COLORADO
Department of Health Care Policy & Financing

Money Map Narrative

Medicaid Commission Advanced Deliverable, September 2, 2026

The Department of Health Care Policy & Financing (HCPF) provides much of this information to the General Assembly as part of our budget request documents on November 1 each year. The primary source of this information is the Schedule 9, the Cash Funds Report, which includes data on fund balances, the dollars going in and out over the course of the fiscal year, and the purpose of the fund.

The following dataset takes the information presented in FY 2026-27's Schedule 9 and organizes it into a single table. Please note, HCPF has not included a federal match in this table as federal match rates depend on population rather than particular fund origins.

In addition to the cash funds assigned to HCPF, HCPF also manages different sources of cash funds, specifically certification of public expenditure and "intergovernmental transfers" Although each of these fund sources are considered cash funds, they function in different ways than other state cash funds.

Certification of public expenditure (CPE) is a Medicaid financing mechanism in which a governmental entity certifies that it has already spent public funds on Medicaid-covered services, allowing the state to claim the associated federal Medicaid matching funds. A CPE generally does not involve transferring the state-share dollars to the Medicaid agency or to the State; the certified governmental expenditure itself serves as the non-federal share supporting the federal claim. Key examples of this include payments for county administration, where counties certify the funding they've spent on Medicaid-related expenses and that allows HCPF to draw and provide matching federal funds for those expenditures. Similarly, this mechanism is used to provide federal funds to schools, where state and local tax dollars support the provision of Medicaid-eligible services, which allows us to draw federal funds to offset the schools' cost of those services. CPE has no TABOR impact, because funds are never transferred to the state agency.

An **intergovernmental transfer (IGT)** is a transfer of public funds from one governmental entity—such as a county, public hospital, or other governmental provider—to the state Medicaid agency to help finance the non-federal share of Medicaid expenditures. Unlike CPE, IGTs are money that comes directly to the state before becoming payments to providers. IGTs typically create a TABOR impact; in 2025, the General Assembly adopted HB 25-1213 which gave the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to accept transfers from governmental agencies by determination that they are are not "grants" under section 20 of article X of the state constitution (section 25.5-4-402.4(2)(f.5), C.R.S.). This allows IGTs to be used for business purposes related to CHASE without creating a TABOR impact. HCPF is using IGTs from certain hospitals as a mechanism to finance additional hospital payments through managed care programs, known as "State Directed Payments."

