Legislative Council Staff
Nonpartisan Services for Colorado's Legislature

Memorandum

September 17, 2025

TO: Interested Persons

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SUBJECT: An Overview of Colorado's Medicaid Program

Overview

Medicaid is a joint federal and state insurance program that provides health care coverage to low-income families and individuals, including children, pregnant people, seniors, and people with disabilities. The federal government establishes general rules and policies for Medicaid, including required services and eligible populations, and each state administers its own Medicaid program. Within these federal rules and with federal approval, states have the flexibility to cover certain optional services, expand coverage to additional populations, and offer unique services to targeted populations. As such, Medicaid programs vary considerably from state to state. This memorandum provides an overview of Colorado's Medicaid program, Health First Colorado, including its history, governing structures, coverage and eligibility, and funding.

Background

Legislative History

Medicaid was first established in 1965 under Title XIX of the Social Security Act to provide states with federal funding to address health care access for low-income individuals. Originally, Medicaid only served low-income parents with dependent children, pregnant women, seniors, and people with disabilities.

The program was not significantly amended until the Affordable Care Act (ACA) of 2010, which permitted states to expand Medicaid eligibility to nearly all adults with incomes up to 138 percent of the federal poverty level (FPL). The ACA also enhanced the federal government's

share of funding for these expansion populations. To date, 40 states and the District of Columbia have adopted and implemented Medicaid expansion under the ACA, including Colorado.[1]

During the 2020 COVID-19 public health crisis, the American Rescue Plan Act (ARPA) again modified Medicaid administration by requiring states to maintain enrollment of nearly all enrollees regardless of subsequent eligibility changes. These enrollment requirements ended in 2023, and states have since "unwound" by resuming normal Medicaid operations and disenrolling ineligible members.

Medicaid was not considerably modified again until 2025 under the One Big Beautiful Bill Act (OBBBA), which made several changes to coverage, eligibility, federal funding, and administration. For additional information, see LCS's memo on Medicaid Impacts from the One Big Beautiful Bill Act.

Participation

All 50 states offer a Medicaid program, which enrolls about 71.3 million people nationwide, or roughly 21 percent of the population. Of that amount, an estimated 30.0 million are children and 41.3 million are adults and seniors.[2] When accounting for the Children's Health Insurance Plan (CHIP)—an additional government-sponsored insurance plan for children with family income above the Medicaid limit—about 49 percent of all children in the United States are enrolled in a public health assistance program.

Colorado's Medicaid program, Health First Colorado, enrolls about 1.1 million people or 18 percent of the state population. Children make up an estimated 36 percent of that population, with the remaining 64 percent being adults and seniors. Comparatively, Colorado ranks in the bottom third of states for Medicaid enrollment as a share of the population, which ranges from a high of 32.1 percent in New Mexico down to 8.6 percent in Utah.[1]

Medicaid v. Medicare

In addition to establishing Medicaid, the Social Security Act of 1965 also created Medicare. Often confused for one another, Medicare serves a different population—predominantly individuals 65 and older regardless of income, and is operated solely by the federal government. As a federal program without state administration, Medicare costs, eligibility, and benefits are the same across the entire nation.

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[1] Status of State Medicaid Expansion Decisions, KFF.

[2] April 2025 Medicaid & CHIP Enrollment Data Highlights, Medicaid.gov.

In contrast, Medicaid largely serves low-income individuals and families, and varies widely across the country due to each state's authority to customize their program. The remainder of this memorandum focuses singularly on Medicaid. Additional information about Medicare can be located on the program's website.

Governing Structures

Medicaid is a joint federal and state program where the federal government sets mandates and guidelines through policies and regulations, while state governments implement the program and have latitude to make state-specific program changes with federal approval.

Federal Government

Medicaid policy and implementation is governed through laws enacted by Congress and rules, regulations, and guidelines issued by the Centers for Medicare and Medicaid Services (CMS), respectively.

Congress establishes the core framework for Medicaid through legislation and the federal budget. Broad policy guidelines in law include the eligibility groups that states must cover, required benefits, and state-federal cost sharing agreements. While minor program changes occur though law on a regular basis, only the ACA and the OBBBA have made significant and permanent amendments to Medicaid since its enactment in 1965.

Concurrently, CMS in the federal Department of Health and Human Services issues rules and regulations to implement the intent of the law and guide states' administration of the program. Unlike the broad legislative provisions, CMS rules address specificities such as verification requirements, application and renewal processes, eligibility determination processes, state waiver approvals, and more.

