funding for select Home- and Community-Based Services (HCBS) for the implementation of caps on annual use.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: A net reduction of $2.3 million total funds, including $1.2 million General Fund, and an increase of 1.5 FTE.
- Year 1 and ongoing: A net reduction of $13.9 million total funds, including $6.9 million General Fund, and an increase of 3.0 FTE.

Personal care, homemaker, and health maintenance activities are core HCBS benefits and are available under Community First Choice. These services are not currently limited and are authorized base on assessed need. Personal care services assist with activities such as bathing, dressing, eating, mobility, and hygiene. Homemaker services provide assistance with household tasks including meal preparation, cleaning, laundry, and shopping. Health maintenance activities include supports such as medication administration, catheter care, or respiratory assistance that can be safely performed in the home or community setting.

The Department proposes implementing soft caps for these services. The cap will limit annual utilization, but a process for requesting an exception will be established. The Department requests three staff positions to manage the exceptions process.

Annual HCBS Service Limits

Service	Limit (units)	Daily Hours
Personal care	10,000	6.5
Homemaker	4,500	3.0
Health maintenance activities	19,000	13.0

R6.36 IDD cost share: The Department asks to reduce funding for the DD waiver for the implementation of a policy to require members on the waiver to contribute financially for their residential services.

The Department anticipates implementing this change on July 1, 2026. The change reduces the Department's forecast by:

- Year 1: $12.6 million total funds, including $6.3 million General Fund.
- Year 2: $26.3 million total funds, including $13.1 million General Fund.

The Department plans to institute post eligibility-treatment of income (PETI) for individuals enrolled in the DD waiver. PETI is the process used to determine how much of a member's income must be contributed toward the cost of their long-term care in programs that provide residential services. The current policy is to allow individuals enrolled in the DD waiver to retain all income beyond what they pay for room and board, while Medicaid covers the full cost of residential services. Members enrolled in other HCBS residential services are subject to PETI requirements. The PETI process accounts for a personal needs allowance and other allowable deduction and expenses permitted by regulations.

R6.18 IDD waitlist: The Department asks to reduce funding for DD waiver enrollments.

The Department anticipates implementing this change July 1, 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: An increase of $72,922 total funds, including $36,461 General Fund, and 0.5 FTE.
- Year 1: A net reduction of $6.5 million total funds, including $3.2 million General Fund, and increase of 1.0 FTE.
- Year 2: A net reduction of $18.7 million total funds, including $9.4 million General Fund, and increase of 1.0 FTE.

The DD waiver currently has a waitlist. When an individual leaves the DD waiver, the next person on the waitlist is authorized to replace them. The process of filling vacant enrollment with new enrollments from the waitlist is referred to as "churn." The Department monthly approves churn enrollments from the waitlist for individuals based on the date they were determined eligible and placed on the waitlist. The process maintains a rolling enrollment list, based on the previous month's reported vacancies.

The Department proposes reducing churn enrollments by 50.0 percent. For every two members that disenroll from the DD waiver, the Department would enroll one individual. As of September 2025, 2,749 individuals were identified as needing DD services as soon as available. While the majority of these individuals receive services through other programs, including the SLS waiver, some may not be receiving the level of services required to meet their needs. This proposal will increase the length of time and number of individuals on the waitlist. The Department requests an additional staff position to support the review of emergency enrollment authorizations and the appeals process.

R17 Community connector age limit: The Department asks to reduce funding by limiting access to community connector benefit to minor members ages 6 years or older.

The Department anticipates implementing this change in the Spring or Summer of 2026.The change reduces the Department's forecast by:

- Year 1 and ongoing: $5.2 million total funds, including $2.6 million General Fund.

The Department reports that utilization and expenditures for community connector service, particularly for children under the age of 6 years, have significantly increased since FY 2018-19. In that last six fiscal years:

- Total average monthly utilization has increased from 508 to 2,102, while total expenditures have increase from $5.0 million to $67.0 million.
- Total average monthly utilization for member under 6 years old has increase from 45 to 523, while total expenditures for this group has increase from $0.5 million to $11.2 million.

The Department has expressed concern that community connector services are being utilized, in some cases, for activities that should already be provided by the child's caregiver as typical parental responsibilities. The Department reports that few states offer this service to children, and fewer compensate parents for providing the service. The Department is seeking to update its policy guiding community connector services to ensure the service is appropriately authorized.

R6.29 LTSS presumptive eligibility: The Department asks to reduce funding to delay the implementation of presumptive eligibility for long-term services and supports (LTSS) until July 1, 2027.

The change reduces the Department's forecast by:

- Current Year: $1.3 million total funds, including $0.7 million General Fund.

