



COLORADO'S HOSPITAL PROVIDER FEE

**Protecting Medicaid Coverage
& Access to Care for Coloradans**

SEPTEMBER 2026

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Welcome Letter

On behalf of the more than 100 Colorado hospitals and health systems that the Colorado Hospital Association (CHA) represents, we are pleased to share Colorado's Hospital Provider Fee: Protecting Medicaid & Access to Care for Coloradans, a report that lays out how Colorado's hospital provider fee works, where it came from and what it will take to keep it strong in the years ahead.

Now known as the Healthcare Affordability and Sustainability (HAS) fee within the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE), Colorado's hospital provider fee was created in 2009 to expand access to Medicaid and strengthen support and reimbursement for the state's Medicaid providers. In the years since, Colorado's health care landscape has changed considerably — and with more change ahead, this is a timely moment to build a shared understanding of this critical financing mechanism and the role it plays in sustaining Medicaid expansion, access to care and provider reimbursement across the state.

In communities across Colorado, hospitals are essential service providers, economic engines and community cornerstones. Open 24/7/365, hospitals care for Coloradans and travelers alike in life's most urgent and important moments — responding to emergencies, nurturing new life, helping Coloradans of all ages and backgrounds stay healthy, recover from illness and injury, manage chronic conditions and live life to the fullest. They are also major employers and drivers of economic activity, playing essential roles in our local and state economies. Through their life-sustaining and mission-driven service and their steadfast contributions to our economy, Colorado's hospitals play a critical role in the success of our state. Over the past two decades, the hospital provider fee has directly financed Medicaid coverage for hundreds of thousands of Coloradans and helped ensure access to care for all Coloradans by providing an essential funding source to Colorado hospitals. Protecting and modernizing the hospital provider fee means protecting Medicaid coverage and the hospitals that Coloradans and Colorado communities depend on every day.

This report reflects an extensive collaborative effort. CHA engaged member hospitals and health systems representing every type of facility in Colorado, alongside external consultants and CHA's own finance and policy staff, to produce a resource that speaks clearly to the realities facing our state's hospitals. Report contributors' expertise, time and candor shaped every page of this document, and we are deeply grateful.

We also want to thank you, the reader, for taking the time to engage with this report. Understanding the hospital provider fee — how it works, why it matters, and where it's headed — is essential for anyone invested in the health and well-being of Coloradans, the strength of our health care system and the future of Colorado. We hope this report equips you with the context and clarity to help guide the decisions ahead.

Colorado's patients, communities, health care workforce and hospitals all depend on a sustainable, well-functioning provider fee program. We're proud of the work captured here, and we look forward to continuing this important conversation together.

Sincerely,



Jeff Tieman
President & Chief Executive Officer,
Colorado Hospital Association



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Executive Summary

Colorado's health care landscape has changed significantly since 2009. Over time, Colorado's hospital provider fee has grown and evolved to become an integral part of our Medicaid program. However, the policy and operational framework for the program remains largely unchanged since 2009.

On April 21, 2009, the bipartisan HB 09-1293, also known as the Health Care Affordability Act of 2009, was signed into law by Governor Bill Ritter for three specific purposes: increasing payments to hospitals, funding the administrative costs of the program's implementation and expanding Medicaid coverage to more Coloradans.

Estimates anticipated that the program would generate roughly \$680 million in its first year and support health coverage for about 100,000 Coloradans making it, at the time, the largest Medicaid expansion in Colorado history. Since then, the program has grown and evolved in response to changing federal policy, state fiscal constraints and the needs of Colorado communities, while preserving its core purpose of leveraging federal funding to support hospitals and Medicaid beneficiaries. Specifically, in 2025, the program had \$5.6 billion in total expenditures, supporting Medicaid coverage for 438,000 Coloradans while providing supplemental payments to 100 hospitals.

Colorado's Medicaid program is struggling to fulfill its statutory funding obligations, and federal policy changes resulting from H.R. 1 will reduce hospital provider fee revenue and associated federal match, requiring Colorado to either: (a) find new sources of non-federal share funding to sustain the program at current levels or (b) reduce spending.

In 2024-25, Colorado assessed fees to the federal limit of 6% of net patient revenue. Even with that maximum assessment, the State used CHASE reserves to fully fund program obligations. Under H.R.1, the 6% net patient revenue limit will be lowered to 3.5% in 2032.

H.R. 1 fundamentally changes the federal policy environment that has supported state Medicaid financing for decades, requiring Colorado to prepare for a future with fewer financing tools, reduced federal funding and greater pressure on both Medicaid coverage and hospital reimbursement. These new federal restrictions intensify existing vulnerabilities, making thoughtful governance, transparency and sustainable financing strategies more important than ever to preserving Medicaid coverage and access to care in Colorado.

Coloradans benefit from both hospital supplemental payments, which protect access to care and Medicaid coverage. The path forward must not be framed as access vs. coverage — Coloradans need both.

Supplemental payments financed by the hospital provider fee are an essential part of Colorado's Medicaid strategy, funding 51% of total payment to hospitals for care provided to Medicaid clients. But even with supplemental payments from the hospital provider fee program, almost 70% of Colorado hospitals operate with unsustainable margins. That jumps to almost 85% with unsustainable margins when looking at rural hospitals only.

These supplemental payments are core components of Medicaid financing that preserve access to care, support hospitals that serve Medicaid patients, and reduce pressure on the General Fund and other state share sources. Without adequate supplemental payments, hospitals will be forced to either cut services or close, threatening access to care not just for Medicaid members but for all Coloradans.

Medicaid coverage financed by the hospital provider fee supports services for 438,000 Coloradans — more than 35% of Colorado's Medicaid population. Without this essential coverage, many if not most of these Coloradans would be uninsured or underinsured, risking their health and financial security and further contributing to the uncompensated care burden on Colorado's health care providers.

Preserving the fee as a fee, in the enterprise structure, is essential to avoiding catastrophic impacts to Colorado's state budget. Ensuring benefit to fee payers is the central legal tenet of the fee / enterprise construct and must be protected as the policy is updated.

The hospital provider fee functions as a fee because it provides a specific service that benefits the fee payer. In this case, the fee paid by hospitals leverages federal matching funds which are then used to finance supplemental payments and Medicaid coverage. The supplemental payments and Medicaid coverage reduce the financial burden of undercompensated and uncompensated care for the hospitals that pay the fee. As such, the fee can be administered in an enterprise, or a government owned business, which exists outside the state's General Fund for the purpose of providing this specific service to hospital fee payers.

But Colorado's hospital provider fee program is approaching an inflection point. Long-standing structural challenges, coupled with impending federal Medicaid financing changes, require a thoughtful reassessment of how the program is designed, financed, and operated. Ensuring continued benefit to fee payers will be an essential consideration in that work.

Now is the time to do the hard work of evaluating and modernizing Colorado's hospital provider fee program. We should do that work carefully and collaboratively, through a principles-driven process that includes state policymakers, the hospital industry and Medicaid stakeholders.

Rather than preserving the status quo or pursuing isolated policy changes, CHA advocates for a collaborative, data-driven effort to modernize the program in a way that protects access to care, preserves hospital financial stability and sustains Medicaid coverage for as many Coloradans as possible. We're ready to do that work, together.

Medicaid Financing & Provider Fees

Section Summary

Medicaid is one of the nation's most important public health insurance programs, providing essential coverage for millions of low-income Americans and serving as a cornerstone of hospital financing. Yet Medicaid reimbursements often fall below the cost of providing care, creating funding gaps that threaten patient access and provider financial stability. As a joint federal-state partnership, Medicaid relies on a complex financing structure, including federal matching funds and state financing mechanisms such as provider fees, to address these challenges and sustain access to care. Understanding these mechanisms is essential to understanding the policy choices that shape Colorado's Medicaid program, support hospitals, and strengthen the state's health care system and economy.

Medicaid is woven into the fabric of America's health care safety net. Established in July 1965 under Title XIX of the Social Security Act, Medicaid is a means-tested entitlement, meaning that coverage is required for anyone who meets the eligibility criteria — whether they are a low-income family, an adult, a senior in long-term care or a person living with a disability. States set Medicaid eligibility policy within federal guidelines.

As of late 2025, Medicaid served as a lifeline for about 70 million Americans¹, including approximately 1.2 million Colorado residents² — nearly one in five people in the state.

What is FMAP?

FMAP is the formula for determining the federal share of reimbursement for state Medicaid costs. Under Medicaid statute, the FMAP ranges from about 50 to 83%, depending on state per capita income.⁶ In practice, federal Medicaid spending is often higher due to enhanced matching rates for certain populations and services, including the 90% match for the Affordable Care Act expansion population.⁷

Medicaid: A Shared Financial Responsibility

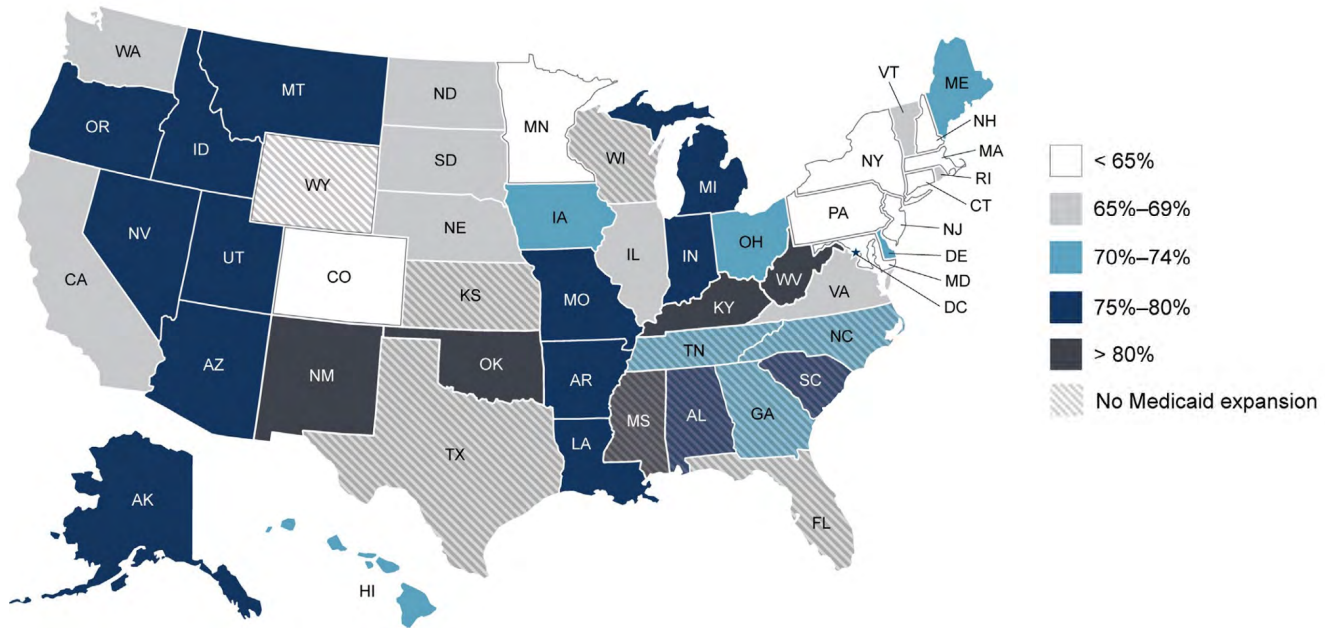
Medicaid relies on a joint-funding model between state and federal governments. Medicaid is structured as a match: For every dollar a state spends on allowable health care services, the federal government sends a matching amount back to the state. This matching rate, known as the Federal Medical Assistance Percentage (FMAP), is the engine of Medicaid financing.

In Colorado, the federal share of total Medicaid spending is lower than that of many Affordable Care Act (ACA) expansion states, reflecting both Colorado's base FMAP

and the composition of its Medicaid spending. Colorado's covered populations and services include a smaller share of expenditures eligible for enhanced federal matching rates than many other expansion states. For example, Colorado's disability buy-in program is a Medicaid expenditure financed by the hospital provider fee, but it is not eligible for the 90% match rate available to the ACA expansion population. As Medicaid and CHIP Payment and Access Commission (MACPAC) demonstrates, total federal share is distinct from Colorado's statutory FMAP and incorporates the effect of enhanced matching rates across populations.

Figure 1

Federal Share of Total Medicaid Spending by State, FY 2023



Note: The temporary increase in the FMAP from the Families First Coronavirus Response Act of 2020 (FFCRA, P.L. 116-127) was still in effect during FY 2023.

Source: MACPAC, 2024 Exhibit 16 in MACStats: Medicaid and CHIP Data Book, December 2024.

Source of Map: Holly Saltrelli and Chris Park, Medicaid in Context: Payment and Financing Presentation, April 10, 2025, Medicaid and CHIP Payment and Access Commission (MACPAC), retrieved from macpac.gov/publication/mcicaid-in-context-payment-and-financing.

The accompanying map (Figure 1) reflects each state's total federal share of Medicaid spending in FY 2023. This measure captures the combined effect of base FMAP and enhanced matching rates that have since expired and is therefore not directly equivalent to a state's statutory FMAP, but still demonstrates the continued underfunding issues in Colorado due, in part, to comparatively lower FMAP relative to other Medicaid expansion states. This puts increased pressure on state share resources, which are already limited.

While the federal government provides substantial funding, states are responsible for securing the remaining portion of Medicaid expenditures, called the non-federal share. Federal law requires that at least 40% of this share comes from state funds, while the remaining 60% may be derived from local government sources, such as counties or municipalities.

Why We Use the Term "Provider Fees"

At the federal level, the terms "provider tax" and "provider fee" are used interchangeably. In Colorado, there is a legal difference between taxes and fees. We have done the due diligence to ensure this is a fee in the state of Colorado (see Section 2 for more discussion). As most readers of this report are expected to be in Colorado, we have chosen to use "provider fee" throughout the remainder of the report.

States employ a variety of mechanisms to fund the non-federal share of Medicaid:

- **State General Funds:** The primary source of Medicaid funding in most states, accounting for the majority of the non-federal share nationwide.

Provider fees help address the gap between Medicaid reimbursement and the cost of care, allowing states and providers to maintain access to services for Medicaid beneficiaries and other vulnerable populations. Medicaid underfunding refers to the gap between the costs hospitals incur to provide care to Medicaid patients and the Medicaid payments they receive.

Health care-related taxes — also known as provider taxes, provider fees or provider assessments — are specialized

All States but Alaska Use Provider Taxes to Help Finance the State Share of Medicaid Spending



According to analysis of the Colorado Department of Health Care Policy and Finance (HCPF)'s 2026 CHASE Annual Report, Colorado hospitals received approximately 66 cents for every dollar spent caring for Medicaid patients in 2024, resulting in an estimated \$2 billion in Medicaid under-reimbursement even after accounting for hospital provider fee supplemental payments.³ Adequate reimbursement is critical to maintaining patient access, as hospitals rely on Medicaid payments to support staffing, services and infrastructure necessary for patient care. When payments consistently fall below the cost of providing care, hospitals must absorb those costs or cut access to services, making it difficult to preserve access for Medicaid patients and communities.