State Government

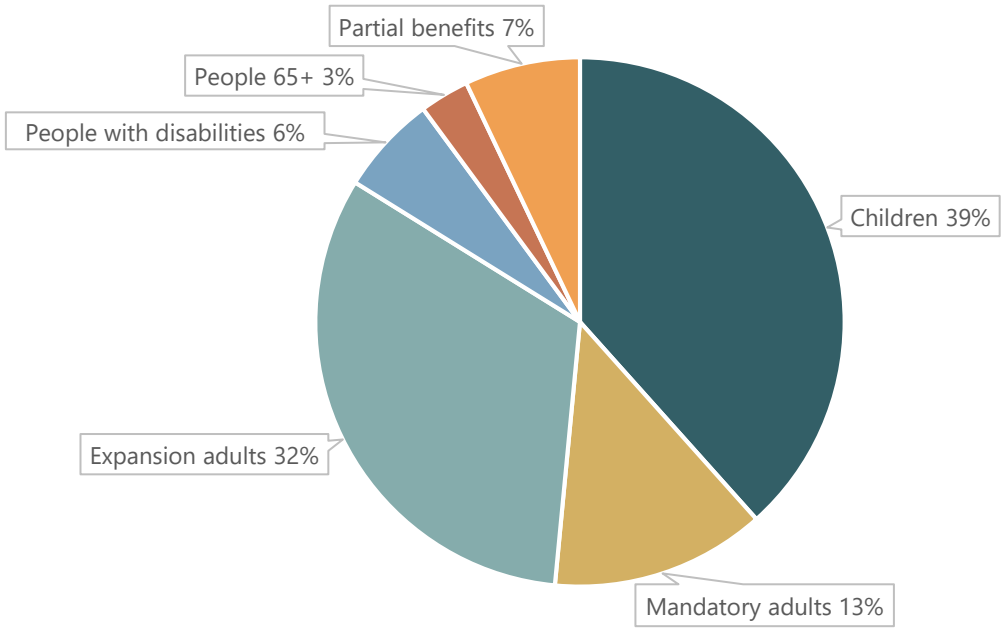
Each state may choose to run a Medicaid program for their state's population. Colorado established Health First Colorado in 1969 and by 1982, all 50 states elected to administer their own program. State Medicaid programs must cover certain core populations and services, but with federal approval, may expand coverage to certain optional services and to additional populations. States may also offer unique services to targeted populations through waivers of certain federal rules and requirements.

Health First Colorado is governed by laws enacted by the state legislature and implemented by an executive branch state agency. The General Assembly introduces and passes legislation each session that expands and adjusts the program to the specific needs of Colorado's population, as well as appropriates funding to cover the state's share of Medicaid costs. Once laws and budgets are enacted, the Department of Health Care Policy and Financing (HCPF) adopts rules and develops systems and processes to administer the program. HCPF also coordinates with the federal government to ensure state actions comply with federal requirements.

Medicaid Eligibility

Medicaid programs across the nation must cover certain mandatory populations, as established by the federal government. Individual states may further expand their programs to include optional coverage groups, such as the expansion population of adults without dependent children under the ACA. Figure 1 illustrates the populations of Coloradans accessing Medicaid. For additional information on eligibility and benefits, see HCPF's Medical Assistance Coverage Fact Sheet.

Figure 1
Colorado Populations Accessing Medicaid



Source: Report to the Community, Fiscal Year 2023-24, HCPF

Mandatory Coverage

At a minimum, every state must cover certain populations under their Medicaid program. These baseline eligibility groups include, among others:

- families, including parents and children, with incomes below certain FPL thresholds;
- children age 18 years and younger with a household income up to 133 percent of the FPL;
- pregnant people with incomes up to 133 percent of the FPL;
- newborn children of a Medicaid-eligible birthing parent;
- individuals receiving Supplemental Security Income; and
- various other groups based on medical need or disability.

In Colorado, about 723,000 Health First enrollees—or 66 percent of all members—qualify under these mandatory Medicaid eligibility criteria.