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Cash fund	Purpose/Background of Fund	Fee Sources	Non-Fee Sources	TABOR Treatment	Budget Effect if Revenue Changes
Healthcare Affordability and Sustainability Fee Enterprise Cash Fund (CHASE) — 2410	All money in the fund is subject to federal matching as authorized under federal law and is continuously appropriated to the enterprise for the following purposes: to maximize the inpatient and outpatient hospital reimbursements to up to the upper payment limits; to increase hospital reimbursements under the colorado indigent care program to up to one hundred percent of the hospital's costs of providing medical care under the program; to pay the applicable quality incentive payments; to expand eligibility for public medical assistance… The stated purposes also include continuous eligibility for children, enterprise administrative costs, offsetting loss of federal matching money due to a decrease in the certification of the public expenditure process, delivery-system reform incentive payments, and additional business services to hospitals.	Provider fees collected from hospitals pursuant to section 25.5-4-402.4, C.R.S. beginning July 1, 2017. Fee level is set annually by the Medical Services Board, as recommended by the Colorado Healthcare Affordability and Sustainability Enterprise Board. The amount of the fee is to be set so that the amount collected shall approximate the projected expenditures for that year per 25.5-4-402.4, C.R.S.	Monies in the fund shall be subject to federal matching as authorized by federal law. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	Exempt - Enterprise status	Federal matching funds are directly linked. The fee level is also designed to approximate projected expenditures, so changes can affect the cash-fund share, associated federal match, and expenditures financed by the enterprise.
Healthcare Affordability and Sustainability Nursing Facility Provider Fee Cash Fund — 2411	With the passage of SB 25-270, this fund was created and became part of the CO healthcare affordability and sustainability enterprise. Initially created through the passage of HB 08-1114, the purpose of the fund is to deposit nursing facility provider fees, pay for the administrative costs of implementing new reimbursement rates, pay a portion of the new per diem rates established under 25.5-6-202, C.R.S, and satisfy settlements or judgments from nursing facility provider reimbursement appeals.	Provider fees collected pursuant to section 25.5-6-203, C.R.S. beginning July 1, 2008. The Department is required to collect a Quality Assurance Fee from nursing facilities, including facilities that do not serve Medicaid clients.	Monies in the Fund shall be subject to federal matching as authorized by federal law and subject to annual appropriation by the General Assembly. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the Fund.	Exempt - Enterprise status	Federal match moves with the fund because the money is expressly subject to federal matching.
Healthcare Affordability and Sustainability Intermediate Care Facility Fee Cash Fund — 2412	With the passage of SB 25-270, this fund was created and became part of the CO healthcare affordability and sustainability enterprise. This fund was previously administered by the Department of Human Services. After the passage of SB 13-167, the fund was moved from the Department of Human Services to the Department of Health Care Policy and Financing in order to simplify the collection of matching federal funds. The fund is primarily used to provide reimbursements to intermediate care facilities for services rendered for individuals with intellectual disabilities.	Service fees are collected from private and public intermediate care facilities who provide care for individuals with intellectual disabilities. Fee level is set by the Medical Services Board, not to exceed five percent of the total costs incurred by all intermediate care facilities.	Monies in the Fund shall be subject to federal matching as authorized by federal law and subject to annual appropriation by the General Assembly. All interest and income derived from the investment and deposit of moneys in the fund shall be credited to the fund.	Exempt - Enterprise status	Federal match moves with the fund. The fund was structured in part to facilitate collection of matching federal funds.
Healthcare Affordability and Sustainability Medicaid Buy-in Cash Fund — 2413	Created through the passage of SB 25-228, this fund is part of the Colorado healthcare affordability and sustainability enterprise. The fund collects premium revenue paid by members that offset the cost of administering the Buy-In Program For Working Adults With Disabilities & the Buy-In Program For Children With Disabilities.	Premiums will be paid by clients eligible for and participating in the program based on a sliding-fee scale.	The Department is authorized to solicit and accept federal grants to cover the costs of an actuarial study. If an individual is eligible for Medicaid under 25.5-6-1404 (1), C.R.S., and the individual's employer would pay for all or a portion of the individual's private insurance, the Department may accept contributions from the individual's employer to offset part of the cost of providing services under the program.	Exempt - Enterprise status	Member premiums offset Buy-In program costs. If premium collections change, the amount of premium-supported program financing changes.
Children's Basic Health Plan Trust — 11G0	The purpose of the fund is to pay for the administration and purchase of insurance and health care services for clients of the Children's Basic Health Plan established by HB 97-1304 and HB 98-1325.	Starting in FY 1999-00, premiums are collected from families of enrollees who enter the program. Amounts are $25 for families with one child enrolled and $35 for families with two or more children enrolled. Fees collected from parents are assumed to be used first before other funding sources are used.	Tobacco Litigation Settlement monies, General Fund appropriations, Tobacco Tax appropriations, donations, and interest earned on the fund balance.	Non-Exempt	Other financing sources move after family premiums. The stated financing assumption is that family premiums are used first before other sources.
Health Care Expansion Fund — 18K0	To fund expanded eligibility in the Children's Basic Health Plan for children and pregnant women from 185% to 200% of federal poverty level, fund enrollment in the Children's Basic Health Plan above the FY 2003-04 level, to remove the asset test under the Medical Assistance Program for children and families, to expand the number of children that can be enrolled in the Children's Home and Community Based Service Program and the Children's Extensive Support Program… It also identifies additional Medicaid eligibility and benefit expansions.	There are no fees.	The State Treasurer and State Controller transfer money into the fund from Tobacco Tax revenues received with an allocation based on statutory percentages stated in 24-22-117 (2)(a)(I), C.R.S.	Exempt - Approved tax	Tobacco-tax collections drive the source. If collections change, the statutory transfer available for the specified coverage expansions changes.
Primary Care Fund — 18L0	To provide financing for comprehensive primary care provided by eligible providers beginning in FY 2005-06. This financing arrangement was created with the passage of HB 05-1262. This funding partially compensates federally qualified health centers, school based health centers, certified rural health clinics, and other such entities that provide uncompensated care to indigent and uninsured clients.	There are no fees.	Funding contingent on the amount of tobacco tax revenue collected, as annually appropriated by the General Assembly.	Exempt - Approved tax	Directly tied to tobacco-tax collections. If tobacco-tax revenue declines, the amount available for primary-care financing declines, subject to appropriation.
Adult Dental Fund — 28C0	Created through the passage of SB 13-242, the purpose of the fund is to provide for the direct and indirect costs associated with the implementation of a limited oral health benefit for adults in the Medicaid program.	There are no fees.	Monies in the fund are comprised of Unclaimed Property Trust Fund monies allocated to the fund. The monies in the Fund are subject to annual appropriation by the General Assembly for the purposes described in legislation. All interest and income derived from the investment and deposit of moneys in the Fund shall be credited to the Fund.	Non-Exempt	A change in the Unclaimed Property allocation changes the cash support available for the adult dental benefit and related administration. While the fund still exists in statute, HB 26-1401 reduced appropriations of this cash fund for HCPF and offset them with GF. That is to say, for FY 26-27 and ongoing, that Department has no budget from this CF.