These fees serve a critical function in state budgets. States use the revenue from provider fees as the non-federal share of funding required to draw down matching federal dollars for their Medicaid programs. While federal policy permits states to impose these fees on 19 different classes of providers, they are most frequently applied to three main groups: hospitals, nursing facilities and intermediate

care facilities for individuals with intellectual and developmental disabilities (I/DD).

The federal framework governing these arrangements dates back to the 1991 Medicaid Voluntary Contribution and Provider-Specific Tax Amendments, which established the core requirements that structure provider fees.

This expansion reflects broader fiscal and policy trends, including growth in Medicaid enrollment and spending, rising gaps between Medicaid reimbursement and actual costs borne by providers, and the capacity for provider fees to generate state matching funds that draw down federal Medicaid dollars. As a result, provider fees have become a widely used financing mechanism for supporting Medicaid coverage, reimbursement and supplemental payment programs.

In 2004, only 12 states had a hospital provider fee. By 2019, that number had surged to 49 states that used a hospital provider fee to generate their state matching funds. As of December 2025, Colorado is one of 39 states with three or more Medicaid provider fees, reflecting

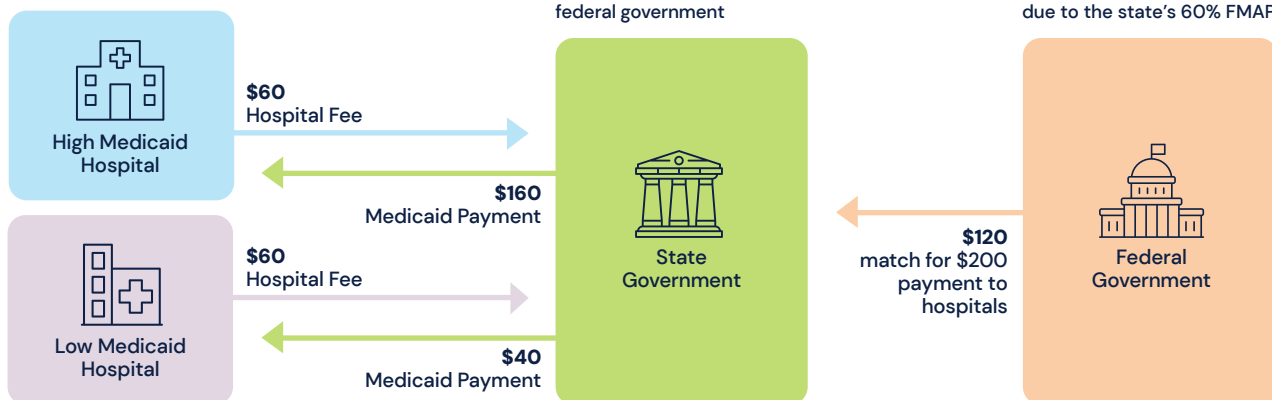
Figure 3

Illustration of Provider Fee–Financed Payments

Each hospital makes a **\$60** fee payment to the state

The state makes **\$200** in additional Medicaid payments to hospitals and reports payments to the federal government

The federal government reimburses 60% of Medicaid payments to the hospitals due to the state's 60% FMAP



Source of the Graphic: Holly Saltreli and Chris Park, Medicaid in Context: Payment and Financing Presentation, April 10, 2025, Medicaid and CHIP Payment and Access Commission (MACPAC), retrieved from: <https://www.macpac.gov/publication/medicaid-in-context-payment-and-financing/>

states' increasing reliance on provider-based financing across multiple health care sectors to fund Medicaid programs and maintain provider reimbursement levels.⁴

Every provider fee varies in size, structure and details; there is no “typical” program. The following example helps illustrate the basic mechanics of a provider fee program.

Assume a state has two similarly sized hospitals, but one serves a higher volume of Medicaid patients. The state assesses a provider fee using a broader metric, often based on all-payer activity (e.g., net patient revenue) rather than Medicaid utilization alone. The state may then use the resulting revenue as permissible non-federal share under federal Medicaid financing rules to draw down federal matching funds and make Medicaid payments to hospitals based in part on Medicaid volume. As a result, these programs must be generally redistributive: Some hospitals may receive more in Medicaid payments than they pay in fees, while others may receive less. This is consistent with Colorado's experience.

Under this example, both hospitals pay the same fee, but the payments they receive back differ because their Medicaid volumes differ: Hospital 1, the high-volume Medicaid hospital, sees a net benefit of \$100, while Hospital 2, the low-volume Medicaid hospital, sees a net loss of \$20. This is an intentional, redistributive design element of provider fees, because Medicaid volumes vary across providers.

Under a provider fee program, payments back to the health care entities paying the fee generally fall into two categories:

1. **Base Payments:** These are standard payment rates for services rendered, like fee-for-service rates tied to a specific beneficiary or service.
2. **Supplemental Payments and Directed Payments:** Beyond base payment rates, states can make two additional types of Medicaid payments to advance specific program or policy goals:
 - Supplemental payments apply in fee-for-service Medicaid, and include Disproportionate Share Hospital (DSH) payments, Graduate Medical Education (GME) payments and uncompensated care pools authorized in certain circumstances.

- Directed payments apply in states with Medicaid-managed care programs and operate under separate federal rules, allowing states to require managed care plans to pay providers according to specified methodologies or performance goals.

For certain Medicaid fee-for-service provider classes, federal law imposes upper payment limits (UPLs) that compare aggregate Medicaid payments to what Medicare would have paid for comparable services. UPL rules can affect hospital base and supplemental payments in fee-for-service Medicaid. Separate federal rules govern Medicaid-managed care capitation and state-directed payments, which are not subject to the same UPL framework.

Federal Parameters for Provider Fees

Because Medicaid is a joint federal-state partnership, the federal government must approve state financing mechanisms. For a state provider fee to be approved, it must operate within federal parameters established by Congress and the Centers for Medicare and Medicaid Services (CMS) at the U.S. Department of Health and Human Services. These guidelines are built upon three fundamental requirements:

1. **Broad-Based:** As a general rule, the fee must apply to the full provider class, or class of items or services identified under the federal rules, subject to limited exceptions and any waiver authority recognized by CMS.
2. **Uniform:** As a general rule, the fee must be imposed consistently across all members of the provider class subject to the fee. Federal rules permit certain exclusions — such as excluding Medicaid or Medicare revenues under specified circumstances — provided these exclusions are applied uniformly. CMS may also approve waivers to this requirement in limited circumstances.
3. **No Hold Harmless:** The state may not directly or indirectly guarantee that fee payers will be repaid for the cost of the fee. Whether a fee creates an impermissible hold harmless arrangement is evaluated under multiple federal standards, including tests focused on correlation, Medicaid payments and guarantees.

Federal law also limits the amount and structure of provider fees states may use in Medicaid financing. Historically, fees at or below 6% of the taxed provider class' net patient revenue fell within the traditional federal safe harbor for hold harmless purposes. That framework changed on July 4, 2025, when H.R. 1 imposed immediate restrictions on new or increased provider fees and targeted certain waiver-based tax structures.⁵

Additional implementation consequences apply beginning Oct. 1, 2027, and, for Medicaid expansion states, the relevant threshold is phased down over five years beginning in FY 2028 to a maximum 3.5%. (See Section 4 for details on how H.R. 1 policies will impact Colorado's program.)

How does a provider fee work?

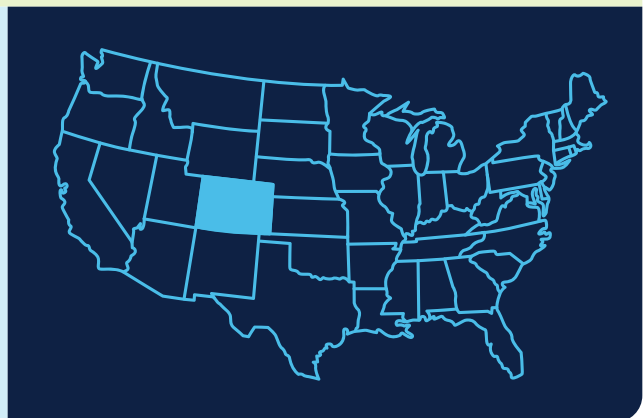
A provider fee creates a financing structure linking providers, the state and the federal government. The process generally follows three steps:

1. **Assessment:** The state levies a broad-based fee on a specific class of providers (e.g., all hospitals or all nursing homes) to serve as the "state share" or the "non-federal share" of funding for qualifying Medicaid expenditures.
2. **Match:** If structured in compliance with federal requirements, these funds may be used to claim federal matching funds under Medicaid financing rules.
3. **Expenditure:** State and federal funds are then used to pay for valid Medicaid expenditures, including increased reimbursement rates, expanded coverage and benefits, and other program costs. Many programs are designed so the provider class receives substantial Medicaid payments, although individual providers may be net recipients or net contributors. Many states, including Colorado, choose to also fund other Medicaid expenditures.

Provider Fees in Colorado

Colorado has three provider fees: one for hospitals, one for nursing homes and one for intermediate care facilities.

Colorado's hospital provider fee generates significantly more funding than the other two provider fees and is the only one that supports payments for all services of expanded Medicaid eligibility groups. See Section 2 for more detail.



Section Conclusions

1. Medicaid is a joint federal-state partnership, financed through both federal and non-federal sources. Colorado's Medicaid program receives a relatively low amount of federal matching funds compared to other states that have expanded Medicaid under the ACA.
2. It is common for states to use sources other than State General Fund to finance the non-federal portion Medicaid funding. Provider fees are a long-standing and common financing mechanism for non-federal share. Every state but Alaska has provider fees, and Colorado is one of 39 states with three or more provider fees. Despite current political discourse at the federal level, the use of provider fees is common and does not appear to follow partisan trends.
3. Provider fees vary significantly in size, structure and mechanism. While there is a basic federal framework common to all provider fees, there is no "typical" provider fee.
4. The federal government establishes parameters for provider fees that states must follow. CMS must approve state provider fees. While waivers enable some flexibility, federal rules require provider fees to be broad-based and applied uniformly to a class of providers and that states cannot guarantee a net benefit to tax/fee payers. As a result, provider fee programs are redistributive.
5. Supplemental payments mitigate Medicaid underpayment to ensure Medicaid beneficiaries and uninsured patients still have access to care.

Recommendations for Additional Reading

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Colorado's Hospital Provider Fee: History & Structure

Section Summary

Colorado's hospital provider fee has been most effective at improving health care system financial stability, expanding access to care and strengthening Medicaid financing when hospitals, state leaders, policymakers and other stakeholders work in sustained collaboration toward a shared goal. Over nearly two decades, the program has evolved in response to changing federal policy, state fiscal constraints and the needs of Colorado communities, while preserving its core purpose of leveraging federal funding to support hospitals and Medicaid beneficiaries. The following section highlights the major lessons from that evolution and the considerations that should guide the program's future.

Colorado set off on a path to reform health care in 2006, when the state legislature passed SB 06-208, establishing the Blue Ribbon Commission for Health Care Reform, commonly known as the "208 Commission." Composed of 27 health care stakeholders appointed by legislative leaders and Governors Bill Owens and Bill Ritter, the group spent 18 months rigorously evaluating proposals for comprehensive state-level reform. Their primary focus was clear: reducing the number of uninsured Coloradans and creating a more rational health care delivery system. On Jan. 31, 2008, the Commission delivered a report to the General Assembly featuring 32 recommendations. One key recommendation was Medicaid expansion.⁸

Establishment & Early Operation of the Hospital Provider Fee (2008-2012)

Shortly after the Commission's report was released, the focus shifted from theory to implementation. In spring 2008, officials from the Ritter administration invited CHA leadership to partner in exploration of a hospital provider fee. They sought to establish a policy solution that would benefit three key groups in distinct ways:

- **Coloradans:** Expand Medicaid access for low-income residents to reduce the number of uninsured Coloradans.
- **Hospitals:** Increase supplemental Medicaid payments and reduce the burden of uncompensated care provided to uninsured Coloradans.
- **State Government:** Strengthen the budget by drawing down more federal matching funds.

A working group formed to refine this concept, bringing together leaders from the Governor's Offices of Policy and Budgeting, HCPF, and CHA members and staff. They worked together for six months studying successful models in other states and modeling various financial scenarios to ensure the plan's viability.

Based on the collaborative planning done in summer and fall 2008, the effort transitioned to the legislative arena in early 2009 as CHA and the Ritter administration worked together to secure legislative sponsors and draft the proposal. On March 2, 2009, HB 09-1293, the Colorado Health Care Affordability Act of 2009, was introduced.⁹ Hospitals and the Ritter administration operated in

lockstep to pitch this innovative Medicaid financing model to newspaper editorial boards and advocacy organizations across the state. Ultimately, a strong and diverse coalition of business, health care and consumer advocacy groups endorsed the measure. HB 09-1293 enjoyed support from more than 30 legislative co-sponsors and was approved with bipartisan support in both the House and Senate. Ritter signed the landmark legislation into law on April 21, 2009.

This legislation authorized HCPF to officially establish the hospital provider fee. Revenue generated was earmarked for three specific purposes:

- increasing payments to hospitals
- funding administrative costs of the program's implementation
- expanding Medicaid coverage to more Coloradans, as revenue became available

Estimates anticipated that the program would generate roughly \$680 million in its first year. Once fully implemented, the Medicaid expansion was expected to support health coverage for about 100,000 Coloradans, making it, at the time, the largest Medicaid expansion in Colorado history.¹⁰

In the summer of 2009, HCPF convened the first Hospital Provider Fee Oversight & Advisory Board. To ensure balanced perspectives, the board consisted of 13 members appointed by the governor, with no more than six representatives from any single political party. This diverse group included:

- five hospital representatives
- two HCPF officials
- one CHA staff representative
- one insurance carrier representative
- one broader health care industry (not hospitals or insurers) representative
- one consumer advocate
- one disability community representative
- one business sector representative

The board's initial responsibility was to approve a plan for submission of hospital provider fees to the federal government. The state submitted plans to CMS in fall 2009 that requested to waive the uniform and broad-

based provider fee requirements, and allowed Colorado to create fee discounts for certain provider types (see Section 3 for more detail).¹¹ In March 2010, CMS approved Colorado's plans, completing the final step to implement the program.