ACA-Driven Expansion

The ACA required a mandatory expansion of eligibility to all non-elderly adults with incomes up to 138 percent of the FPL. Prior to the ACA, the average FPL income threshold for eligible parents was around 60 percent of the FPL and childless adults were not eligible. However, a 2012 U.S. Supreme Court ruling made the expansion optional for states.[3] As previously noted, 40 states and D.C. have opted into this ACA expansion. For the first two years, federal matching funds for the expansion population was 100 percent of expenditures, which gradually reduced to 90 percent beginning in 2020. For traditional Medicaid enrollees, by comparison, the federal government pays between 50 and 77 percent of the cost of health coverage, depending on the state.

Colorado opted into the ACA expansion in 2013 and by the end of FY 2014-15, about 252,000 newly eligible Coloradans were added to Health First Colorado. In these first two years, expansion enrollees cost the program about $1.1 billion—the entirety of which was covered by federal funding. Today, about 377,000 Health First enrollees are eligible under the ACA expansion, with the federal government covering 90 percent of the costs to serve this population.

[3] *National Federation of Independent Business v. Sebelius*

Other Optional Coverage

In addition to the ACA expansion, the Colorado General Assembly has expanded Medicaid eligibility to various optional groups. This additional eligibility includes pregnant people with incomes up to 195 percent of the FPL, individuals receiving home- and community-based services, and persons who a hospital may deem presumptively eligible.

Emergency Medical Services

Under federal law, only citizens and legal permanent residents may qualify for Medicaid. However, federal law requires states to offer medical assistance to certain undocumented immigrants during medical emergencies, known as Emergency Medicaid Services. Emergency Medical Services provides limited medical coverage to this population during medical emergencies if the individual would have qualified for Medicaid if not for their immigration or citizenship status.

State-only Coverage

If states choose to provide health care coverage outside of federal Medicaid law, they must do so with state-only resources. For this reason, Colorado supplements Health First Colorado and EMS with several state-only funded programs. The Reproductive Health Care Program (RHCP) expands EMS to include family planning services for low-income undocumented immigrants, Deferred Action for Childhood Arrivals (DACA) recipients, visa holders, and more. Additionally, Cover All Coloradans provides health care coverage to low-income children and pregnant individuals regardless of their immigration status.

Medicaid Benefits and Services

In addition to mandatory eligibility groups, the federal government also requires states to offer a minimum set of health benefit to persons on Medicaid. States may choose to expand Medicaid benefits to include certain optional services identified in federal law, or to add benefits for certain populations through the use of Medicaid waivers.

Mandatory Benefits

Mandatory benefits that states must offer include, among other things:

- physician services;
- inpatient hospital services;
- outpatient hospital services;

- home health services;
- transportation to medical care;
- laboratory and x-ray services; and
- certified pediatric and family nurse practitioner services.

In addition, services at certain facilities such as federally qualified health centers and rural health centers must also be covered.

Optional Benefits

Among other things, optional Medicaid benefits that have been authorized in Colorado include:

- physical therapy;
- prescription drugs;
- dental services;
- eyeglasses;
- hospice;
- occupational therapy; and
- prosthetics.

Typically, these optional services are added through legislation enacted by the General Assembly. Unlike mandatory benefits, the General Assembly may limit or end optional benefits.

Waiver Services

The state may also offer unique benefits to specified populations through Medicaid waivers. Under these agreements with the federal government, the state is allowed to waive certain restrictions or requirements under federal law to provide services that more effectively serve a given population. More information about the different types of waivers and the process for waiver approval is available later in this document.

Typically, waiver services are provided in order to prevent the need for higher levels of care such as a nursing facility. Thus, the additional services under a waiver are able to reduce overall costs to the state and federal government. The most common waiver type is known as a home- and community-based service (HCBS) waiver, which provides additional services to allow individuals to continue living at home and in the community, rather than in a nursing facility. Examples of services on the various HCBS waivers include personal care services for daily living, homemaker services, adult day care, transportation, respite care, home modifications, and other services.

There are currently nine HCBS waiver programs in Colorado, serving various populations such as:

- adults and children with developmental disabilities;
- persons with brain injuries;
- persons who are elderly, blind, or disabled; and
- persons with spinal injuries or related disorders.

HCPF has additional information on eligibility and benefits under adult waiver services and children waiver services.

Making Changes to State Medicaid Programs

Importantly, states are not permitted to expand or change their Medicaid programs, or use federal funds without first obtaining approval from CMS. This authorization is submitted by HCPF through a **state plan amendment** or **waiver**. It can take several months or longer for CMS to review and approve, request changes, or deny state plan amendments and waiver requests.