	Old Age Pension Health and Medical Care Fund — 28P0	To fund health and medical care to persons who qualify to receive old age pensions and who are not patients in an institution for tuberculosis or mental diseases. All Funding is appropriated to the Old Age Pension State Medical Program appropriation and appears as reappropriated funds in other appropriations.	There are no fees.	Any moneys remaining in the state old age pension fund after full payment of basic minimum awards to qualified old age pension recipients and after establishment and maintenance of the old age pension stabilization fund in the amount of five million dollars shall be transferred to the fund, money in excess of ten million dollars in any fiscal year shall be transferred to the general fund of the state to be used pursuant to law. Moneys in the old age pension health and medical care fund shall be subject to annual appropriation by the general assembly.	Exempt (HCPF component of this cash fund)	The amount available depends on the residual balance in the Old Age Pension Fund after the specified obligations and stabilization reserve. Amounts above the statutory $10 million level transfer to the General Fund.
	Department of Health Care Policy and Financing Cash Fund — 23G0	Created through the passage of HB 94-1193, the purpose of the fund is to collect fees or otherwise by the Department. Moneys from the fund shall be appropriated by the General Assembly for the direct and indirect costs of the Department's duties as provided by law.	Fee Revenue currently consists of provider screening fee revenue which, pursuant to federal regulations under 42 CFR § 455.460, must be collected and spent on provider screening costs, with any remaining amount being refunded back to the federal government.	The Department may receive any gifts, grants, or donations to be deposited into the fund and appropriations approved by the General Assembly.	Non-Exempt	Provider-screening fee revenue must be used for provider-screening costs. Any remaining amount is refunded to the federal government rather than being available for unrelated spending.
	Health-Related Social Needs Reinvestment Cash Fund — 25HR	Created with the passage of SB 25-308, this fund captures the state savings raelized when Medicaid dollars begin partially funding health-related social needs services. HCPF must use money in the cash fund to provide health-related social needs services and to support the implementation of the 1115 waiver and manage Medicaid coverage of health-related social needs services. The amount transferred into the fund by the State Treasurer is an estimate and the final transferred amount will depend on services reimbursed by Medicaid and administrative expenses by state agencies. Transfers are expected to be similar in FY 2026-27 and future years.	There are no fees for this cash fund.	The bill requires the State Treasurer to transfer the amount of unspent General Fund appropriations for eligible services that would otherwise revert to the General Fund at the end of the fiscsal year to the appropriate cash fund.	Exempt (via SB 25-308, 24-75-402(5)(nnn), C.R.S)	The cash transfer moves with Medicaid-generated state savings. More or less Medicaid reimbursement of eligible services changes the amount of General Fund that remains available for transfer.
	Reentry Services for Justice-Involved Individuals Reinvestment Cash Fund — 25RS	Created with the passage of SB 25-308, this fund captures the state savings raelized when Medicaid dollars begin partially funding reentry services for justice-involved individuals. HCPF must use money in the cash fund to provide reentry services and to support the implementation of the 1115 waiver and manage Medicaid coverage of reentry services. The amount transferred into the fund by the State Treasurer is an estimate and the final transferred amount will depend on services reimbursed by Medicaid and administrative expenses by state agencies. Transfers are expected to be similar in FY 2026-27 and future years.	There are no fees for this cash fund.	The bill requires the State Treasurer to transfer the amount of unspent General Fund appropriations for eligible services that would otherwise revert to the General Fund at the end of the fiscsal year to the appropriate cash fund.	Exempt (via SB 25-308, 24-75-402(5)(mmm), C.R.S)	The cash transfer moves with Medicaid-generated state savings from Medicaid coverage of qualifying reentry services.
	Provider Stabilization Cash Fund — 12PS	Created with the passage of SB 25-290, the purpose of this fund is to make provider stabilization payments to eligible safety net providers that serve low-income, uninsured populations in the state, and, in connection therewith, maximizing federal funds to stabilize the health-care safety net and making an appropriation.	There are no fees for this cash fund.	This fund consists of (I) Money credited to the fund as a loan from the unclaimed property trust fund pursuant to section 38-13-801 (6); (II) Any other money the general assembly may appropriate, transfer, or credit to the fund; and (III) Any gifts, grants, or donations the state department may receive from public or private sources for the fund.	Interest income is non-exempt. Grants, gifts, and donations are exempt.	Changes in the Unclaimed Property Trust Fund loan/transfer or other credited money change the amount available for provider-stabilization payments and the ability to maximize associated federal funding.
	Recovery Audit Contractor Recoveries Cash Fund — RACF	Created with the passage of SB 25-314, this fund was set up with a transfer from the Departments recoveries cash fund to increase transparancy around RAC audits and how much money the Department is collecting from them.	There are no fees for this cash fund.	This bill set up the original appropriation with a transfer from the Recoveries Cash Fund. In the future, the RAC amounts will be filled with money collected from RAC payments that the Department find through Audits.	N/A- this is an operating transfer and no new revenue is generated. Interest income is exempt.	The source moves with RAC audit recoveries. More or fewer recoveries change the amount available to support Medical Services Premiums.
	Breast and Cervical Cancer Prevention and Treatment Fund — 15D0	Main Fund: Created with the passage of SB 01S2-012, the purpose of the fund is to provide for the prevention and treatment of breast and cervical cancer for women for whom it is not otherwise available for reasons of cost. The field also describes the former Eligibility Expansion Account and the conditions under which its balance could be appropriated.	Main Fund: There are no fees.	Main Fund: Per SB 01S2-012, monies for this fund are appropriated annually by the General Assembly from interest accrued by the Tobacco Litigation Settlement Trust Fund… Any gifts, grants, or donations also may be credited to the fund. It also identifies the breast-cancer-awareness special license-plate surcharge as revenue deposited to the fund and states that the surcharge does not qualify as a ‘fee’ pursuant to section 24-75-402(2)(e)(V), C.R.S.	Non-Exempt	Changes in tobacco-settlement interest, license-plate surcharge collections, gifts/grants/donations, or transfers affect the cash available for the specified cancer-related Medicaid and administrative costs.