Colorado's reliance on CMS-approved waivers is an important part of the program's history, and holds current significance under the federal provider fee changes enacted through H.R. 1 on July 4, 2025. Although Colorado's longstanding provider fee appears to meet federal standards for an existing and acceptable fee, it is not clear if previously approved, waiver-based structures will be exempt from new federal restrictions. As a result, Colorado's approach may need to be revisited. (See more in Section, 4 for how H.R. 1 may impact Colorado's program.)

Under the original model, the program was structured around two distinct fees: an inpatient fee and an outpatient fee. While most facilities participated, certain hospitals were excluded or paid reduced fees based on specific, legislature-selected criteria, as described further in Section 3¹². On the distribution side, the model featured 13 supplemental payment categories, allowing eligible hospitals to receive payments based on their specific characteristics.

In its early years, the program operated on a smaller scale but was still significant. By FY 2012, two years into the program, the hospital provider fee had generated total revenue exceeding \$1.1 billion. This total comprised:

- \$585.7 million in provider fees
- \$528.3 million in federal matching funds
- Nearly \$1 million in earned interest

Expenditures for 2012 reflected the program's core priorities. Most funds — \$896.7 million — were distributed as supplemental payments to hospitals. Additionally, \$134.3 million was dedicated to expanding Medicaid and CHP+ eligibility, while \$15.8 million covered the program's administrative costs. These early data underscore the fee's success in reducing uncompensated care costs while simultaneously expanding coverage for Colorado's most vulnerable populations.

Table 1

Medicaid Hospital Provider Fee Program Revenue & Expenditures by Source & SFY (in Millions)

Revenue & Expenditure Category	2010	2011	2012	Percentage Change 2010-2012
Revenue				
Hospital Provider Fees Collected	\$340.9	\$441.1	\$585.7	72%
Federal Financial Participation ¹	298.4	422.9	528.3	77
Recovery Act Funding ²	46.3	53.5	0.0	-100
Interest Earned	0.9	1.5	0.8	-11
Total Revenue	\$686.5	\$919.0	\$1,114.8	62%
Expenditures				
Supplemental Payments	\$590.2	\$745.2	\$896.7	52%
Expansion of Medicaid Eligibility	3.2	90.1	134.3	4,097
Administration	2.9	5.7	15.8	445
Medicaid General Fund Offset — Recovery Act ³	46.3	53.5	0	-100
Medicaid General Fund Offset — Other ⁴	0	7.9	65.7	100
Total Expenditures	\$642.6	\$902.4	\$1,112.5	73%
Revenue Less Expenditures	\$43.9	\$16.6	\$2.3	-95%
Refund to Hospitals	\$38.0	\$0.0	\$0.0	-100%
Carry Over from Prior Fiscal Year	\$0.0	\$5.9	\$22.5	n/a
Cash Fund Balance	\$5.9	\$22.5	\$24.8	320%

Source: Office of the State Auditor's analysis of hospital provider fee revenue and expenditures contained in the Colorado Financial Reporting System.

¹ Federal Financial Participation is the federal matching funds received based on the supplemental payments made to hospitals as part of the Hospital Provider Fee Program.

² American Recovery and Reinvestment Act provided an enhanced federal matching funds rate for supplemental payments in FY 2010 and FY 2011, resulting the state receiving a range of 57-62% reimbursement rather than 50% for supplemental payments made to hospitals as part of the Hospital Provider Fee Program.

³ Medicaid General Fund Offset — Recovery Act includes federal matching funds received through the Recovery Act in excess of the 50% matching rate that were used for general fund relief per Section 25.5-4-4023(4)(b)(VIII), C.R.S.

⁴ Medicaid General Fund Offset — Other includes transfers made to the general fund per Section 25.5-5-402.3(4)(b) subparts (VII) and (IX), C.R.S.

Source of Chart: Medicaid Hospital Provider Fee Program Performance Audit, September 2012, Office of the State Auditor, Retrieved April 2026:
https://content.leg.colorado.gov/sites/default/files/documents/audits/hospital_provider_fees_report_complete_final_print_ready9.26.12_mg_km.pdf

ACA Expansion & Opt-In (2012-2014)

Just as Colorado finalized its provider fee program in March 2010, the national health care landscape shifted dramatically with the passage of the ACA.¹³ This comprehensive federal health reform policy included a major provision: a required expansion of Medicaid to cover low-income parents and adults without dependent children earning up to 138% of the Federal Poverty Level (FPL).

The ACA soon faced a significant legal hurdle in the Supreme Court case *National Federation of Independent Business v. Sebelius*. Plaintiffs challenged two key provisions of the law: the individual mandate for all Americans to obtain health insurance and Medicaid expansion. While the Court upheld the individual mandate

for health insurance, it ruled that the mandated Medicaid expansion was unconstitutionally coercive to states.¹⁴ This landmark decision effectively turned a federal requirement into a state-level choice, leaving Colorado leaders to decide whether to officially opt-in to the Medicaid expansion.

In 2013, Colorado lawmakers embraced federal Medicaid expansion through SB 13-200, Expand Medicaid Eligibility.¹⁵ The bill had a clear path through the legislature before being signed into law by Governor John Hickenlooper on May 13, 2013.¹⁶ Effective Jan. 1, 2014, this legislation leveraged the existing hospital provider fee to increase Medicaid eligibility for parents and adults without dependent children to the 138% FPL threshold.¹⁷

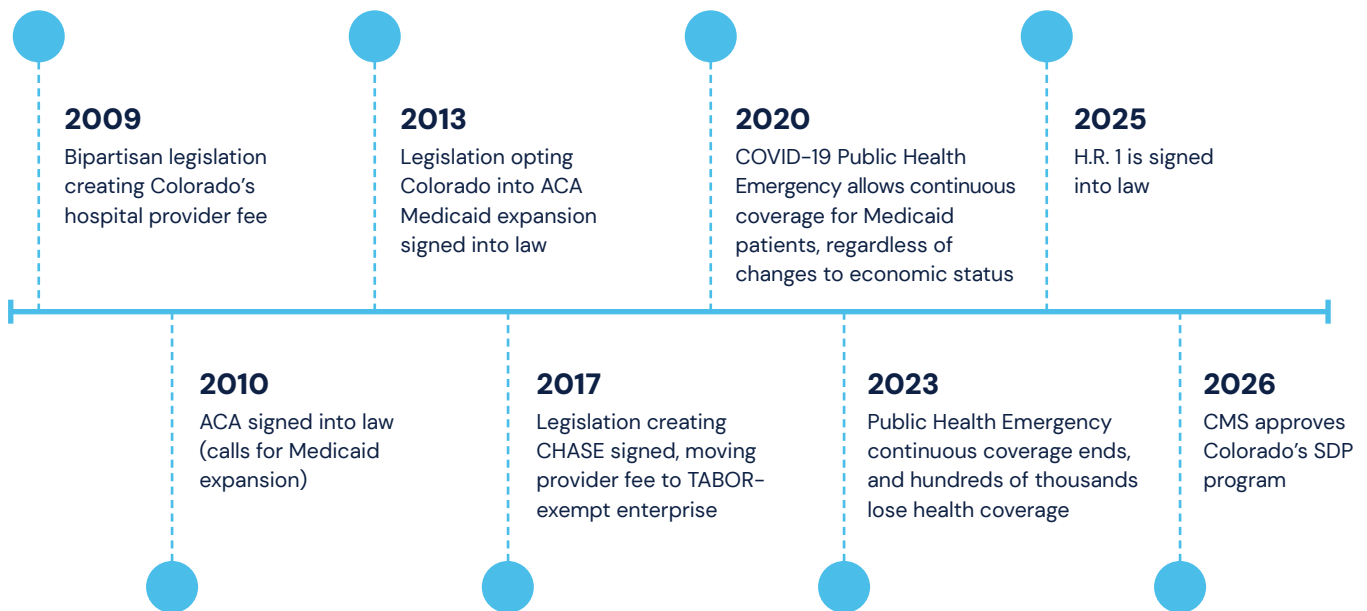
While the bill technically only modestly increased eligibility for these two specific population categories, the impact was profound. The sheer volume of newly eligible individuals meant that the hospital provider fee — and related federal match — needed to grow substantially to sustain the program.

By opting into the ACA expansion, Colorado unlocked enhanced FMAP for these specific populations. The expansion was fully federally funded for the first three years and then transitioned gradually to a permanent

90%-to-10% federal-to-state match. This federal policy change created a dual-funding structure. While the newly expanded ACA populations enjoyed enhanced federal match, other populations previously established in 2009 — including the CHP+ expansion to 250% FPL, the Medicaid disability buy-in up to 450% FPL, and the policy of 12-month continuous eligibility for children — continued to be financed through the traditional FMAP rate. As Medicaid enrollment among Coloradans expanded, federal investment in the state's healthcare infrastructure grew proportionally.

Figure 4

Colorado's Hospital Provider Fee: A Timeline



The Enterprise Shift: Navigating TABOR & Ensuring Sustainability (2017)

By 2016, Colorado's healthcare landscape had transformed. Following the implementation of the ACA expansion, the hospital provider fee program and Medicaid caseloads had grown substantially. Medicaid enrollment more than doubled between June 2012 to June 2016, growing from

approximately 651,000 to 1,331,000.¹⁸ However, this success created a new challenge under the Taxpayers' Bill of Rights (TABOR), Article X, Section 20 of the Colorado Constitution, which strictly limits state budget growth.

As revenue from the provider fee increased, it threatened to push the state over its TABOR limit, which would have triggered mandatory taxpayer refunds and forced deep cuts to other critical areas of the state budget.

To avoid this conflict, CHA and Governor John Hickenlooper's administration investigated the possibility of reclassifying the program as an enterprise — a state-owned business that operates independently of the state's TABOR district and is therefore not subject to its spending constraints.

To qualify as an enterprise, the program had to meet the definition of a “government-owned business” as defined in TABOR. Governor Hickenlooper and legislative leaders concluded that the program qualified because,

in addition to collecting fees from hospitals, leveraging them to obtain federal matching funds, increasing hospital reimbursement rates and expanding coverage, the program provided specified business services to fee payers.

The program thus reduced the financial burden of undercompensated and uncompensated care for the hospitals paying the fees. In a formal opinion issued on Feb. 29, 2016, Colorado Attorney General Cynthia Coffman agreed that the program qualified as an enterprise and that its charges to hospitals were permissible enterprise fees, not taxes.¹⁹ With this legal rationale in hand, CHA pursued the statutory changes necessary to move the fee into an enterprise structure.

Understanding Enterprises

Under TABOR, an enterprise is: 1) a government-owned business, 2) with authority to issue revenue bonds, 3) that receives less than 10% of its annual revenue from state and local governments.

An enterprise cannot levy taxes, but it may generate revenue through fees charged for goods or services that benefit fee payers. Fee revenue paid into an enterprise is exempt from the growth and spending limits that apply to state and local governments under TABOR. Because enterprise programs are primarily financed through user fees and not tax revenue, the enterprise can grow over time at rates sufficient to fund its operations without being constrained by TABOR limits or triggering TABOR refunds.

From 1993-2023, more than 30 government programs received enterprise status for at least one year. In state FY 2022-23, Colorado enterprises had revenue totaling more than \$23 billion. Examples of enterprises other than CHASE include:

- All state higher education institutions
- The Colorado Lottery
- Statewide Tolling Authority
- Colorado Parks & Wildlife
- Family and Medical Leave Insurance (FAMLI)

Ultimately, the legislative vehicle for this change was SB 17-267, a 60-page, multi-part bill aimed at supporting the economic vitality of rural Colorado. Amid various adjustments to state budgeting, the bill included a transformative provision for the hospital provider fee.²⁰ The bill repealed the original hospital provider fee statute and established a new entity called the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) within HCPF.

CHASE was charged with implementing a new Healthcare Affordability and Sustainability (HAS) fee, which mirrored the construct of the previous provider fee but operated within the new enterprise structure. Ultimately, SB 17-267 functioned as a “repeal and replace” measure. It preserved the fundamental mechanics of the health care funding program while rehousing it within a more flexible enterprise that protected the rest of the state budget from TABOR-related cuts.

Optimizing Funding in a Post-COVID Environment (2023-2026)

As Colorado emerged from the COVID-19 public health emergency, the state's health care system faced a perfect storm of financial pressures. Medicaid enrollment had surged during the pandemic and then quickly dropped (the “Medicaid unwind”) following expiration of the Medicaid continuous coverage requirement.²¹ While federal relief funding to states had initially cushioned the blow of financial and economic impacts from the public health crisis, those funds eventually expired, leaving Colorado's state budget under significant strain. Hospitals were simultaneously grappling with the rising costs of providing care and an increase in uncompensated services due to the increase in uninsured Coloradans caused by the Medicaid redetermination, creating an unsustainable financial environment that threatened patient access across the state.

To address these challenges, CHA began investigating new strategies to optimize federal Medicaid funding to Colorado. Research pointed toward State Directed Payment (SDP) programs as an additional federal funding opportunity. Forty-one states have employed this common financing process.²² Historically, Colorado's hospital provider fee program focused exclusively on “fee-for-service” Medicaid. However, this left a gap: Colorado's Medicaid program uses a managed care model for behavioral health, as well as for physical health services in some regions. SDP programs offer a solution:

They allow states to draw down an enhanced federal match when funding is used to increase reimbursement rates for specific services within a managed care framework. By adopting an SDP program, Colorado could better support targeted services and ensure a more stable financial foundation for its safety net health care infrastructure.

In late 2024, CHA and HCPF began exploring whether Colorado should add an SDP program to complement the existing hospital provider fee model. After the CHASE Board authorized a working group, the parties developed a proposal that HCPF submitted to CMS in late June 2025.²³

CMS approved Colorado's initial hospital SDP program in spring 2026. This marked a significant expansion of Colorado's Medicaid financing strategy beyond the traditional fee-for-service provider fee model by creating a mechanism to support additional hospital reimbursement for services delivered through Medicaid-managed care. While the state has not fully implemented the new SDP program, the projected incremental net benefit to hospitals will be approximately \$457 million. This new funding comes at a time when hospitals face rising costs and cuts to Medicaid reimbursement rates, including year-over-year, across-the-board cuts to hospital fee-for-service reimbursements. While helpful in the short term, the new SDP funding cannot be used as a long-term solution due to H.R. 1 policy changes discussed in Section 4.

In addition to the SDP, CHA also identified underutilization of federal matching opportunities in non-emergency medical transport (NEMT) program. CHA worked with Governor Polis' Administration and legislators to update that categorization via HB 26-1328. Following passage of that legislation, HCPF acted to recategorize that funding, unlocking additional federal funds.

The Architecture of Accountability: CHASE Structure & Governance

Established within HCPF, CHASE is classified as a Type 2 entity in the Executive Branch of Colorado government. This means it operates under direct supervision and leadership of its principal agency, HCPF, while maintaining a distinct board and business functions, as required to maintain enterprise status.