State Plan Amendment

State plans are agreements between a state and the federal government describing how the state will administer its Medicaid program. The state plan helps ensure that a state Medicaid program will abide by federal rules and will remain eligible to receive federal matching funds for its program activities. A state plan amendment is a formal request to update the state plan within federal Medicaid laws and regulations. State plan amendments usually are more straightforward or routine types of changes such as expanding or adjusting eligibility, adding or removing optional benefits, and changing reimbursement structures for health care providers.

Waivers

As discussed earlier, a waiver allows the state to waive certain federal Medicaid requirements in order to test or implement programmatic changes that are not typically permitted within federal Medicaid law and regulation. Waiver applications are more complex and require detailed information from the requesting state, including the population to be served under the waiver, a description of the specific services proposed, plans for evaluating the effectiveness of the waiver, and evidence that the waiver changes will be budget neutral to the federal government. During the waiver application process, states often provide follow up information and engage in negotiations about the parameters of the waiver with CMS. The three most common waiver types are as follows:

- **1915(c) Home and Community-Based Service Waivers** allow a state to extend medical coverage for Medicaid-eligible people requiring long-term services and support to home- and community-based services, rather than traditional institutional settings. This waiver may target specific populations or geographic areas.
- **1115 Demonstration Waivers** allow a state to pilot novel approaches to Medicaid that are not otherwise permissible under federal law. They can modify eligibility, benefits, delivery systems, and cost sharing for a set period. They must also demonstrate budget neutrality, meaning that any changes either cost the same as existing practices or result in savings.
- **1915(b) Managed Care Waivers** allow a state to mandate beneficiary enrollment in managed care and/or to limit provider networks. Managed care organizations (MCOs) contract with states to receive a monthly payment per enrollee in exchange for services.

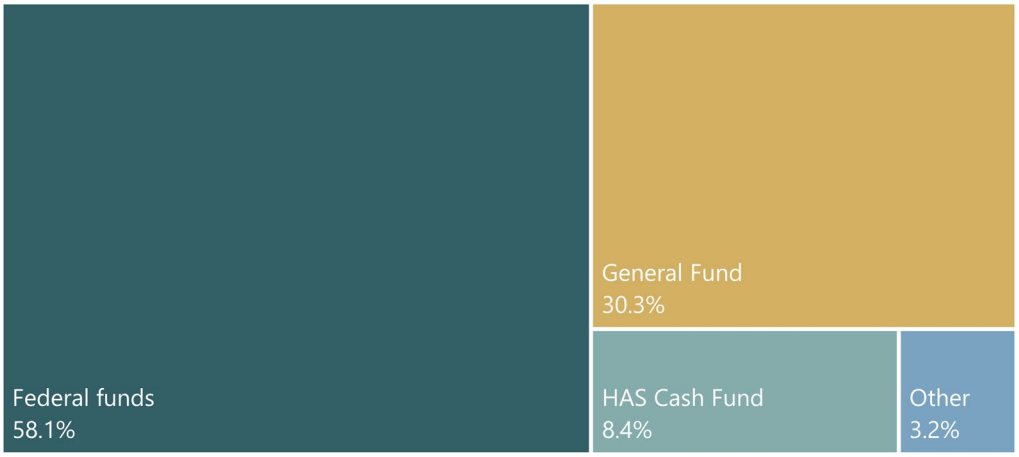
Funding

Funding for state Medicaid programs are a shared obligation between the state and the federal government. The state covers a portion of cost, and based on actual spending and predetermined matching rates, the federal government covers the remaining balance. In 2024, the federal government spent about $606.3 billion on Medicaid expenses, comprising 8 percent of the federal budget, with a total state contribution of $273.7 billion.[4] In the same year, Colorado's Medicaid spending reached $15.0 billion, $6.3 billion of which came from state funding sources and the remainder from federal assistance.[5] The fund sources for Colorado's Medicaid program are shown in Figure 2 below.

[4] Medicaid Financing and Expenditures, Congressional Research Service.

[5] Report to the Community, Fiscal Year 2023-24, HCPF.