COLORADO
Department of Health Care Policy & Financing

How Medicaid Rates are Determined

Medicaid Commission Advanced Deliverable, September 2, 2026

The Department of Health Care Policy and Financing (HCPF) relies on a variety of authorities and sources for rate setting within the Medicaid program. This process is highly dependent on state budget constraints, federal policy, guidance and expectations, and federal actuarial and access to care assessment requirements.

HCPF's rate-setting authority is not wholly independent. Rather, HCPF must operate within a number of parameters set by the federal Centers for Medicare and Medicaid Services (CMS), the Governor's Office of State Planning and Budget (OSPB), and ultimately, the Joint Budget Committee and General Assembly. CMS sets the federal parameters under which we must work, OSPB sets the parameters for the executive agencies' budgets, and the General Assembly ultimately appropriates the HCPF budget in the Long Bill.

Each of these governing entities set boundaries under which HCPF must operate. Federal regulation establishes ceilings for certain service categories, such as the upper payment limits applicable to clinical diagnostic laboratory and durable medical equipment services. Other requirements operate as floors: capitation rates must fall within a range certified as actuarially sound, cost-based rates must reflect providers' reported and audited costs, and federal law requires that payments be sufficient to ensure access to care comparable to the general population. Between the ceiling and the floor sits the amount appropriated, which determines what the Department can pay in practice. CMS approves the State Plan Amendments including rate increases and decreases, waivers, and managed care rate certifications through which federal financial participation flows.

The various processes for setting rates run in parallel, each on its own cycle and with its own decision-makers: the annual appropriations cycle, annual actuarial certification and CMS approval, quarterly updates for certain service categories, the three-year Medicaid Provider Rate Review cycle, and individual contract terms.

This fact sheet describes each of these processes, who is responsible at each stage, and how rate changes occur within each one.

Fee for Service Rate Categories

Fee for service rates may fall into one of three categories: cost based rates, bundled rates, and fee schedule rates.

Cost Based Rates

Cost-based reimbursement is based on costs of individual providers as detailed in their Medicaid or Medicare cost reports. These rates are exempt from inflationary adjustments to rates based on appropriations because they are based on realized costs of providers. Federal regulation dictates aspects of these rates.

- **Institutions for Mental Diseases /Intermediate Care Facilities for Intellectual and Developmental Disabilities**: state-owned facilities with rates based on costs associated with caring highest need members with severe mental illnesses or intellectual and/or developmental disabilities.
- **Skilled Nursing Facilities**: privately owned facilities with cost-based rates caring for members requiring assistance with two or more activities of daily living (ADL's) who have been determined eligible for Long-Term Services and Supports.
    - Lump sum payments are also made to Skilled Nursing Facilities in addition to a nursing facility provider's MMIS per diem reimbursement rate. The supplemental payment is calculated annually using historical data paid as a fixed monthly amount.
    - Nursing facility rate growth is limited by statute. Currently, statute does not allow for automatic growth in nursing facility rates (section 25.5-6-202(9)(b)(I)(D), C.R.S.).
- **Federally Qualified Health Centers:** Cost-based per visit rates are individually calculated per FQHC provider, and increase as provider costs increase. FQHCs must submit Medicaid cost reports on an annual basis, which are audited by a Department contractor to determine each per visit rate. Further, FQHC rates are subject to federal minimums, which grow each year.
- **Rural Health Clinics:** The methodology for hospital-based rural health clinics establishes cost per visit rates as determined in the parent hospital's Medicare hospital cost report.
- **Pharmacy**: Rates paid to pharmacies are typically based on providers' average acquisition cost of the drugs, plus a dispensing fee. Paying providers based on

acquisition costs is federally required; the state has some flexibility to determine the dispensing fee.

Bundled Rates

Bundled rates are those categorized by a single reimbursement package for related services. As an example, the Department's reimbursement for inpatient hospital care is based on prospectively determined bundles calculated from the expected services and resource utilization associated with the inpatient stay. Federal regulations sometimes dictate aspects of these rates.