Governance of the enterprise is vested in a 13-member board, appointed by the governor with the advice and consent of the Colorado Senate. This board maintains the

representation established in 2009, ensuring that diverse voices are present in enterprise's business operations.

These board members serve as volunteers for four-year terms, with the governor designating the chair and the board electing the vice chair. The board's primary annual task is to review the hospital provider fee model and recommend it for approval to the Medical Services Board (MSB), which holds final rule-making authority for HCPF.

By statute, CHASE is empowered with charging and collecting the Healthcare Affordability and Sustainability (HAS) fee and Medicaid buy-in premiums, leveraging that revenue to secure federal matching funds, and expending the total combined revenue as dictated by statute. Notably, as an enterprise, CHASE also holds statutory authority to issue revenue bonds, though it has never exercised this power.

Importantly, the statute establishes that it is the responsibility of the CHASE Board to recommend reductions in medical benefits or Medicaid eligibility, if the money generated by the enterprise (hospital fees + federal match) is insufficient to fund all Medicaid expansions laid out in statute. Those

The Role of the Medical Services Board in Colorado Medicaid

MSB is the 11-member body appointed by the governor and affirmed by the Senate that adopts rules and regulations governing all health care programs under HCPF. Federal regulation requires that there be a single state agency responsible for all Medicaid administration. The MSB at HCPF serves as that rulemaking entity for Colorado.

recommendations are made to the MSB, which is then required to undertake a rulemaking process to cut benefits or eligibility.²⁴ Statute requires the MSB to notify the legislature's Joint Budget Committee (JBC) of that rulemaking process and provides the JBC an opportunity to weigh in if they disagree with MSB decisions. It is worth noting that the statute does not contemplate a scenario where CHASE revenue (fee + federal match) is insufficient to fund supplemental payments to hospitals because supplemental payments to hospitals are the first funding priority established in law.

Figure 5

Colorado Healthcare Affordability & Sustainability Enterprise



CHASE: From Single Fee to Expanded Enterprise

When CHASE was established in 2017, its sole focus was the Healthcare Affordability and Sustainability (HAS) hospital provider fee. In 2025, the General Assembly expanded the CHASE structure to include additional financing streams, including the nursing facility provider fee and the intermediate care facility fee²⁵ and Medicaid buy-in premiums.²⁶ Even with those additions to the enterprise, the hospital provider fee remains by far the largest program within CHASE. The 2025 legislation also added separate support-board structures for the newer programs, reflecting that CHASE's organizational role has expanded over time.

Section Conclusions

1. Since 2008 when the hospital provider fee was first considered, CHA and its members have been constructive partners to the state in shaping the development, structure, and implementation of the hospital provider fee program. It is in that continued spirit of partnership and collaboration that CHA offers this report and seeks to help shape the future of the provider fee, as a key part of the state's broader Medicaid financing and access to care strategy.
2. The hospital provider fee — also known as the HAS fee — has grown substantially over time. What started as a program with \$686 million in total expenditures in 2010, and was anticipated to finance Medicaid benefits for 100,000 Coloradans, has grown to a program with \$5.6 billion in total expenditures in 2025 supporting Medicaid coverage for 438,000 Coloradans. Despite the significant growth and evolution of the program, there has not been a meaningful evaluation or update to the provider fee statute since its establishment 17 years ago.
3. In 2016, a legal due diligence review — confirmed by Attorney General Coffman's opinion — established that the hospital provider fee qualifies as a fee, not a tax. The determination rests on the business benefit provided to fee payers (i.e., drawing down federal matching funds to finance supplemental payments and Medicaid coverage), which reduces the burden of uncompensated care borne by hospitals. This "fee" classification also preserves the program's enterprise structure, keeping revenue outside the General Fund. Maintaining this structure requires ensuring that fee payers continue to receive a clear financial benefit from the program.
4. CHASE is an independent authority that operates under the direct supervision of HCPF. However, the CHASE Board's ability to fulfill its governance responsibilities depends heavily on the capacity and responsiveness of the CHASE/HCPF staff. For this reason, it is critical for HCPF to dedicate sufficient time and attention to the CHASE Board. The CHASE Board must also hold HCPF staff accountable to ensure the board can provide appropriate oversight over programs within the enterprise.
5. The current statutory process for reducing Medicaid benefits, should there be insufficient revenue to fund them, puts critical policymaking decisions in the hands of the Medical Services Board with recommendations from the CHASE Board. This is likely to be relevant in the coming years as provisions of H.R. 1 are implemented, requiring the state to reduce provider fees.

Recommendations for Additional Reading

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Colorado Hospital Provider Fee: Mechanics & Trends

Section Summary

Colorado's hospital provider fee program has helped the state leverage federal funding to expand Medicaid coverage and provided some increase to hospital reimbursements. However, as the program has grown, an increasing share of provider fee revenue has been directed toward financing Medicaid expansion, leaving a smaller portion available for hospital supplemental payments, even as hospital costs continue to rise. Over the last 10 years, provider fees paid by hospitals increased 106%, while net payments back to hospitals grew just 13%. In contrast, fees required to support Medicaid coverage for provider fee-financed populations surged 762% and administration costs rose 177% while fee-for-service rates have remained flat or declined — constituting a cut in inflationary terms.

These longstanding structural pressures, coupled with operational and governance challenges, left the program strained even before H.R. 1. New federal restrictions do not create these problems; they intensify existing vulnerabilities, making thoughtful governance, transparency and sustainable financing more critical than ever to preserving Medicaid coverage and access to care in Colorado.

Basic Operations

CHASE, housed within HCPF, administers Colorado's hospital provider fee program. CHASE/HCPF staff draft program regulations and presents them to the CHASE Board for input, then the MSB promulgates regulations based on the CHASE Board's recommendations. These regulations govern program design and operations, including hospital data reporting requirements, fees and assessments calculation methodology and program timing.

Ideally, establishing and approving the annual hospital provider fee model involves an iterative and collaborative process involving CHASE/HCPF staff, the CHASE Board and the MSB. The annual process typically follows five steps:

1. CHASE/HCPF staff and their consultants work with individual health systems and hospitals to collect, aggregate and verify data used to calculate fee assessments and supplemental payments.
2. CHASE/HCPF staff present a draft model to the CHASE Board for review and discussion.
3. CHASE Board votes on whether to refer model to the MSB.
4. CHASE/HCPF then presents the model to the MSB for official adoption. The MSB typically acts in alignment with CHASE Board recommendations.
5. CHASE/HCPF staff file an annual UPL demonstration with CMS to demonstrate that applicable Medicaid supplemental payments remain within federal UPL requirements.

Recent models have been developed and presented several months into the fiscal year, allowing the state to use more complete Medicaid utilization and expenditure data. The model for the fiscal year spanning Oct. 1, 2024 to Sept. 30, 2025 was not approved until September 2025. While this approach improves Medicaid data accuracy, it compresses the time available to the CHASE Board for review and engagement.

Until the CHASE model is finalized, HCPF makes interim fee and payments transactions based on the prior year's model. Once an approved model is in place, fees and payments are reconciled to the updated amounts and processed monthly via electronic funds transfer for the remainder of the year.

Annual data verification, model development and review processes are critically important and require transparency and collaboration between Colorado's hospitals, CHASE/HCPF staff, and the CHASE Board.

Revenue: Fees & Federal Match

As described in Section 1, federal law generally requires provider fees to be broad-based and uniformly imposed, although states may seek CMS approval for waivers of requirements if the fee remains generally redistributive and does not violate federal hold harmless rules. Federal changes under H.R. 1 further constrain states' ability to rely on new, increased, or modified provider fee arrangements.

Thanks to Colorado's CMS-approved waiver, certain hospitals are eligible for exemptions or discounted rates. Hospitals eligible for fee exemptions include:

- State-licensed psychiatric hospitals
- Medicare-certified long-term care hospitals
- State-licensed, Medicare-certified rehabilitation hospitals

High-volume Medicaid hospitals (defined as having at least 35,000 Medicaid patient days annually) and Essential Access Hospitals (defined as Critical Access Hospitals (CAH) or general hospitals in rural areas with 25 or fewer licensed beds) are eligible for discounted fees. In the 2024-25 program year, of 100 hospitals that participated in the hospital provider fee program, 15 were exempt from paying fees based on facility type and 38 paid a discounted fee amount, leaving 47 of 100 paying the full fee. (In Appendix B, CHA has provided a list of hospitals and indicated if they paid a full fee amount, a discounted fee amount or were exempt.)

During the 2024-25 program year, assessed fees totaled \$1.42 billion. The inpatient fee was set at \$521.40 per non-managed care day and \$116.64 per managed care day. The outpatient fee was established at 1.6940% of total outpatient charges. Overall, the inpatient fee generated 42.44% of the total fees collected, while the outpatient fee accounted for the remaining 57.56%.

In 2024-25, Colorado drew down \$4.2 billion in federal matching funds through the hospital provider fee program.²⁷

Colorado's Hospital Provider Fee: Historical Context & Recent Changes

From 2010–2025, the provider fee operated under an Upper Payment Limit (UPL) structure, which seeks to reduce Medicaid under-reimbursement by paying hospitals supplemental payments for Medicaid services to approach Medicare rates. While the program grew over that period, its structure remained largely unchanged. In April 2026, CMS approved a new SDP program to operate alongside the traditional UPL program. (See Section 2 for more detail.)

The CHASE Board reviewed HCPF's proposed 2025–26 hospital provider fee model, which includes the UPL and SDP components, concurrently with the drafting of this report. In this section we outline the mechanics of the model as it has historically operated and provide specific numbers from the 2024–25 model year to give the reader a sense of the program's scope and function.

The following page outlines the new SDP program and describes, to the best of our ability, how it is intended and expected to function. Implementation is expected to affect the revenue and expenditure trends highlighted in this section and result in hospitals being closer to costs for their Medicaid/uninsured costs through the CHASE program, depending on final implementation.

This section should be read in light of recent federal Medicaid financing changes under H.R. 1, which impose new constraints on provider fees and SDPs that materially affect states' long-term financing flexibility. These changes represent a structural shift in federal Medicaid financing policy, moving away from historical flexibility in provider fee and supplemental payment design and toward a more constrained and prescriptive framework.

New for 2025–26: Colorado's State Directed Payment (SDP) Component

Beginning in the 2025–26 program year, Colorado is adding an SDP component to the hospital provider fee program. The addition of an SDP component represents one of the most significant changes to Colorado's hospital provider fee program since its creation, expanding program activity beyond the traditional UPL framework into the managed care environment.

The SDP component is separate from the traditional UPL model which applies to fee-for-service supplemental payments and operates on the federal fiscal year (Oct. 1 to Sept. 30). The SDP component operates through Medicaid managed care on the state fiscal year (July 1–June 30).

The SDP component is designed to increase Medicaid managed care payments to hospitals based on Medicaid managed care volume and applicable classes. These payments are made through Medicaid managed care directed payments and are distinct from traditional UPL-based supplemental payments. Recent federal changes under H.R. 1 create a more prescriptive framework for Medicaid state directed payments and provider fees. For SDPs, H.R. 1 imposes new payment limits on certain arrangements beginning with rating periods on or after July 4, 2025, while

allowing temporary grandfathering for qualifying arrangements. H.R. 1 also restricts states' ability to increase or restructure provider fee financing over time, which may affect the non-federal share available to support directed payment programs. For Colorado, the long-term fiscal impact of the SDP component will depend on the approved payment methodology, the mix of provider fee revenue and IGT funding used for the non-federal share, available federal matching funds, and the application of federal SDP limits and phase-down rules over time.

The first year that SDP will be funded in Colorado is July 1, 2025 to June 30, 2026. Total new revenue (fee + match) will be: \$725M // Net benefit to hospitals (new revenue, less fees and IGT) is expected to be around \$457M.

The non-federal share for this program is expected to be financed through a combination of hospital provider fee revenue and IGTs.

Funding from the SDP component is expected to be distributed to hospitals through Medicaid managed care directed payments based on Medicaid managed care volume and hospital class-specific rates.

Table 2

UPL Program vs. SDP Program

	UPL Program	SDP Program
Fiscal Year	Federal (Oct. 1 – Sept. 30)	State (July 1 – June 30)
Payment Type	Fee-for-service	Managed care directed payments
Framework	Traditional UPL	New SDP structure
Start	2010	2025-26

Expenditures

Statute requires hospital provider fee revenue — which combines the hospital provider fee and the federal match — is allocated across several categories, including hospital supplemental payments, CHASE administrative expenses, Medicaid eligibility expansion and other statutory line items such as offset revenue loss, as reflected in Table 3.

Supplemental Payments

In total, hospital supplemental payments reached \$1.9 billion during the 2024-2025 program year, representing just under 34% of the \$5.5 billion in total CHASE expenditures. After subtracting the \$1.4 billion in CHASE fees paid by the hospitals, the net reimbursement to hospitals under the program was \$483.4 million as explained in Table 3.

These supplemental payments are allocated to hospitals using six payment types. All hospitals are eligible for inpatient and outpatient supplemental payments. However, the remaining four categories of supplemental payments are restricted to qualifying subsets of hospitals.

There are six categories of supplemental payments:

- 1. Inpatient Payments:** Calculated by multiplying Medicaid patient days by an adjustment factor. Hospitals are divided into 14 distinct adjustment groups to determine their specific inpatient supplemental payment rate.
- 2. Outpatient Payments:** Calculated by multiplying estimated Medicaid outpatient cost by an adjustment factor. Similar to the inpatient payments, hospitals are assigned to one of same 14 adjustment groups to establish their payment rate. The 14 adjustments groups are the same for inpatient and outpatient payments.
- 3. Rural Support Program:** Distributes a fixed pool of money evenly by dividing the total allocated amount by the number of qualified rural hospitals.
- 4. Essential Access Hospitals:** Distributes a fixed pool of money evenly by dividing the total allocated amount by the number of qualified Essential Access Hospitals.
- 5. Disproportionate Share Hospitals (DSH):** Benefits hospitals serving high volumes of low-income patients by allocating funds to hospitals that provide expanded charity care services and meet the federal obstetrics requirement. Hospitals must have estimated costs that exceed estimated payments to qualify. Hospitals that meet both requirements receive DSH funding based on their DSH category and uncompensated care costs.
- 6. Hospital Quality Incentive Program (HQIP):** Uses a value-based payment (VBP) methodology, where a hospital's payment is calculated as: Quality Points Awarded x Health First Colorado-Adjusted Discharges x Dollars per Adjusted Discharge Point. Adjusted discharges are a standardized measure that converts inpatient discharges into a metric that also reflects outpatient activity.