Figure 2
Colorado Medicaid Funding Sources



Source: Report to the Community, Fiscal Year 2023-24, HCPF

Federal Share

Medicaid is an entitlement program, not a discretionary program, which means that the federal government is legally obligated to provide its share of uncapped funding for anyone who meets eligibility requirements. For every dollar the state spends on Medicaid, the federal government matches it at a Federal Matching Assistance Percentage (FMAP). The base FMAP amount for each state is determined based on a formula that considers each state's per capita income relative to the national average. Colorado's base FMAP for most services and populations is 50 percent, which is the minimum FMAP amount allowed under federal law. However, certain populations and services are matched at a higher federal rate, including those members covered under the ACA expansion who are matched at a 90 percent FMAP rate.

Congress may adjust FMAP rates through legislation or the federal budget in certain circumstances. For example, Congress temporarily increased FMAP rates during the COVID-19 public health crises to incentivize states to maintain coverage for newly ineligible members.

State Share

States pay the remainder of Medicaid costs not covered by the FMAP through various funds and mechanisms. Colorado uses two primary funding sources: the Healthcare Affordability and Sustainability Provider Fee and General Fund.

Healthcare Affordability and Sustainability Provider Fee

Federal law permits states to levy a provider tax or fee on certain types of hospitals that serve Medicaid members to help cover the state share of Medicaid expenditures and draw down federal matching funds. Colorado assesses this type of fee, known as the Healthcare Affordability and Sustainability (HAS) Fee, on hospitals based on inpatient days and outpatient revenue. Fee revenue is deposited to the HAS Cash Fund, which the state uses to pay for a portion of its share and trigger a federal match. HAS fee revenue and subsequent expenditures are restricted to certain Medicaid-eligible services, but any excess may be used to increase Medicaid payments to hospitals through supplemental payments, mitigate uncompensated care, fund coverage expansions, and support safety-net hospitals.

In FY 2023-24, Colorado hospitals paid $1.26 billion in HAS fees and received $1.76 billion in supplemental payments from revenue redistribution and matching federal funds. This generated a net increase of $495 million in Medicaid hospital payments and reductions in uncompensated care. $179 million of this net increase in funding was received by rural and frontier hospitals. HAS fee revenue paid for about 8.4 percent of total expenditures for Colorado's Medicaid program. This revenue accounted for about 20 percent of the state's share of total program costs.[6]

General Fund

The largest share of state funding for Medicaid comes from the state General Fund. The General Fund is the primary source for Medicaid expenses that cannot be paid using the HAS Cash Fund. This includes non-hospital services, such as primary care, dental care, long-term care, and limited administrative costs. In FY 2023-24, the state General Fund paid for about $4.5 billion of the total expenditures for Colorado's Medicaid program, or roughly 30.3 percent of the total costs. This General Fund spending accounted for about 72.3 percent of the state's share of total program costs.[6]

Other Funds

State law permits the use of other funds to cover specific populations and benefits. This funding includes tobacco settlement funds, nursing home provider fees, and pharmaceutical rebates. These funding sources make up the remaining 3.2 percent of the state's share of total program costs.

[6] Report to the Community, Fiscal Year 2023-24, HCPF.

Providers and Reimbursement

Provider Types

Health First Colorado partners with a broad network of health care providers, including physicians, behavioral health professionals, dentists, pharmacies, hospitals, nursing facilities, and home care agencies. These providers deliver covered services to Medicaid members and are reimbursed by the state through two primary models: managed care and fee-for-service.