- Year 1: $2.8 million total funds, including $1.5 million General Fund.
- Year 2: $1.4 million total funds, including $0.7 million General Fund.

The Department is currently developing a new presumptive eligibility program for long-term support services that would allow adults with disabilities access to some community-based services while their Medicaid application is processed. The program is intended to help individuals in crisis situations to stabilize in the community, preventing unnecessary and unwanted institutionalization. The Department plans for presumptive eligibility to be initiated through a self-declaration of eligibility referral, followed by application verification.

The Department plans to implement the delay based on feedback and guidance from the Centers for Medicare and Medicaid Services (CMS). CMS gave verbal notice that the State's 1115 waiver will be renewed with a no-cost extension, which means the federal government will not consider any new additions to the waiver and has a year to review the presumptive eligibility program. The proposed delay aligns with the timing of the federal review.

R6.31 Caregiving hours soft cap: The Department asks to reduce funding for caregiving services with the implementation of a cap on the paid weekly hours per caregiver providing these services.

The Department anticipates implementing this change in the Spring of 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year. A net reduction of $0.3 million total funds, including $0.2 million General Fund, an increase of 0.5 FTE.
- Year 1 and ongoing: A net reduction of $2.3 million total funds, including $1.1 million General Fund, an increase of 1.0 FTE.

The Department plans to implement a weekly limit of 56 hours per caregiver per member. The limit applies to total hours across personal care, homemaker, health maintenance activities, home health aide, and nursing services. The Department anticipates authorizing exceptions to the cap only in extraordinary and short-term circumstances and requests a staffing resource to manage policy compliance and the exception review process.

R6.32 Homemaker soft cap: The Department asks to reduce funding for homemaker services for the implementation of a cap on paid weekly hours for legally responsible persons providing these services.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: $74,350 total funds, including $37,175 General Fund.
- Year 1 and ongoing: $0.4 million total funds, including $0.2 million General Fund.

Homemaker services provide assistance with household tasks including meal preparation, cleaning, laundry, and shopping. The Department proposes reducing the cap for legally responsible persons from 10 hours per week to 5 hours per week. Legally responsible persons are typically family members who have a legal responsibility to care for the individual enrolled in Medicaid. Homemaker services are core HCBS services and are available under Community First Choice.

Provider rates

The Department requests 18 provider rate changes across four prioritized requests. Four changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R13 Denver Health fed funds	$11,331,455	$0	$3,527,482	$7,803,973	0.0	EK
R14.2 IV nutrition rates	615,320	203,628	24,453	387,239	0.0	EP
R6.11 Provider rates -1.6%	-160,972,816	-56,992,200	-8,810,550	-95,170,066	0.0	EK
R6.23 Rates above 85% Medicare	-53,241,533	-15,046,057	-3,780,149	-34,415,327	0.0	EK
R15 Home health/nurse rates [1]	-26,582,980	-13,670,319	160,503	-13,073,164	1.0	TD
R6.16 Dental rates	-20,668,949	-3,774,150	-3,121,011	-13,773,788	0.0	EK
R6.33 Community connector -23% [1]	-18,331,864	-9,165,932	0	-9,165,932	0.0	TD
R6.24 Drug rates	-15,805,934	-3,772,279	-1,178,513	-10,855,142	0.0	EK
R6.15 Pediatric behavioral therapy rates	-13,057,068	-6,528,534	0	-6,528,534	0.0	EP
R6.02 Behavioral health incentives	-12,644,332	-3,000,000	-3,322,166	-6,322,166	0.0	EP
R6.12 Community connector -15% [1]	-12,052,939	-6,026,469	0	-6,026,470	0.0	TD
R6.13 Nursing minimum wage	-8,719,922	-4,359,961	0	-4,359,961	0.0	EK
R6.14 Individual residential srvcs & supports [1]	-5,801,116	-2,284,479	-616,079	-2,900,558	0.0	TD
R6.01 Accountable care incentives	-2,325,290	-750,000	-412,645	-1,162,645	0.0	EK
R6.28 Drug dispensing fees	-1,690,905	-509,509	-111,694	-1,069,702	0.0	EK
R6.35 Movement therapy rates	-716,467	-358,234	0	-358,233	0.0	EP
R6.27 Specialty drug rates	-516,928	-193,431	-24,809	-298,688	0.0	EK
R6.03 Primary care stabilization	0	0	0	0	0.0	EK
Total	-$341,182,268	-$126,227,926	-$17,665,178	-$197,289,164	1.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R15 Home health and nurse rates: The Department asks for a net reduction in funding resulting from the modification of the private duty nursing (PDN) rate structure and the home health rate structure, as well as to develop and implement a new rate negotiation strategy for the DD waiver and the CHRP waiver.