Table 3

FFY 2024–25 Hospital Provider Fee & Supplemental Payments

Item	Amount
Inpatient Fee	\$602,717,759
Outpatient Fee	\$817,300,474
Total CHASE Fee	\$1,420,018,233
Inpatient Supplemental Payment	\$838,141,038
Outpatient Supplemental Payment	\$634,701,759
Essential Access Supplemental Payment	\$26,000,004
Rural Support Supplemental Payment	\$11,999,997
Hospital Quality Incentive Supplemental Payment	\$126,882,385
Disproportionate Share Hospital Supplemental Payment	\$265,720,314
Total Supplemental Payments	\$1,903,445,497
Net Reimbursement to Hospitals	\$483,427,264

Source: 2026 CHASE Annual Report, Colorado Department of Healthcare Policy and Financing, Jan. 15, 2026, retrieved May 2026 from <https://hcpf.Colorado.gov/sites/hcpf/files/2026%20CHASE%20Annual%20Report%20%5BFINAL%5D.pdf>

CHASE Administration

Per statute, a portion of total CHASE revenue, which includes both the hospital provider fee and the federal match, can be used to fund HCPF's "actual administrative costs." These expenses must relate directly to managing CHASE activities, including the administrative costs for CHASE-funded Medicaid expansion populations.

By law, expenditures on administrative costs are limited to 3% of total CHASE expenditures.²⁸ In the 2024-25 fiscal year, CHASE administration accounted for over \$159 million. Most hospital provider fee administrative funds are spent on operational expenses for CHASE-funded Medicaid populations, including information technology, eligibility determination and client services, and utilization review. Only a small fraction of this administrative funding goes toward staffing to support CHASE operations. Specifically, just 0.22% of the total CHASE expenditure for the 2024-25 program year was used for the personal services costs of the full-time equivalent (FTE) staff who administer the program. The limited investment in staff support for the CHASE Board has proven challenging in recent years, as CHASE/HCPF staff often don't have capacity or resources to address critical issues in a timely or satisfactory manner. This is not to say that more funding for administrative activity is required, but rather that allocation of administrative funding should be evaluated to ensure the CHASE Board is fully supported and the work of running the program is handled effectively.

Medicaid Expansion

The original hospital provider fee statute from 2009 established the five Medicaid eligibility categories that could be funded with hospital provider fee revenue. In 2013, Colorado adopted the ACA Medicaid expansion, increasing FPL eligibility limits for two of these categories: parents of Medicaid-eligible children and adults without dependent children. The CHASE statute authorizes funding, subject to available revenue, for coverage and benefits for the following groups:

- Parents with incomes from 61% to 138% of FPL who have Medicaid-eligible children
- Children and pregnant individuals covered through CHP+ with incomes up to 250% of FPL
- Adults without dependent children with incomes up to 138% of FPL²⁹
- Adults and children living with disabilities who qualify for the Medicaid Buy-In Program with incomes up to 450% of FPL
- Children under age 19 are guaranteed 12 months of continuous eligibility regardless of family income changes

Table 4

Medicaid Population Benefits

Medicaid Population/Benefit Financed by HPF	Number*
Adults without dependent children with incomes up to 133% FPL	333,000
Parents with incomes ranging from 61% to 133% FPL	48,000
CHP+ children and pregnant people with incomes ranging from 206% to 250% FPL	31,000
Working adults with disabilities up to 450% FPL and children with disabilities up to 300% FPL	27,000
Additionally, hospital provider fee revenue finances the 12 months continuous eligibility benefit for children in Medicaid	

*Note: Numbers as of June 30, 2025

Source: HCPF's 2026 CHASE Annual Report, Jan. 15, 2026, retrieved on Aug. 24, 2026 from <https://hcpf.Colorado.gov/sites/hcpf/files/2026%20CHASE%20Annual%20Report%20%5BFINAL%5D.pdf>

In 2024-25, CHASE funded Medicaid and CHP+ coverage for 438,452 Coloradans³⁰—just over 34% of the state's total Medicaid population of 1,270,000. Of the \$5.5 billion of total expenditure in the 2024-25 CHASE program, \$3.57 billion (64%) went to health care services for CHASE-financed populations.

Of that \$3.57 billion spent on health care services, approximately 24% (just over \$847 million) went to hospitals for services rendered. The remaining 76% went to other Medicaid providers for services provided in non-hospital settings, including primary care clinics, behavioral health clinics and long-term care settings. In some cases, hospitals or health care systems also operate non-hospital

provider businesses, like primary care clinics, that benefit from this broader Medicaid spend.

As federal financing flexibility narrows, state-level policy decisions on program design, revenue allocation and Medicaid coverage priorities will increasingly influence the sustainability of Colorado's hospital provider fee program.

Table 5

SFY 2024–25 Hospital Provider Fee Expenditures

Item	Total Fund
Supplemental Payments	\$1,837,191,208
CHASE Administration	\$131,302,311
Expansion Populations	\$3,530,635,125
25.5-4-402.4(5)(b)(VIII)-Offset Revenue Loss	\$15,700,000
Total Expenditures	\$5,514,828,644

Source: HCPF's 2026 CHASE Annual Report, Jan. 15, 2026, retrieved on Aug. 24, 2026 from <https://hcpf.Colorado.gov/sites/hcpf/files/2026%20CHASE%20Annual%20Report%20%5BFINAL%5D.pdf>

An Evolving Program: Key Trends Over Time

The hospital provider fee program has grown and changed significantly since its inception. Below are key trends in revenue and expenditure through the 2024-25 program year that help to illustrate those changes.

A Note About the 2025–26 Program Year

2025–2026 is the first year that will include both the traditional UPL model and the new SDP program. Because the SDP model was not yet approved when this report was drafted, it is not reflected in this analysis. While the SDP program is a net benefit to hospitals as a group, these trends in the historic UPL program are concerning, particularly as the state prepares to implement H.R. 1 provisions (discussed further in Section 4).

Total Growth: Program Expenditures Have Grown More Than Eightfold Since the First Full Program Year While (1) Number of Patients Covered Has Increased Fourfold and (2) Hospital Benefit Has Remained Mostly Flat

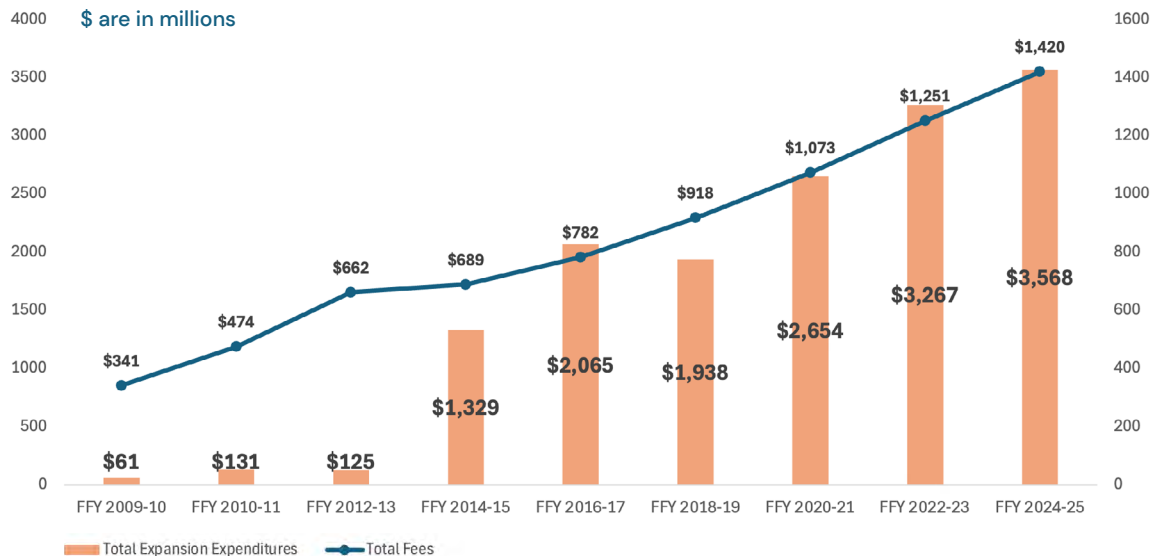
What started as a program with \$686 million in total expenditures in 2010, anticipated to finance Medicaid benefits for 100,000 Coloradans and supplemental payments to 83 hospitals, has grown to \$5.6 billion in total

expenditures in 2025, supporting Medicaid coverage for 438,000 Coloradans and supplemental payments to 100 hospitals.

The following chart shows the growth in total expenditures for CHASE-financed Medicaid populations (fee + federal match), from \$61 million in FFY 2009-10 to \$3.5 billion in 2024-25. Collected fees have grown from \$341 million to \$1.4 billion over the same period.

Figure 6

Hospital Provider Fee Program: Hospital Fees vs. Expenditures for Expansion



Source: CHA original analysis produced for this report, created from CHASE Board materials

Note: Chart includes first two years of the program and then every other year

Supplemental Payments Are Essential to Medicaid Financing — But Still Not Enough

Hospitals receive base Medicaid payments for services provided to Medicaid beneficiaries through fee-for-service and managed care arrangements. The General Fund and Amendment 35 tobacco tax revenue finance Medicaid costs, including provider reimbursement, for populations eligible for Medicaid before the hospital provider fee was established in 2009 — roughly 62% of Medicaid

populations.³¹ For CHASE-financed Medicaid populations — the five population categories authorized in statute, which represents approximately 38% of total Medicaid enrollment — CHASE revenue helps finance those base rate payments. Supplemental payments, also financed by the hospital provider fee, are paid on top of base rates. These supplemental payments make up 51% of total hospital reimbursement in Medicaid, as illustrated in the chart below.

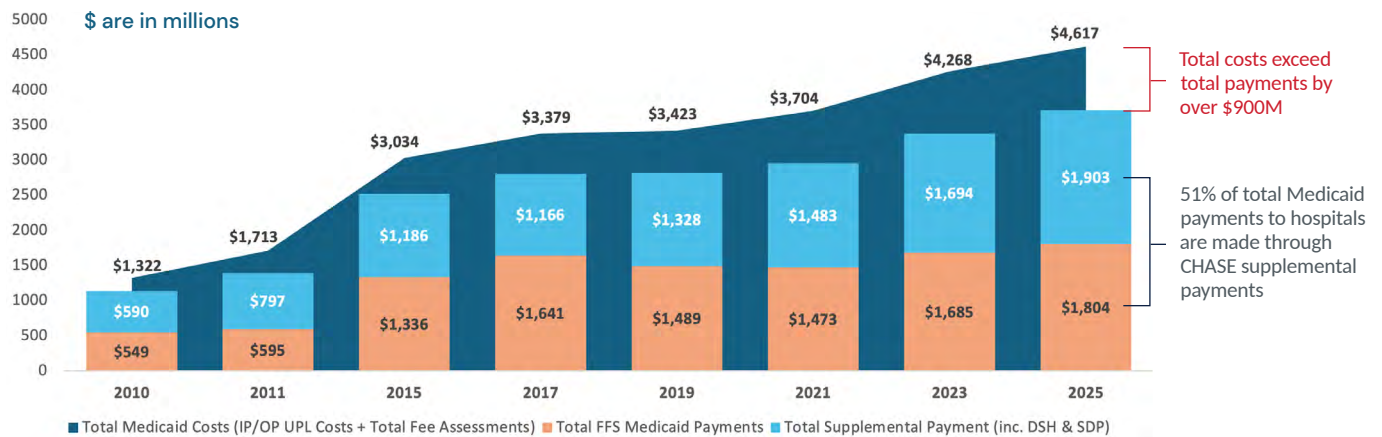
Colorado hospitals lose more than \$900 million per year treating Medicaid patients.³² Without CHASE-financed supplemental payments, hospitals would require significantly higher General Fund appropriations to cover base reimbursement rates. Without these supplemental payments or increased reimbursement rates, hospitals would be forced to close unsustainable service lines or shutter completely,

leaving all patients regardless of payor in need of essential health care services without a place to turn for care.

Since H.R. 1 limits the allowable financing mechanisms, Colorado likely needs to work within approved, available frameworks to ensure hospitals get reimbursed at rates that allow them to continue treating patients.

Figure 7

Hospital Costs & Payments for Medicaid Services



Source: CHA original analysis produced for this report, created from CHASE Board materials

Note: Chart includes first two years of the program and then every other year. Data for 2013 was not available.

Note: For this chart, Medicaid costs are calculated using the UPL calculations from the FFY 2025 CHASE model, before the Medicaid portion of fees is added for UPL purposes. Additionally, the full CHASE fee assessment is added to the costs. As the UPL calculation does not include all Medicaid costs (i.e., Medicaid managed care costs), it is reasonable to assume hospitals incur greater losses on services provided to Medicaid patients.

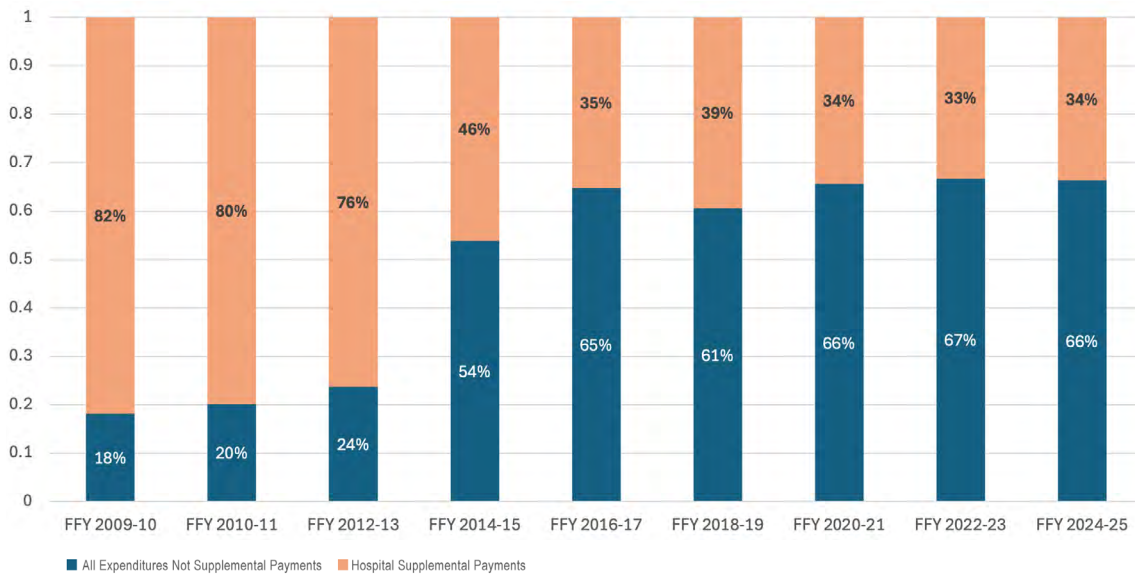
Revenue Allocation Has Shifted: A Greater Share of Revenue Now Supports Medicaid Coverage & Other Program Costs

When the hospital provider fee program was started, the majority (82%) of total revenue (fee + federal match) was used to finance supplemental payments to hospitals and just 18% went to all other priorities: Medicaid coverage, administrative expenses and general fund offset.³³

That changed after Colorado adopted the ACA Medicaid expansion, and has continued to shift as the costs of care have grown for Medicaid populations financed by the hospital provider fee. Now, almost two-thirds (66%) of hospital provider fee revenue supports Medicaid coverage, administration and other program costs, while just over one-third (34%) finances hospital supplemental payments.