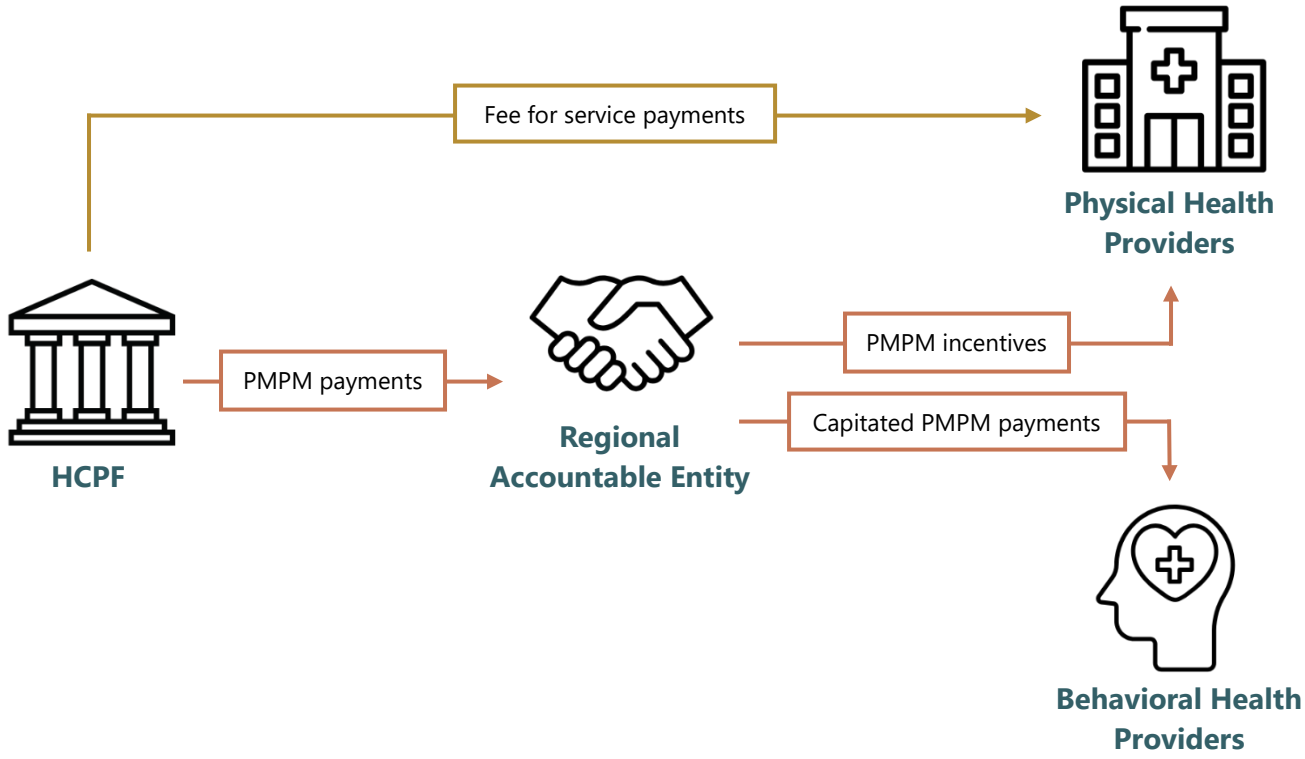
Reimbursement Models

Colorado pays Medicaid providers for services rendered using a combination of federal and state funds. Participating providers are paid in one of following two ways.

- **Managed care.** In the managed care model, HCPF negotiates and pays Regional Accountable Entities (RAEs) a per-member, per-month (PMPM) rate to coordinate member care and ensure that they are connected with primary and behavioral health services. The RAE is responsible for building provider networks and reimbursing providers for services using the monthly funds. About 90 percent of Colorado Medicaid enrollees use RAEs.
- **Fee-for-service payments.** The remaining 10 percent of members are covered through a fee-for-service model, in which HCPF pays providers directly based on rates for medical services as outlined in fee schedules. Certain services such as dental care, long-term support services, home- and community-based services, prescription drugs, and nursing facility care are carved out of managed care and paid through the fee-for-service model.

Figure 3 below outlines these payment models. Specialty services such as dental, long-term support services (LTSS), home- and community-based services (HCBS), and prescription drugs are typically funded through unique arrangements between the state, providers, and managed care organizations. Dental services, for example, are contracted through a single statewide dental administrative services organization (ASO) that receives capitated PMPM from the state, and pays providers on a fee-for-service basis. LTSS and HCBS, on the other hand, are typically reimbursed by HCPF through fee-for-service payments.

Figure 3
Provider Reimbursement Models



Source: Accountable Care Collaborative (ACC) Phase II, HCPF
Note: This flowchart is based on ongoing updates to Health First Colorado reimbursement structures. ACC Phase III began in July 2025 and may continue to adjust provider payments.

Participation and Access

Provider participation in Health First Colorado is voluntary. However, Medicaid represents a substantial payer in Colorado's health care system, particularly for safety net providers, rural hospitals, and long-term care providers. Provider participation is affected by several factors including reimbursement levels, administrative complexity, and patient volume. While Medicaid plays a critical role in financing care, provider reimbursement is often below Medicare or commercial insurance rates, which may deter participation.

The state has implemented various strategies to promote provider participation and address access gaps. These include targeted reimbursement rate increases, workforce development initiatives, and the use of temporary ARPA federal funds to support home- and community-based services. Recently, House Bill 25-1213 created a state-directed payment program to allow the state to align Medicaid reimbursement rates with Medicare and commercial rates.