The change temporarily increases the Department's administrative expenses and reduces, on an ongoing basis, the Department's forecast by:

- Year 1: $26.6 million total funds, including $13.7 million General Fund, and 0.9 FTE.
- Year 2: $58.4 million total funds, including $27.8 million General Fund, and 1.0 FTE.
- Year 3 and ongoing: $58.7 million total funds, including $28.8 million General Fund.

Private duty nursing provides skilled nursing services in a residential setting to individuals with complex medical needs. These services are billed on an hourly basis based on the level of staff providing the care (i.e., registered nurse, licensed practical nurse, or a blended rate) and the setting. A prior authorization request (PAR) is required for reimbursement of these services, which can be a barrier to service for members discharged from a hospital. The Department is proposing the creation of a blended per-diem rate and of an acute care period for PDN services. The blended per-diem rate is intended for use by members with a range of care needs that are provided by a range of staffing levels. Establishing an acute care period for PDN services would allow members a short window of time in which they can receive services prior to an PAR.

The home health benefit provides services from a licensed and certified home health agency for members needing intermittent home health services. Services are billed and reimbursed based on the provider type, typically on a per-visit basis. The providers for these services include certified nursing assistants, physical therapists, occupational therapists, and speech-language pathology therapists. The Department is proposing creating a single 15-minute rate for certified nursing assistant services and 30-minute rate increments for the therapy services.

Community Fist Choices services provide select home health benefits. These services are billed at a 15-minute rate interval regardless of whether the service is provided in an individual or group setting. Direct care workers are required to track their hourly work on a per-member bases, which can lead to duplication of services. The Department proposes creating a group rate for these services to be used when a direct care worker provides services in a group setting.

Members enrolled in the DD and CHRP waivers are provided access to 24/7 supervision and care. Living arrangements can range from host home settings with 1-2 persons, staffed settings of 1-3 persons, and group settings of 4-8 persons, as well as residential supports for participants who live in their own home or who live with and/or are provided services by members of their family. Reimbursement is based on a member's support level need, ranging from 1 (lowest need) to 7 (highest need). For several service categories, the level 7 rate is not set, rather it is negotiated on a per-member basis. The rate is set based on information provided by a member's case management agency. The tool used by the Department to evaluate and set the level 7 rates was developed in 2007 and has not been updated since. The Department proposes creating new negotiation strategies that could lead to more accurate reimbursement for members with a level 7 need.

R6.33 Community connector – 23%: The Department asks to reduce funding for the community connector rate to align this rate with the tier 3 supported community connections rate in the adult SLS waiver.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: $3.1 million total funds, including $1.5 million General Fund.
- Year 1 and ongoing: $18.3 million total funds, including $9.2 million General Fund.

The Department argues that the current rates are disproportionately high compared to the training and qualification required for the services and has led to unusually high profit margins for provider agencies. The proposal is the second of two cuts to the community connector rate. The first, summarized in R6.12, reduces the rates by 15.0 percent. This second rate cut makes the following changes.

- from $10.23 to $7.71 per 15-minute unit outside of Denver County, and
- from $10.51 to $7.83 per 15-minute unit within Denver County.

R6.12 Community connector rate – 15%: The Department asks to reduce funding for a community connector rate cut of 15.0 percent.

The Department anticipates implementing this change January 1, 2026. The change reduces the Department's forecast by:

- Current Year: $6.0 million total funds, including $3.0 million General Fund.
- Year 1: $12.1 million total funds, including includes $6.0 million General Fund.

The Department is implementing a rate for community connector services as a cost containment measure directed by the Governor's August 28th Executive Order. The rate cut reduces the community connector rate as follows:

- from $12.22 to $10.39 per 15-minute unit outside of Denver County, and
- from $12.56 to $10.67 per 15-minute unit within Denver County.

R6.14 Individual residential services and supports: The Department asks to reduce funding for adjustments to the rate structure for individual residential services and supports (IRSS).

The Department anticipates implementing this change April 1, 2026. The change reduces the Department's forecast by:

- Current Year: $2.9 million total funds, including $1.5 million General Fund.
- Year 1 and ongoing: $5.8 million, including $2.3 million General Fund.

Individual residential services and supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of individuals enrolled in the DD waiver. Individuals may access IRSS services in several settings, including host homes, family homes, member homes, and staffed homes. The way IRSS settings are defined in regulation is unclear and does not account for the variety of settings available to members receiving these services.