Figure 8

Percent Share of Expenditures in the Hospital Provider Fee Program



Source: CHA original analysis produced for this report, created from CHASE Board materials

Note: Chart includes first two years of the program and then every other year

Medicaid Coverage Costs & Federal Limits on Hospital Provider Fee Increases

As the Medicaid population financed with hospital provider fee revenue grew and the costs associated with that population increased, hospitals have been required to pay more in fees to cover these groups. Further, a greater proportion of fee expenditures has been dedicated to Medicaid coverage costs. Federal Medicaid financing rules have historically allowed provider fee revenue at or below 6% of Net Patient Revenue (NPR) to qualify for the applicable safe-harbor threshold under the hold harmless framework. Colorado's hospital provider fee program is currently structured at or near that 6% threshold, meaning the state has limited flexibility to absorb additional Medicaid expenditure growth through provider fee increases.

H.R. 1 further restricts states' ability to increase existing provider fees, modify tax structures or establish new provider fees. H.R. 1 also reduces the current 6% NPR safe harbor threshold for ACA expansion states over time. H.R. 1 distinguishes between provider fees that were enacted and imposed as of July 4, 2025, and new or modified taxes adopted after that date. As a result, Colorado's existing hospital provider fee may have different federal treatment than future increases,

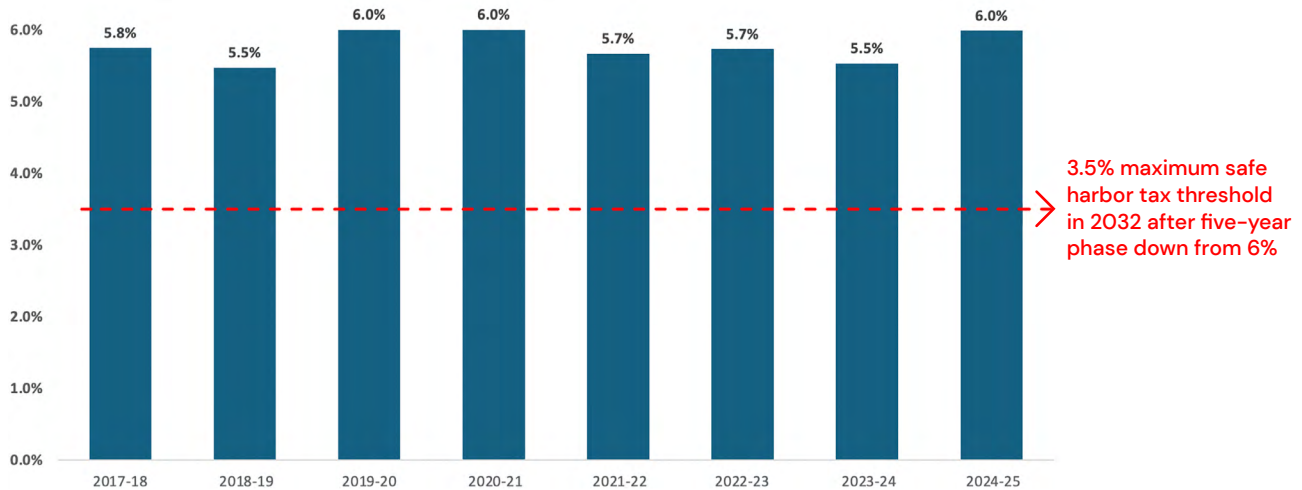
restructurings or new provider tax arrangements, further limiting the state's flexibility to finance future Medicaid cost growth through hospital provider fee changes. (See Section 4 for detail on how H.R. 1 affects Colorado's hospital provider fee.)

Total Dollars for Administration Have Grown Substantially As Program Has Grown

State statute limits administrative spending to 3% of total program size. HCPF has never exceeded the 3% administrative limit; in fact, they are usually below it, with administration being just under 2.4% of total program budget in 2024-25. However, as the total program size has grown, so have the total dollars available to support administration. As shown below, administrative spend has increased from \$7.5 million in FFY 2009-10 to \$159 million in FFY 2024-25 — an increase of roughly 2,000% in total dollars allocated to administration over this 15-year period, or approximately 22.5% annual growth. As noted above, the majority of this administrative spend is related to costs associated with administering benefits for the Medicaid populations financed with hospital provider fee funds, including information technology expenses, eligibility determination and client services, and utilization review services.

Figure 9

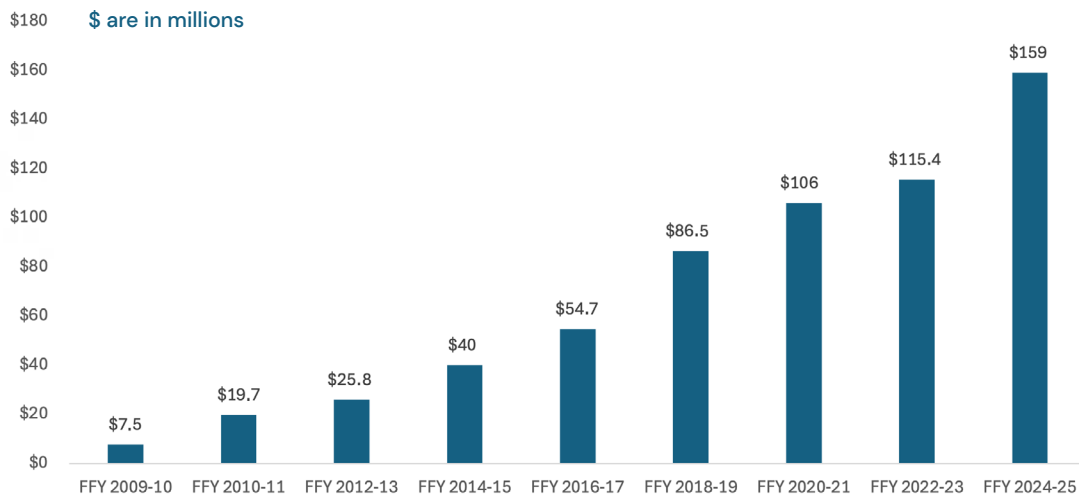
Hospital Fees as a Percent of Hospital Patient Revenue



Source: CHA original analysis produced for this report, created from CHASE Board materials

Figure 10

HCPF Administration Expenses Charged to the Hospital Provider Fee Program



Source: CHA original analysis produced for this report, created from CHASE Board materials

Note: Chart includes first two years of the program and then every other year

Amount of Fees Paid by Hospitals & Revenues Allocated to Medicaid Coverage & Administration Far Outpace Net Benefit to Hospitals

Over the last 10 years, provider fees paid into the program by hospitals increased 106%, but net payments to hospitals (supplemental payments less fees paid) increased just 13%, as shown in the chart below. Fees required to support Medicaid coverage for CHASE-financed populations increased 762% and administration increased 177%. Hospitals have been required to pay more in fees, primarily to fund increases in Medicaid coverage costs, not supplemental payments.

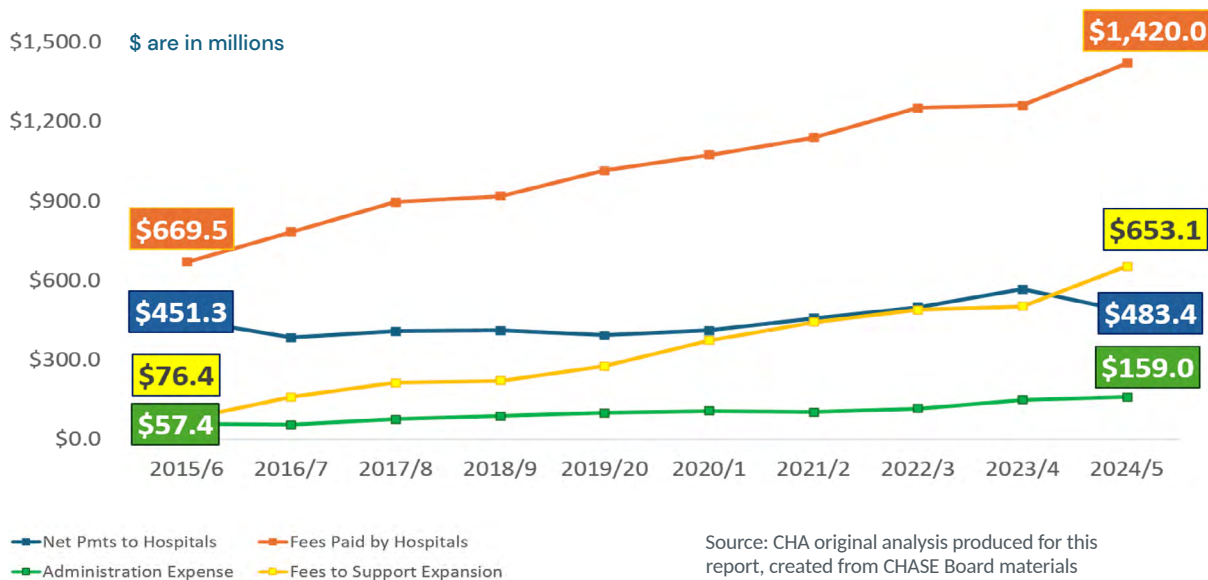
This trend illustrates a fundamental shift in the purpose of the hospital provider fee. While hospitals continue to finance the program through increasing fees, a progressively smaller share of total program growth is

returned to hospitals through supplemental payments. Instead, most new revenue has gone toward the growing cost of Medicaid coverage and program administration. As a result, the financial value of the program to hospitals has become increasingly constrained, raising important questions about its long-term sustainability and whether the current financing structure still aligns with the program's original policy objectives of a "win, win, win" framework at a time of rising hospital costs.

These trends are occurring at a time when federal policy changes are narrowing states' Medicaid financing options. As a result, understanding how Colorado's hospital provider fee program functions and how its revenue is allocated will be critical for policymakers evaluating future sustainability and access to care.

Figure 11

Hospital Provider Fee Program: 10-Year Summary



Section Conclusions

1. There are several policy choices reflected in modeling methodology decisions approved by the CHASE Board and the MSB. The annual modeling process, including CHASE Board review and approval and MSB adoption, is a critically important check and balance in administration of the program. Appointing knowledgeable and dedicated Coloradans to the CHASE Board and MSB and providing sufficient and appropriate support to ensure those boards can meaningfully fulfill their function is critically important to ensuring a strong program.
2. The hospital provider fee program is central to Colorado's Medicaid program. Many important constituencies directly benefit from the provider fee, including:
 - 438,452 Coloradans (more than one-third of the state's total Medicaid population) whose Medicaid or CHP+ coverage is financed through the provider fee.
 - Thousands of hospital and non-hospital Medicaid providers whose services are paid for with provider fee revenue. Of the \$3.537 billion of provider fee revenue spent on health care services for CHASE-financed Medicaid populations, 76% (\$2.6 billion) is paid for non-hospital Medicaid services provided in settings such as primary care, behavioral health clinics and long-term care. The remaining 24% (just over \$847 million) is paid for hospital services.
 - 100 hospitals receive supplemental payments which, together with base rate payments, help cover the cost of providing care to Medicaid beneficiaries.
3. Supplemental payments are an essential part of Colorado's Medicaid financing strategy, funding 51% of total payment to hospitals for care provided to Medicaid clients. Based on the methodology of this report, even with supplemental payments, total Medicaid reimbursement to hospitals remains more than \$900 million below the estimated cost of care. These supplemental payments are core components of Medicaid financing that play a critical role in preserving access to care, supporting hospitals that serve Medicaid patients and reducing pressure on the General Fund and other state share sources. Without adequate supplemental payments, hospitals will be forced to either cut services or close, which will threaten access to care for all Coloradans — not just Medicaid members.
4. Over the years, the share of hospital provider fee revenue dedicated to hospital supplemental payments has declined from 82% to 34% as Medicaid enrollment and associated coverage costs have grown.
5. Recent federal changes under H.R. 1 reduce states' long-term flexibility to finance Medicaid through provider fees and SDPs. Preserving sustainable financing tools will become increasingly important as Colorado evaluates future Medicaid funding needs.

Recommendations for Additional Reading

2024-25 Report to the Community, Colorado Department of Health Care Policy and Financing, retrieved June 2026: <https://hcpf.Colorado.gov/2025-report-to-community>.

2026 CHASE Annual Report (reflective of 2024-25 program year), Colorado Department of Health Care Policy and Financing, Jan. 15, 2026, retrieved May 2026: <https://hcpf.Colorado.gov/sites/hcpf/files/2026%20CHASE%20Annual%20Report%20%5BFINAL%5D.pdf>.

The CHASE Board operates in accordance with Colorado's public meeting laws. As such, HCPF maintains a dedicated webpage where you can access CHASE Board meeting materials. There are several useful resources relevant to hospital provider fee mechanics on this site: <https://hcpf.Colorado.gov/colorado-healthcare-affordability-and-sustainability-enterprise-chase-board>.

Colorado's Hospital Provider Fee: H.R. 1 Impacts

Section Summary

H.R. 1 fundamentally changes the federal policy environment that has supported state Medicaid financing for decades, requiring Colorado to prepare for a future with fewer financing tools, reduced federal funding, and greater pressure on both Medicaid coverage and hospital reimbursement. While the precise impacts will depend on future federal guidance, state policy decisions and economic conditions, the direction is clear: Colorado faces difficult choices that cannot be solved by preserving coverage or hospital funding in isolation. The modeling presented in this section demonstrates the urgency of proactive planning and reinforces the need for collaborative, balanced solutions that protect access to care, preserve the financial stability of hospitals and sustain Medicaid coverage for as many Coloradans as possible in an increasingly constrained fiscal environment.

A Changing Federal Landscape

H.R. 1 includes several Medicaid financing and eligibility provisions expected to significantly reduce federal Medicaid funding and materially affect state provider fee and SDP financing.

A large portion of these Medicaid spending cuts stem from key policy changes regarding how states implement Medicaid provider fees. Colorado-specific impacts are currently unclear.