- **Hospitals**
  - Inpatient: All-Patients Refined Diagnosis Related Groupers (APR-DRG)
  - Outpatient: Enhanced Ambulatory Patient Groups (EAPG)
  - Specialty: Per Diem
- **Hospital Back Up:** The Hospital Back Up (HBU) Program is a long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting.
- **Ambulatory Surgery Centers**: A provider entity that may be independent or part of a hospital, but only if the building space utilized by the ASC is physically, administratively, and financially independent and distinct from other operations of the hospital.

Fee Schedule Rates

Fee for service rates for applicable State Plan services may be found on the Department's Provider Rates & Fee Schedule webpage. Details of allowable service provisions and provider types are available in the Provider Billing Manual under the CMS 1500 heading. Rates do not typically change unless the legislature appropriates funding for increases, or reduces funding for decreases, which occurs via the annual Long Bill process.

Rate Review Process

The HCPF Medicaid Provider Rate Review process and Medicaid Rate Review and Advisory Committee (MPRRAC) work hand in hand to conduct an annual review of Medicaid provider rates. See our Commission fact sheet on the MPRRAC for more information on this relationship.

HCPF reviews provider rates based on several parameters such as service grouping descriptions, rate comparison analyses, access to care analyses, additional research, and recommendations for each service under review each year by the MPRRAC. Services

reviewed annually are a subset of services reviewed throughout the entire three-year cycle. For each service grouping, rate benchmark comparisons describe (as a percentage) how Colorado Medicaid payments compare to other payers, as well as anticipated fiscal impacts of recommendations, are listed in the report. This HCPF rate review process, which considers internal findings, MPRRAC recommendations and budget constraints and priorities, informs HCPF budget requests each year.

The Medicaid Provider Rate Review process does not review all rates, however. Several service categories or provider types are not reviewed through this process and have separate update and review processes. For example, Physician Administered Drugs (PADs) are reviewed and updated quarterly. Additionally, several fee for service providers have rate methodologies based on cost reporting, such as Federally Qualified Health Centers (FQHCs). Services excluded from the Medicaid Provider Rate Review process are reviewed periodically by other methods and mechanisms measuring rate sufficiency and access to care.

Managed Care Capitation Rate Setting

Medicaid physical health, behavioral health, CHP+ managed care, and Program for All-Inclusive Care for the Elderly (PACE) capitation rates are set prospectively, meaning they are developed before the rating period begins. The Department pays a set amount (capitation) for each enrolled member each month, regardless of whether that member uses health care services during that month.

The rate-setting process begins well before the new rating period. Initial data is gathered by HCPF and provided to HCPF's contracted actuary each October. HCPF and its contracted actuary use several sources of information to develop the rates, including: historical utilization and costs, historical membership and enrollment, policy or program changes, and financial reporting of operations and administration. This information is used to identify historical patterns, develop expected trends, and make adjustments for known or expected changes during the upcoming rating period.

Based on this analysis, the actuary develops a range of capitation rates that could be certified. The Department has the discretion to negotiate with the managed care organizations within that limited range. Once a point in the range is agreed upon, the actuary certifies the specific capitation rate as actuarially sound for each applicable cohort or risk group. The rates, and the certification, must then be approved by CMS.

The capitation rates do not go through a separate rate review process. CMS has specific guardrails in place, like the Medical Loss Ratio (MLR), to evaluate capitation payments against the amounts spent on covered services and other allowable activities. HCPF utilizes MLR results to evaluate the appropriateness of the actual claims experience as defined in 42 C.F.R. § 438.8.

Certification of Actuarial Soundness

The Department's contracted consulting actuaries, certify the actuarial soundness of the specific capitation rates established for each managed care cohort or risk group within each managed care program. Actuarial soundness generally means that Medicaid managed care capitation rates are reasonably sufficient to cover the costs of providing the benefits and services required under the managed care contract. The actuary submits a rate certification to HCPF and CMS that describes the methodologies, assumptions, and data used to develop and select the rates. The capitation rates submitted by the actuary represent the rates they determine and certify, at that point in time, to be reasonable and appropriate for the covered populations and services.

Federal requirements for capitation rates differ based on the program. Requirements are different for physical and behavioral health, CHP+, and PACE; however, all programs are subject to the same basic requirements.

Accountable Care Collaborative Payments

Fees paid to the Regional Accountable Entities (RAEs) for case management and care coordination were negotiated as part of a competitive bid. Increases in the fees beginning July 1, 2025 were approved by the General Assembly as part of the annual budget process. These fees do not include payments for behavioral health, which are paid via capitated rates.

Dental ASO Rates

The Dental ASO rates are not risk-based capitations and are not required to be actuarially sound. These rates are generally negotiated between the contracted Dental vendor and HCPF. The Department does evaluate these rates for reasonableness at regular intervals.