There are currently two series of rates for IRSS and billing guidance has not been clear or consistent. Rate series are set by care level and setting. One rate series is intended for host homes, family homes, and member homes. This series is named Individual Residential Services and Supports/Host Home and ranges from:

- $84.91 per day to $312.56 per day outside of Denver County, and
- $91.40 per day to $343.40 per day within Denver County.

The second rate series is intended for staffed home. This series is named Individual Residential Services and Supports and ranges from:

- $92.11 per day to $339.35 per day outside of Denver County, and
- $99.32 per day to $373.65 per day within Denver County.

The Department acknowledges that confusing and unclear communication about IRSS policies and rates has led to inconsistent billing practices and higher than expected expenditures. Circumstances have led to many providers billing at the higher Individual Residential Services and Supports rate series for family caregivers for many years. The Department is in the process of clarifying billing rules through revisions to regulations and guidance updates.

Administration

The Department requests 15 administrative changes across 12 prioritized requests. Four changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R7 Eligibility administration [1]	$16,626,704	$1,503,264	$1,560,567	$2,455,447	$11,107,426	3.0	TD

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R9 Provider directory	5,955,875	451,455	248,360	0	5,256,060	0.0	EK
R10.1 Disability determinations [1]	1,381,020	837,000	-146,491	0	690,511	0.0	TD
R11 Salesforce support	700,172	223,727	120,059	0	356,386	1.8	EK
R14.1 Chronic pain management	290,738	94,867	50,502	0	145,369	1.0	EP
R12 Home health administration	95,738	31,237	16,631	0	47,870	1.0	EK
R8 Single assessment [1]	-11,668,682	-6,192,265	60,986	0	-5,537,403	2.7	TD
R6.21 Children in Rocky PRIME	-3,476,470	-1,738,235	0	0	-1,738,235	0.0	EK
R6.07 Immigrant services outreach	-750,000	-262,500	0	0	-487,500	0.0	EK
R6.06 SBIRT training grants	-500,000	-500,000	0	0	0	0.0	EP
R16 Unspent grant admin	0	-800,000	800,000	0	0	0.0	EP
R10.2 3rd party insurance	0	-781,598	-418,965	0	1,200,563	1.8	EK
R6.22 Provider credentialing ACC	0	0	0	0	0	0.0	EK
R19 Line item consolidation [1]	0	0	0	0	0	0.0	TD
R20 CHP+ Trust consolidation	0	0	0	0	0	0.0	EK
Total	$8,655,095	-$7,133,048	$2,291,649	$2,455,447	$11,041,047	11.3	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R7 Eligibility administration [legislation]: The Department asks for funding to centralize some administrative functions for the provision of medical and public assistance programs.

The change increases the Department administrative expenses by:

- Current Year: $0.6 million total funds, including includes $0.2 million General Fund, and 1.0 FTE.
- Year 1: $16.6 million total funds, including $1.5 million General Fund, and 3.0 FTE.
- Year 2: $40.8 million total funds, including $2.7 million General Fund, and 3.0 FTE.
- Year 3 and ongoing: $38.0 million total funds, including $2.1 million General Fund, and includes 3.0 FTE.

The Departments of Health Care Policy and Financing and Human Services propose to centralize four medical and public assistance administrative functions through contracts with high-performing counties: call center support, document management, quality assurance for Medicaid programs, and fraud investigations for Medicaid programs. The Department anticipates that the centralization of these services will be fully implemented beginning July 1, 2028. The proposal seeks to address increasing cost pressures on administrative, eligibility, and enrollment activities associated with medical and public assistance programs, as well as recent federal policy changes that increase administrative burdens on counties and the risk of severe financial penalties to the State.

R10.1 Disability determinations: The Department for funding for projected caseload increases and to rebalance funding sources to accurately reflect the caseload split of traditional Medicaid members versus expansion population members.

The change increases the Department contract expenses by:

- Current Year: $1.3 million total funds, including $0.4 million General Fund.
- Year 1: $1.4 million total funds, including $0.8 million General Fund.
- Year 2: $1.5 million total funds, including $0.9 million General Fund.
- Year 3 and ongoing: $1.6 million total funds, including $0.9 million General Fund.

Disability determinations assess whether an individual's medical condition qualifies for Medicaid benefits under disability-based eligibility. Administrative costs for disability determinations should be allocated according to the

proportion of cases from traditional Medicaid (General Fund) versus the expansion population (hospital provider fees). Based on current caseload projections the correct funding splits should reflect two-thirds of determinations for the traditional Medicaid population and one-third for the expansion population. To accurately reflect this split, the appropriation needs to be reweighted toward the General Fund.