- Provider Fee Freeze and Moratorium:** H.R. 1 uses July 4, 2025 as a key date for determining whether a provider fee was already enacted. After that date, the law significantly restricts states' ability to establish new provider fees or increase or restructure existing provider fees that were in place by that date, subject to applicable statutory effective dates, transition rules and future CMS implementation guidance.
- Safe Harbor Threshold Reduction:** Under current federal Medicaid financing rules, provider fees at or below 6% of net patient revenue have been treated as within the indirect hold harmless safe harbor. H.R. 1 phases down that safe harbor threshold for existing provider fees in Medicaid expansion states by 0.5 percentage points per year beginning in FFY 2028, until the threshold reaches 3.5% in 2032. The practical effect is to reduce the amount of provider fee revenue that ACA expansion states can use as non-federal share, which reduces the federal matching funds that may be drawn down using those revenues. This change applies to most Medicaid provider classes, including hospitals, but excludes nursing facilities and intermediate care facilities for individuals with I/DD. This policy is expected to impact provider fee programs in 31 states.

- **SDP Reductions:** H.R. 1 also imposes federal limits on Medicaid managed care SDPs. For certain non-grandfathered SDPs, the new limits apply beginning with rating periods on or after July 4, 2025, and cap total payment rates at 100% of Medicare rates in Medicaid expansion states and 110% of Medicare rates in non-expansion states. Certain eligible SDPs may qualify for temporary grandfathering, but grandfathered arrangements must be phased down by 10 percentage points annually, beginning with rating periods on or after Jan. 1, 2028, until they comply with the applicable Medicare-based payment limit. CMS has released proposed rulemaking to implement the H.R. 1 SDP payment-limit provisions, but implementation details remain subject to the final rule and any further CMS guidance.

New limits on provider fees will substantially reduce funding for Medicaid in Colorado, forcing significant program reductions. A 2025 HCPF analysis shows that the provider fee policy changes will cause annual losses between \$900 million and \$2.5 billion in federal funds, alongside a significant drop in provider fee revenue to the state.³⁴ H.R. 1 restricts SDPs by capping them at Medicare rate levels by 2028. Colorado anticipated using such payments to generate \$725 million (including \$446 million federal funds) in FFY 2025-26. Under H.R. 1 these amounts will be scaled down 10 percent yearly starting in FFY 2027-28.

Colorado's newly approved SDP is directly relevant to this analysis. CMS approved Colorado's SDP on April 24, 2026, for the July 1, 2025 through June 30, 2026 rating period, with a separate payment term amount of up to \$725,112,312. CMS preliminarily determined that the SDP likely qualifies for temporary grandfathering under Section 71116 but also stated that this determination is preliminary and subject to future rulemaking and enforcement. CMS further stated that, until the required phase down begins, the total dollar amount of a grandfathered SDP cannot increase through amendment or renewal. Accordingly, the model should separately account for: (1) the approved 2025-26 SDP amount, (2) any restriction on increasing that amount during the grandfathering period and (3) the phase-down, beginning with rating periods on or after Jan. 1, 2028.

In addition to the direct provider fee changes, H.R. 1 also changes Medicaid eligibility and enrollment rules. The law introduces stricter immigrant eligibility guidelines, mandates work and community engagement requirements, and implements tougher eligibility redetermination policies. Together, these measures are expected to substantially reduce overall Medicaid enrollment.³⁵ It is difficult to project the likely combined impact of these federal policies on Medicaid enrollment in Colorado, and, as such, HCPF has declined to publish specific estimates. However, the Urban Institute, a non-partisan economic and social policy research organization based in Washington, D.C., has estimated that between 95,000 and 108,000 Colorado adults are likely to lose Medicaid coverage due to the federal work requirement provision of H.R. 1 alone. Because Colorado's hospital provider fee program relies on hospital volume, payer mix, Medicaid utilization and Medicaid expenditure assumptions to calculate fees, supplemental payments and coverage-related expenditures, reductions in Medicaid enrollment could affect both sides of the program: the revenue available to support Medicaid financing and the costs associated with caring for Medicaid-covered populations.

H.R. 1 comes on the heels of Congress's decision not to extend the ACA premium tax credits, which supported the cost of insurance for Americans with incomes up to 400% FPL. While not part of H.R. 1, this concurrent policy change will also result in Americans losing health coverage and will likely increase uncompensated care costs for providers.

These policy changes will be implemented on varying timelines, leaving them subject to shifting political winds. Between July 2025, when H.R. 1 was signed, and 2032, when the provisions impacting Medicaid provider fees are set to be fully implemented, there will be four federal elections that could change the configuration of Congress or control of the Executive Branch. As a result, H.R. 1 provisions could be changed prior to implementation. However, these policies are current federal law and Colorado needs to plan for their full implementation.

A Financial Model to Inform Planning

In 2025, CHA built a financial model to explore how Colorado's hospital provider fee could change between 2028 and 2032 as H.R. 1 provisions take effect. The team developed this model strictly for exploration and learning purposes. The model includes several adjustable variables to allow users to explore various scenarios based on different assumptions. Because there are several variables and hundreds of possible outcomes, this model serves as an informational tool rather than a budgeting tool.

CHA staff built the model using publicly available data sets. Over a four-month period, the team used an iterative process to improve their work. They engaged hospital members and national experts in Medicaid financing to refine the tool. Analyzing the potential futures of this program requires understanding the key program components and variables. The following section describes how the model works and outlines the key conclusions from multiple rounds of funding scenarios.

Safe Harbor Threshold Step-Down

The model tracks the scheduled reduction in the federal provider fee safe harbor threshold applicable to existing provider fees in Medicaid expansion states. The phased step-down schedule is applied to each of the following FFYs:

- 2028: Decreases from 6% to 5.5% of NPR
- 2029: Decreases from 5.5% to 5% of NPR
- 2030: Decreases from 5% to 4.5% of NPR
- 2031: Decreases from 4.5% to 4% of NPR
- 2032: Decreases from 4% to 3.5% of NPR

NPR Factors

The model breaks NPR into separate inpatient and outpatient categories, allowing audiences to isolate different assumptions. The primary factors affecting these revenue categories include:

- Commercial insurance volume and reimbursement rates
- Medicare volume and payment rates
- Medicaid enrollment numbers and state rates

CHA's Financial Planning Model

CHA's financial model is a scenario-based planning tool with multiple adjustable assumptions. Because the model is designed for interactive exploration rather than budget forecasting, CHA is available to provide in-person briefings and live model demonstrations for policymakers and stakeholders interested in understanding potential outcomes.

To understand how the model calculates revenue into the program, analysts looked at two central fee assessment variables: the safe harbor threshold amount and NPR.

CHA established baseline numbers and trend lines for all these data points. Because these variables are fully adjustable, users can change the inputs to explore how different real-world scenarios might alter the programs financial performance.

Note: During the modeling period from December 2025 to March 2026, CMS was still reviewing Colorado's preprint submission to implement its SDP program. As such, the model was built to allow users to assume either SDP approval or rejection. Since CMS approved Colorado's SDP for the July 1, 2025-June 30, 2026 rating period, the model has been updated to include an SDP component. The estimates below reflect a Colorado program that includes both the traditional UPL-based fee-for-service (FFS) supplemental payment component and the newly approved managed care SDP component. Future SDP amounts, financing mechanisms, grandfathering treatment and phase-down requirements remain subject to federal limits, CMS guidance and state implementation decisions.

To complete the picture, the model balances revenue inputs with expenditures. This side of the ledger calculates how state funds are distributed and spent.

Hospital Supplemental Payments

The model measures money flowing out of the provider fee program through specific hospital payment streams. It isolates three critical spending variables:

- **Upper Payment Limit (UPL):** The model estimates Medicaid FFS hospital costs and subtracts Medicaid FFS base payments to estimate remaining room for UPL-based supplemental payments. This calculation is distinct from the managed care SDP component, which is subject to separate federal managed care rules and payment limits. Users can adjust the Medicaid cost trends and the FFS base rate variables to test different scenarios.
- **Disproportionate Share Hospital (DSH):** The model tracks these specific payments, which support facilities serving a high number of low-income patients. While most DSH cuts have been delayed in recent legislative actions, FFY 2028 could see a DSH reduction, so a variable has been included to model with and without that potential cut.
- **SDP:** This variable accounts for the federal reductions caused by H.R. 1, which lowers reimbursement limits by 10% each year toward the Medicare equivalent rate, and it accounts for the new federal SDP limits under H.R. 1. For non-grandfathered SDPs, applicable payment rate limits apply beginning with rating periods on or after July 4, 2025. For grandfathered SDPs, the model should reflect the temporary grandfathering period and the required phase-down beginning with rating periods on or after Jan. 1, 2028, while also allowing for future changes based on CMS rulemaking and guidance.

State Expenditures

In addition to supplemental payments, the hospital provider fee supports three other expenditure types:

1. **Medicaid Costs by Population Groups:** The model analyzes spending across the five Medicaid population groups financed by hospital provider fee. The model allows users to make varying assumptions about Medicaid cost trends, enrollment reductions and cost per member within each CHASE-financed population category.
2. **HCPF Administrative Spend:** This variable calculates what funding HCPF can allocate to administrative costs. While administrative spending is statutorily capped at 3%, users of the model can set the administrative spend at a lower level or adjust current growth trends.
3. **General Fund Offset:** The provider fee program has historically included a General Fund offset. This model allows users to set that at various numbers.

Current Colorado state law dictates how provider fee revenue must be spent. State statute requires that funding must first cover supplemental hospital payments and HCPF's actual administrative costs. After meeting those needs, any remaining revenue is then available to fund Medicaid coverage for specific populations. While changing the funding priority order in the future as a policy decision would expose the enterprise to legal risk, the CHA model allows users to evaluate the financial impacts of covering Medicaid costs for the five specific populations before hospitals receive supplemental payments.

Finally, the model attempts to quantify some of the cascading impacts to hospital finances outside the hospital provider fee program. Specifically, if Coloradans covered by Medicaid today lose their coverage due to new administrative policies in H.R. 1, many or most will likely be unable to afford private health insurance and will therefore become uninsured. The model estimates how the resulting increase in uninsured patients seeking care could affect hospitals' uncompensated care costs and overall revenue.

Observations from Modeling

After an iterative model refinement process and multiple rounds of modeling, CHA offers the following observations about likely impacts of H.R. 1:

- Time is of the essence:** If Colorado's Medicaid cost growth continues unchecked and H.R. 1 is fully implemented, hospital provider fee revenue (fee + federal match) will be insufficient to fully fund statutory priorities. Without a new funding source or drastic measures to reduce Medicaid spending, cuts may be required as soon as FFY 2027.
- Federally required reductions to the fee and resulting federal match will accumulate quickly, giving Colorado policymakers limited time to act. In FFY 2028, the 0.5% safe harbor threshold reduction translates to a \$118

million reduction in fees collected and up to \$820 million reduction in federal match. In FFY 2032, the 2.5% safe harbor threshold reduction translates to a \$588 million reduction in fees collection and up to a \$2.8 billion reduction in federal match.

- If Colorado does not replace the hospital provider fee revenue serving as non-federal share, cumulative cuts over five years will add up to \$11 billion in federal fund reductions in Colorado.
- Historically, states have been permitted to design their SDP programs with reimbursement rates allowable up to commercial rate equivalents. Starting in FFY 2028-29, there is a 10% per year reduction in SDP payment rates down to the Medicare rate equivalent. There are many outstanding questions as to how CMS will implement this reduction. However, Colorado's new SDP program was built with reimbursement rates well above the Medicare equivalent, so we anticipate significant reductions from the first year of Colorado's program — 2025-26. We estimate an additional \$800 million reduction in the first five years.
- Under current state statute, if revenue is insufficient to fund all provisions of the statute, the CHASE Board and MSB at HCPF are empowered to make decisions about cutting benefits or coverage to Medicaid populations financed by hospital provider fees.
- There is urgency for policymakers and stakeholders, particularly fee-paying hospitals, to start planning now for a sustainable future for this program.

We believe hospital and state interests are largely aligned.

Protecting access to care and coverage should be the goals. Maintaining a program that funds both supplemental payments to hospitals and a sustainable level of Medicaid coverage for as many Coloradans as possible is important for all program stakeholders.

- Supplemental payments account for 51% of Medicaid reimbursements to hospitals and are essential to ensuring hospital financial stability and patient access to care. Hospitals in rural Colorado are even more reliant on provider fees, with 68% of the state's Critical Access Hospitals' Medicaid reimbursement coming from CHASE supplemental payments. Rural hospitals that are not designated as CAHs receive 66% of their total Medicaid

reimbursement from supplemental payments.

- If supplemental payments were eliminated, the Medicaid under-reimbursement to hospitals would double from an estimated \$2 billion to approximately \$4 billion.³⁶ This would threaten the financial viability of hospitals across Colorado, particularly in rural communities.
- Medicaid coverage is a lifeline to low-income Coloradans. Without it, many would likely be uninsured, increasing uncompensated care in Colorado hospitals. Under some scenarios modeled, Colorado's total Medicaid population declined by 36%, increasing uncompensated care costs in Colorado hospitals more than 200%.
- Flipping the priority order in the statute to fund Medicaid populations ahead of hospital supplemental payments would be financially ruinous to hospitals and significantly reduce access to care for Coloradans. Similarly, preserving hospital supplemental payments as first priority while cutting Medicaid coverage for hundreds of thousands of Coloradans would generate \$1.6 billion in additional costs to hospitals for uninsured patient care — and up to three times that for other Medicaid providers.

Medicaid coverage costs are not sustainable: With declining revenue into the program, Colorado must determine how to better manage health care costs for Medicaid members to protect coverage for as many Coloradans as possible and preserve access to care through supplemental payments.

- Medicaid expenditure costs across hospital provider fee-financed populations have grown 750% over the last 10 years and 67% over the last five years.
- While health care costs are rising for all consumers, these hospital provider fee-financed Medicaid cost growth rates are substantially higher than other health care cost trends in Colorado. Using data from the HCPF 2026 CHASE Annual Report for comparison purposes, total Medicaid costs have grown 103% over the last 10 years and 34% in the last five years, while commercial health care costs have grown 55% over 10 years and 39% over five years.³⁷

- Not all hospital provider fee-financed Medicaid populations are financially equivalent. The populations included in the 2009 state statute but not included as part of ACA expansion — specifically the Medicaid disability buy-in to 450% FPL, the CHP+ expansion to 250% FPL and the 12 months continuous eligibility for children — receive a lower federal match rate, creating

a disproportionate reliance on provider fee revenue to finance them. Financing considerations alone should not determine policy choices for coverage of these populations and benefits. However, it is worth noting the financing variations among populations included in the hospital provider fee program.

Section Conclusions

1. H.R. 1 will have significant impacts on Colorado's Medicaid program broadly and the hospital provider fee specifically, through policies that limit provider fees and policies that reduce Medicaid enrollment.
2. With impacts beginning in FFY 2028, Colorado policymakers have a limited window to assess the situation and pursue policy changes to mitigate damages.
3. Policymakers should seek a nuanced solution that preserves a hospital provider fee program capable of funding both hospital supplemental payments and meaningful Medicaid coverage for as many Coloradans as possible.