Conclusion

The key takeaway from this rate setting discussion is that HCPF conducts annual analysis, negotiation and rate review, to develop a single package of rate recommendations and budget requests that eventually go before the Joint Budget Committee for review and inclusion in the Long Bill. As noted, some rates have floors and upper payment limits, some rates must be actuarially sound, per federal regulation, and others are subject to federally imposed payment methodologies. While the JBC, in many circumstances, has the authority to set rates at specific levels, CMS retains final approval of the Medicaid rates in the state of Colorado. HCPF does not have the authority to operate unilaterally and change Medicaid rates throughout the year.

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COLORADO
Department of Health Care Policy & Financing

Expansion Population & the Statutory Trigger

Medicaid Commission Advanced Deliverable, September 2, 2026

Colorado's Expansion Population

The Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, section 25.5-4-402.4, C.R.S., created the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) fee from hospitals to increase Medicaid reimbursement and fund Disproportionate Share Hospital Payments to hospitals, to fund hospital quality incentive payments, finance the state's share of the health care coverage expansions in the Health First Colorado and CHP+ programs, reduce cost-shifting to private payers, and provide other services to hospitals.

Nearly 450,000 Coloradans' healthcare coverage is funded by the CHASE fee and associated federal matching funds. The following populations are funded using this structure and the table below includes FY 2027-28 Forecasted Expenditures:

Table 1. CHASE Funded Expansion Populations with Caseload and FY 2027-28 Forecasted Expenditures

Population	Caseload	Total Funds	HAS Fee Cash Funds	Federal Funds	FMAP*
MAGI Parents/Caretakers 60-68% FPL	5,401	$27,125,625	$13,562,813	$13,562,813	50%
MAGI Parents/Caretakers 69-133% FPL	45,354	$355,044,795	$39,587,495	$315,457,300	90%
MAGI Adults 0-133% FPL	313,181	$3,098,065,872	$372,775,964	$2,725,289,908	90%
Continuous Eligibility for Medicaid Children	19,207	$46,650,369	$23,325,185	$23,325,185	50%
Buy-In for Individuals with Disabilities*	24,445	$449,833,683	$221,586,461	$221,586,461	49.26%*
CHP+ 206-250%	33,147	$157,232,531	$55,031,386	$102,201,145	65%
Total	**440,735**	**$4,127,292,114**	**$725,869,302**	**$3,401,422,812**	**82.41%**

**Note: While the standard FMAP for each population is shown, various provisions of federal Medicaid law sometimes reduce the actual FMAP received for individuals or populations. For example, the Buy-In for Individuals with Disabilities receives a slightly lower effective FMAP because the premiums collected from members function as a recovery, or reduction, of total program costs, after which the federal share is then calculated. In the above table, premiums collected from members of approximately $6.7 million are reflected in the Total Funds column.*

Statutory Trigger

Under section 25.5-4-402.4(6)(b), C.R.S., state law provides trigger language that applies when hospital provider fee revenue is insufficient to fund all of the statutory purposes supported by the CHASE fee. Subsection (6)(b)(I) provides that the General Assembly is not obligated to backfill the shortfall with General Fund, while subsection (6)(b)(II) establishes the order in which payments shall be made from the fee, utilizing fee and federal matching funds. The order is:

1. Hospital reimbursement increases,
2. Quality incentive payments
3. Related administrative costs
4. Expansion populations (populations listed in Table 1 above)

The reduction process begins under section 25.5-4-402.4(6)(b)(III)(A), C.R.S., when the Department must notify the CHASE Enterprise Board that provider fee revenue and federal matching funds will not be sufficient to pay for all or part of the expanded eligibility. The Enterprise Board must then recommend reductions in medical benefits or eligibility sufficient to bring costs within available revenue, and the Medical Services Board must adopt implementing rules. Under subsection (6)(b)(III)(B), those rules are subject to JBC approval; if the JBC does not approve them, it must recommend an alternative reduction that achieves the required fiscal balance. Under subsection (6)(b)(III)(C), approved rules take effect twenty days after publication and remain effective only until the following May 15 unless extended through legislation.

Federal HR 1 changes a state's ability to draw down federal matching funds from provider fees. Those changes begin in Federal Fiscal Year 2028, beginning in October 2027. Colorado could lose between $900 million to $2.5 billion annually by FFY 2032 due to a reduction in provider fees and corresponding federal matching funds through this provision. With current projections for expenditure, HCPF believes that this federal reduction means that there will not be enough allowable Hospital Provider Fee to cover all of the costs required by statute, which will trigger the hierarchy described above. HCPF will continue to update the CHASE Board and JBC on the impact of those changes throughout the budget process.

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COLORADO
Department of Health Care Policy & Financing

State Directed Payments Inventory

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The State currently has approximately $1.12 billion in State Directed Payments (SDPs) across three arrangements. State directed payments are a Medicaid financing mechanism that allows states to direct managed care organizations to make specified payments to certain providers, rather than leaving all provider payment decisions to the managed care plans. States commonly use SDPs to increase provider payment through uniform rate increases, supplemental payments, or value-based payment arrangements that are incorporated into Medicaid managed care financing. Because the payments flow through managed care organizations, they must be incorporated into actuarially sound capitation rates and comply with federal requirements governing SDPs.