Disability determinations are provided through a contract. Monthly application volume has increased substantially over the last several years, while the appropriation has not kept pace. The Department reports that 14,776 applications were processed in FY 2024-25, as compared to 8,917 in FY 2023-24 and 7,696 in FY 2022-23. Application processing costs are contracted at $285 per application. The Department's request increase appropriations to provide sufficient funding to process 15,000 applications.

R8 Single assessment: The Department asks for funding to deploy a single assessment tool in compliance with S.B. 16-192 (Assessment Tool Intellectual and Developmental Disabilities) that will replace multiple assessment tools currently used. Deployment of the single assessment tool is planned for August 2026.

The change impacts the Department administrative expenses and forecast by:

- Year 1: A net reduction of $11.7 million total funds, including $6.2 million General Fund, and an increase of 2.7 FTE.
- Year 2 and ongoing: An increase of $3.5 million total funds, including $1.4 million General Fund, and 3.0 FTE.

The single assessment tool is designed to support a person-centered approach in developing an individual's Person-centered Support Plan. The Plan uses the results of the single assessment tool to outline the services and supports that meet the individual's care goals and preferences. The deployment of the single assessment tool will be conducted in a phased approach, with the state's 15 case management agencies grouped in three cohorts. The first cohort will begin using the tool August 2026, the second in February 2027, and the third in May 2027. The staggering of deployment is intended to ensure the transition to the single assessment tool is without major problems, while providing the opportunity to address any issues that come up during the rollout.

The Department requests term-limited state staffing and contract resources. The state staff term is proposed from August 2026 through August 2029 and will provide system support, training and technical assistance, and provide quality assurance reviews. The contract resources will assist the Department with launching the new tool and provide system support.

R19 Line item consolidation: The Department asks for a budget neutral restructure of its section of the Long Bill to consolidate the appropriations for the IDD waiver services into the Medical Services Premium line item.

- Year 1 and ongoing: The request is budget neutral.

The Department contends that the current Long Bill structure creates an administrative burden in managing appropriations and reconciling accounting. The current Long Bill structure, which includes a separate budgetary section for the Office of Community Living's waiver programs for individuals with intellectual and developmental disabilities, was created with the FY 2014-15 Long Bill in response to H.B. 13-1314 (Transfer Developmental Disabilities to HCPF). The Office of Community Living also oversees long-term services and support programs through their physical disability waivers, which are appropriated funding in the Medical Services Premium line item. Additionally, recent policy changes including implementation of Community First Choice and conflict-free case management have shifted the appropriations for some services and case management between budgetary sections in the Long Bill. The Department argues that consolidating appropriations for IDD waiver services into the Medical Services Premium line item will reduce their administrative burdens.

Prior year actions

The request includes a net increase of $2.1 million total funds for the impact of prior year budget decisions and legislation for the Office of Community Living budgetary division. The table below only reflects impacts for the division rather than the entire Department.

Prior year actions

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 25-26 Provider rates 1.6% adjustment	$1,721,985	$846,659	$25,403	$0	$849,923	0.0
FY 23-24 BA7 Community access	1,403,874	539,108	0	0	864,766	0.0
FY 25-26 R11 OCL benefits	-1,019,166	-509,583	0	0	-509,583	0.0
Total	$2,106,693	$876,184	$25,403	$0	$1,205,106	0.0

Issues Presented

This is a summary of the briefing issues presented to the Joint Budget Committee by their dedicated non-partisan staff.

Budget Reduction Options: The Department of Health Care Policy and Financing, Office of Community Living, represents 4.1 percent of total state General Fund appropriations in FY 2025-26. The Executive budget request includes proposed reductions of $74.5 million, representing 10.6 percent of the General Fund appropriations in this section of the budget. These reductions are offset by proposed increases, so that the Office's total General Fund is requested to increase by 1.6 percent.

R5 Office of Community Living: The issue brief discusses the annual budget request for adjustments in appropriations that fund services to individuals with intellectual and developmental disabilities. Budget requests are based on projected caseload and the associated costs for the Home- and Community-Based Services: Adult Comprehensive (DD), Supported Living Services (SLS), Children's Extensive Services (CES), and Children's Habilitation Residential Program (CHRP) waivers.

R7 Eligibility administration: This issue brief discusses the Department's proposal to centralize some administrative services for eligibility determinations for medical and public assistance programs that are currently provided by counties.

For More Information

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To read the entire briefing: Go to content.leg.colorado.gov/content/budget#budget-documents-section to use the budget document search tool. Select this department's name under Department/Topic, "Briefing" under Type, and select a Start date and End date to show documents released in November and December of 2025.