All three of Colorado's SDPs are federally approved for FY 2025-26; the exposure described below concerns future rating periods under H.R. 1, not current approval status. Two are paid under "separate payment terms," meaning they are paid outside of the capitation and are non-risk, and are funded through inter-governmental transfers (IGTs) and Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) provider fees. The third is a minimum fee schedule and is incorporated into the capitation rates.

SDP	Purpose	Value	FY 2025-26 Federal Approval	FY 2026-27 Federal Approval
Denver Health Professional Services payment	Reduce gap between Medicaid and commercial payments to Denver Health Hospital physicians and other professionals, ensuring sufficient access and quality for members	$11,331,455 total funds	Approved	Submitted, Pending
Hospital Inpatient/ Outpatient payment	Reduce gap between Medicaid and commercial payments to hospitals for inpatient and outpatient, physical and behavioral health services, ensuring sufficient access and quality for members	$725,112,312 total funds	Approved	Submitted, Pending

Comprehensive Safety Net Provider (CSNP) Prospective Payment System (PPS) fee schedule	Guarantee a base level of reimbursement to CSNPs to ensure consistent funding and access to BH services	$388,305,737 total funds	Approved	Not yet submitted

The first two of these SDPs, the Denver Health and Hospital Inpatient/Outpatient, are funded through an IGT and are subject to several current and proposed federal rules. The Hospital Inpatient/Outpatient SDP was created with the understanding of a total upper limit of 87 percent of the Average Commercial Rate, while the Denver Health Professional SDP was created with an understanding of a total upper limit to the Average Commercial Rate. This limit is being reduced under proposed rules to comply with section 71116 of H.R.1. The limit will be stepped down over time to 100 percent of the applicable Medicare rate. Also under H.R.1, there is a forthcoming transition that will disallow SDPs structured as separate payment terms. At that point, these two SDPs will either need to be ended or be incorporated into risk-based capitation rates as part of the managed care rate build.

The Hospital Inpatient/Outpatient SDP is structured under the CHASE model, and it will also interact with other provisions of H.R.1 which reduce the upper limit used in certain payment mechanisms including the CHASE fee, lowering the current ceiling of 6% of net patient revenues down to 3.5% over four years. This phased reduction in the current ceiling will begin on October 1, 2027.

The CSNP PPS fee schedule SDP has no current federal exposure risks other than general compliance with current and future SDP regulations. There are no current rules or planned rules that HCPF is aware of that would reduce the efficacy of this SDP.

For more information contact

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COLORADO
Department of Health Care Policy & Financing

HCPF's Budget Guiding Principles

Medicaid Commission Advanced Deliverable, September 2, 2026

Category	Guiding Principles
Eligibility for Medicaid and CHP+	1. Changes to eligibility need to produce meaningful General Fund savings 2. Strategic approach to connect to other coverage 3. Eligibility policies must be effective and appropriate 4. Community engagement
Robustness of benefits	1. Changes must be prospective, allow transition, and take a member-centered approach 2. Protect traditional Medicaid functions and focus on benefit limitations 3. Hold providers accountable
Administrative and structures	1. Internal operational efficiency: focus resources on mission-centric work 2. Program operational efficiency: reduce redundancies; evaluate duplication in program operations 3. Administrative reductions resulting in cost savings 4. Design the administrative processes and delivery structures around the member

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COLORADO
Department of Health Care Policy & Financing

HCPF's Approach to Provider and Program Integrity

HCPF protects Medicaid members and public funds by **preventing improper payments, promoting provider compliance, identifying and correcting billing issues, recovering inappropriate payments, and addressing suspected fraud, waste, and abuse (FWA).** HCPF uses education, prevention, review, and corrective action—and refers suspected intentional fraud to the appropriate investigative authorities.

Provider Education

Comprehensive billing manuals, bulletins, and guidance help providers understand Medicaid policies and billing requirements so claims are submitted correctly and recurring errors can be prevented.



Data Analytics & Investigations

Uses claims data and other information to identify unusual billing patterns, emerging risks, and areas requiring additional review with tools like Alivia's FWA Finder; also leverages national Medicare and Medicaid tools and resources.

Automated System Edits

Applies claims-processing controls to identify billing errors and prevent certain improper payments before they occur.

Prepayment Reviews

Reviews selected claims before payment when billing patterns or other indicators warrant additional scrutiny.

Program & Policy Reviews

Cross-Department teams collaborate to identify systemic risks and opportunities to strengthen policy, payment controls, provider guidance, and program oversight.

Post-Payment Audits

Reviews paid claims for compliance and recovers overpayments when appropriate; leverages internal FWA staff, the Recovery Audit Contract (RAC) vendor, the federal Uniform Program Integrity Program (UPIC), as needed. RAEs and MCOs also conduct program integrity activities within their areas of responsibility.

Provider Self-Audits

Encourages providers to identify and correct billing issues, return overpayments when appropriate, and improve internal compliance processes. All providers that receive Medicare or Medicaid funds are required to conduct self-audits.

Additional Program Integrity Safeguards

Provider Enrollment & Revalidation

Enrollment screening, verification, and periodic revalidation help ensure participating providers meet Medicaid requirements and prevent inappropriate participation in the program.

Fraud & Abuse Investigations

When information indicates potential intentional misconduct or fraud, HCPF may refer matters to the **Colorado Medicaid Fraud, Abuse and Neglect Unit (MFANU), federal law enforcement, or other appropriate authorities.**

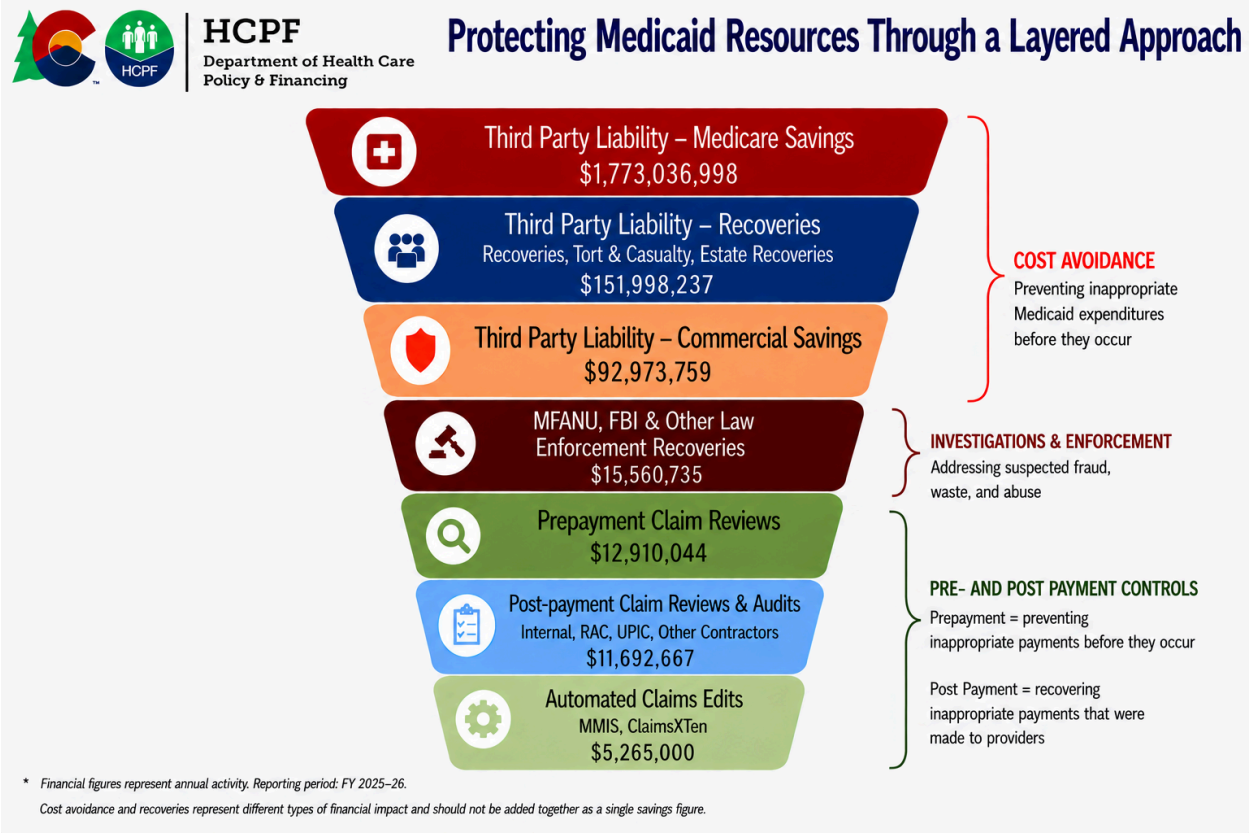
Third-Party Liability

Medicaid is generally the payer of last resort. HCPF identifies Medicare, commercial insurance, and other responsible payers to **avoid Medicaid costs before payment or recover funds after payment.**

COLORADO
Department of Health Care Policy & Financing

Protecting Medicaid Resources

HCPF's program integrity activities produce different types of financial impact. **Cost avoidance prevents inappropriate Medicaid expenditures before they occur, while recoveries return funds after an inappropriate payment has been made.**



HCPF's layered approach to provider and program integrity uses both tried and true techniques, coupled with new technologies to ensure we can effectively meet continuing FWA challenges. Together, these activities help HCPF **support compliant providers, protect Medicaid members, and safeguard public funds.**