Recommendations for Additional Reading

How New Limits on State Provider Taxes Will Affect Medicaid Funding, The Commonwealth Fund, Dec. 19, 2025, retrieved June 2026 from: <https://www.commonwealthfund.org/publications/explainer/2025/dec/how-new-limits-state-provider-taxes-will-affect-medicaid-funding>.

Five Key Facts About Medicaid and Provider Taxes, KFF, Dec. 1, 2025, retrieved June 2026 from: <https://www.kff.org/medicaid/5-key-facts-about-medicaid-and-provider-taxes/>.

H.R. 1 Provisions Impacting Colorado Medicaid: Presentation for Legislative Leadership, Colorado Department of Health Care Policy and Financing Staff, July 2025, retrieved June 2026 from: <https://hcpf.Colorado.gov/sites/hcpf/files/HR%201%20Presentation%20for%20Legislative%20Leadership%207.30.pdf>.

H.R. 1 Resources for Stakeholders, Providers and Partners, Colorado Department of Health Care Policy and Financing Website, accessed June 2026: <https://hcpf.Colorado.gov/hr1-resources>.

Fact Sheet: State-by-State Estimates of Medicaid Expansion Coverage Losses Under a Federal Work Requirement, April 14, 2025, Urban Institute, retrieved June 2026 from: <https://www.urban.org/research/publication/state-state-estimates-medicaid-expansion-coverage-losses-under-federal-work>.

CHA Priorities for Hospital Provider Fee Reform

Colorado's hospital provider fee program is approaching an inflection point. Longstanding structural challenges, coupled with impending federal Medicaid financing changes, require a thoughtful reassessment of how the program is designed, financed, and governed. Rather than preserving the status quo or pursuing isolated policy changes, CHA advocates for a collaborative, data-driven effort to modernize the program in a way that protects access to care, preserves hospital financial stability and sustains Medicaid coverage for as many Coloradans as possible. The priorities outlined in this section are intended to serve as a starting point for that conversation and to guide proactive policy discussions before fiscal pressures force more difficult choices.

The Hospital Provider Fee Program Has Evolved Significantly & Warrants Review

Since 2009, the hospital provider fee program has grown and evolved significantly without corresponding policy evaluation. The program is fragile today — even before implementation of H.R. 1 — and warrants review.

If Medicaid expenditure trends continue and federal reductions to provider fees called for in H.R. 1 are implemented, revenue within CHASE (hospital fees + federal match) will not be sufficient to fund all elements of the program (hospital supplemental payments, HCPF administration and CHASE-financed Medicaid coverage groups). Absent a new funding source (e.g. General Fund or a new dedicated tax or fee), program reductions will be required, potentially as soon as SFY 2028-29. CHA believes it is in our collective best interest to have a collaborative, constructive and proactive policy conversation about how to proceed, beginning as soon as possible.

CHA Seeks a Modernized Hospital Provider Fee Approach With the Following Building Blocks

- 1 An approach that **recognizes the hospital provider fee is just one component of the state's broader safety-net health care financing strategy** and seeks to reform the provider fee program as part of a broader effort to sustain safety-net health care financing in Colorado.
- 2 A hospital provider fee program that **continues the Colorado commitment of benefiting hospitals, low-income Coloradans and the state budget**, which CHA acknowledges could involve difficult choices as we work to shrink the overall program.
- 3 An approach that recognizes that hospital supplemental payments through Medicaid are a critical strategy for preserving essential health care infrastructure and access to care for all Coloradans. As such, CHA seeks a **provider fee program that protects hospital supplemental payments as the primary objective and first priority**.
- 4 **A model that values and seeks to preserve Medicaid coverage for as many Coloradans as possible.** Recognizing that it is unlikely Colorado will be able to sustain all Medicaid benefits for all expansion populations currently funded, CHA supports coverage reforms that protect basic coverage for the greatest number of Coloradans and prioritizes efficient use of federal matching dollars.
- 5 **A model that optimizes funding opportunities for Medicaid.** CHA seeks a provider fee program that assertively captures available federal funding in responsible and smart ways and considers strategies to grow General Fund support for Medicaid.
- 6 **A model that supports an efficient, effective Medicaid program with appropriate cost controls for benefits and administration.** CHA supports efforts to reduce cost growth to a reasonable level for both Medicaid benefits and administration.
- 7 **An administrative structure that ensures the CHASE Board and the MSB have sufficient support** to fulfill statutory obligations for oversight and accountability.

CHA Proposes a Working Group or Collaborative to Shape Hospital Provider Fee Policy Within CHASE

The process must be grounded in facts and data and built around clear-eyed assessments of what is likely coming in terms of federal policy changes. Shared priorities and values, such as those identified above, should guide this work. Input from multiple perspectives should be sought and valued as part of this effort, including but not limited to the following stakeholders:

- Members of the CHASE Board
- Current HCPF leadership and the governor's budget office
- Gubernatorial candidates and their health policy advisors
- Key legislators and legislative staff
- Medicaid stakeholders

Barring any significant federal activity to delay or repeal the provisions of H.R. 1 following the 2026 mid-term federal elections, CHA believes legislative action to reform the CHASE statute is likely needed as soon as the 2027 legislative session. As such, CHA urges preparatory work to begin as soon as possible, and the Association stands ready to engage.

CHA Recommends Policy Scope & Focus Areas

CHA has conducted meaningful analysis to inform a collaborative policy process and can offer specific policy options to shape constructive conversation about the future of the program. Specifically, CHA believes that the scope and focus of this policy work should include:

- 1 Opportunities to optimize Medicaid funding
- 2 Options to reduce health care spending for CHASE-financed Medicaid populations
- 3 Strategies to preserve the fee and enterprise structure to protect the state's General Fund
- 4 Approaches to strengthen governance and ensure efficient administration

Across Colorado, hospitals are essential service providers, economic engines and community cornerstones. They play a critical role in the success of our state. As such, Colorado's hospital community looks forward to being a constructive part of the important discussions to come about the future of Medicaid financing in Colorado.

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APPENDIX A

Glossary

Glossary

Colorado's Medicaid program is a complex partnership between the federal government, the State of Colorado, hospitals, health care providers and community organizations. This guide defines key Medicaid terms and financing concepts in the order they fit together within Colorado's health care system. Terms and concepts are grouped by topic to explain how Medicaid is financed, how hospitals are paid and how policies affect access to care across Colorado. Many of the terms and concepts are connected, and understanding one often informs the next.

Foundational Concepts		
Term	Definition	Importance
Medicaid	A joint federal-state health insurance program that provides health care coverage to eligible low-income children, pregnant people, older adults, people with disabilities and other qualifying populations. In Colorado, Medicaid operates as Health First Colorado and is administered by the Colorado Department of Health Care Policy and Financing (HCPF).	Medicaid covers more than one in five Coloradans and is the state's largest public health coverage program. It is a major source of funding for hospitals and other, non-hospital health care providers. Nationally, Medicaid accounts for roughly 18%-20% of total health care spending. It is one of the largest single payers in the country, alongside private health insurance (which represents about 30%) and Medicare (about 21%).
Medicare	The federal health insurance program primarily serving adults 65 and older and certain younger individuals with disabilities.	Hospitals care for patients covered by both Medicare and Medicaid, but the two programs serve different populations and have different financing, payment and oversight structures.
Affordable Care Act (ACA)	Federal law enacted in 2010 that expanded health insurance coverage through insurance marketplaces, consumer protections and the option for states to expand Medicaid eligibility.	Colorado opted into the ACA Medicaid expansion in 2014, using hospital provider fee revenue to finance the state's share of expansion costs and significantly reducing the number of uninsured Coloradans.
Medicaid Expansion	Extends Medicaid eligibility to adults with incomes up to 138% of the Federal Poverty Level (FPL).	Expansion increased health insurance coverage and access to preventive, behavioral health and hospital care throughout Colorado.
Medicaid Populations	Colorado Medicaid serves multiple eligibility groups, including children, pregnant women, older adults, people with disabilities, expansion adults and participants in the Disability Buy-In program.	Different eligibility groups may receive different benefits and federal matching rates, affecting Medicaid financing and program costs.
Disability Buy-In	Allows working adults with disabilities whose income exceeds traditional Medicaid limits to maintain Medicaid coverage.	Supports employment while preserving access to needed health care services. Not typically offered by private insurance.
Federal Medical Assistance Percentage (FMAP)	The percentage of Medicaid costs paid by the federal government. Non-federal share can be financed from multiple sources, including provider fees.	Federal matching allows every qualifying state Medicaid dollar to leverage additional federal funding.

Hospitals as Financing Partners		
Term	Definition	Importance
Colorado Healthcare Affordability and Sustainability Enterprise (CHASE)	The enterprise responsible for administering Colorado's hospital provider fee program and other Medicaid-related health care fees	Oversees how provider fee revenue supports Medicaid financing, supplemental payments and health care affordability initiatives.
Net Patient Revenue Safe Harbor Limit	The federal limit governing the maximum provider fee that may be assessed, expressed as a percentage of hospitals' net patient revenue.	Colorado currently operates at the federal safe harbor limit, limiting the state's ability to increase provider fee revenue under the current methodology.
CHASE Board	The governing board that reviews provider fee policies and recommends implementation decisions to the MSB.	Provides oversight of one of Colorado's largest Medicaid financing programs.
Healthcare Affordability and Sustainability Fee (Hospital Provider Fee)	A hospital assessment that provides the state share needed to draw down additional federal Medicaid funding. Also known as the Hospital Provider Fee.	Supports Medicaid expansion, supplemental payments, rural hospitals and health care affordability initiatives. It is one of Colorado's primary Medicaid financing tools.
Intergovernmental Transfers (IGTs)	Transfers of public funds from local government entities (e.g., counties or hospital districts) to the state Medicaid agency.	Supports Medicaid expansion, supplemental payments, rural hospitals and health care affordability initiatives. It is an additional Colorado Medicaid financing tool.

Paying for Care: Medicaid Hospital Reimbursement		
Term	Definition	Importance
Base Payment	Standard Medicaid reimbursement hospitals receive for covered services.	Base payments often do not cover the full cost of providing care.
Medicaid Underfunding	The difference between Medicaid reimbursement and hospitals' actual cost of providing care.	Creates the need for supplemental payment programs to reduce payment shortfalls and preserve access to care.
Supplemental Payments	Additional Medicaid payments made outside standard reimbursement methodologies.	Help improve hospital reimbursement and reduce Medicaid underpayment.
Upper Payment Limit (UPL)	Federal limit on certain Medicaid hospital payments based on what Medicare would have paid for comparable services.	Establishes the maximum amount of certain supplemental Medicaid payments.
State Directed Payment Programs (SDPs)	CMS-approved payment arrangements directing managed care organizations to make additional payments supporting quality, access and provider sustainability.	Increasingly important for strengthening Medicaid reimbursement while complying with federal requirements.
Medicaid Disproportionate Share Hospital (DSH) Payments	Federal Medicaid payments supporting hospitals that serve large numbers of Medicaid and uninsured patients.	Help offset uncompensated care and Medicaid payment shortfalls.
Sustainable Margin	A hospital's ability to maintain positive operating performance while meeting community needs.	Enables hospitals to recruit staff, replace equipment, invest in technology, respond to emergencies and maintain essential services.

Hospitals' Community Responsibilities		
Term	Definition	Importance
Emergency Medical Treatment and Labor Act (EMTALA)	Federal law requiring hospitals with emergency departments to evaluate and stabilize anyone seeking emergency care regardless of insurance status or ability to pay.	Makes hospitals the health care safety net and reinforces the importance of sustainable Medicaid financing.
Charity Care	Free or discounted medically necessary care provided to patients unable to pay.	Hospitals receive little or no reimbursement for charity care, making sustainable financing essential to maintaining access.

Program Governance		
Term	Definition	Importance
Centers for Medicare & Medicaid Services (CMS)	Federal agency administering Medicare and overseeing state Medicaid programs.	Approves provider fees, SDPs and other Medicaid financing mechanisms.
Medical Services Board (MSB)	Colorado Medicaid's rulemaking body.	Adopts regulations governing Medicaid eligibility, benefits, reimbursement and CHASE operations
Colorado Department of Health Care Policy and Financing (HCPF)	State agency administering Health First Colorado, CHP+ and other public health care programs.	Oversees Medicaid operations, financing, provider reimbursement and implementation of state and federal Medicaid policy.

Federal Policy		
Term	Definition	Importance
H.R. 1, "The One Big Beautiful Bill" (OBBA)	Federal legislation that changes Medicaid financing rules, including provider fee and SDP Program requirements	Reduces states' financing flexibility and underscores the importance of sustainable Medicaid financing strategies in Colorado.

APPENDIX B

Hospitals Exempt From Fee Assessments in 2024-25 HPF

Hospitals Exempt From Fee Assessments in 2024-25 HPF*

Craig Hospital
Kindred Hospital — Aurora
Kindred Hospital — Denver
Northern Colorado
Long Term Acute Hospital
Northern Colorado
Rehabilitation Hospital
PAM Health Rehabilitation
Hospital of Greeley
PAM Rehabilitation Hospital
of Westminster
PAM Specialty Hospital of Denver
Rehabilitation Hospital
of Colorado Springs
Rehabilitation Hospital of Littleton
Reunion Rehabilitation
Hospital — Denver
Reunion Rehabilitation
Hospital — Inverness
Spalding Rehabilitation Hospital
Vibra Hospital of Denver
Vibra Rehabilitation Hospital of Denver

Hospital With Fee Assessment Discount 2024-25 HPF*

Animas Surgical Hospital
Arkansas Valley Regional Medical Center
Aspen Valley Hospital
Children's Hospital Anschutz
Conejos County Hospital
Denver Health Medical Center
East Morgan County Hospital
Estes Park Health
Family Health West
Grand River Health
Gunnison Valley Health
Haxtun Health
Heart of the Rockies
Regional Medical Center

Keefe Memorial Hospital
Kit Carson County Memorial Hospital
Lincoln Community Hospital
Melissa Memorial Hospital
Memorial Hospital
Middle Park Medical Center
Mt. San Rafael Hospital
Pagosa Springs Medical Center
Pikes Peak Regional Hospital
Pioneers Medical Center
Prowers Medical Center
Rangely District Hospital
Rio Grande Hospital
Sedgwick County Health Center
Southeast Colorado Hospital
Southwest Health System
Spanish Peaks Regional Health Center
St. Thomas More Hospital
St. Vincent Hospital
Sterling Regional MedCenter
The Memorial Hospital
University of Colorado Hospital
Weisbrod Memorial County Hospital
Wray Community District Hospital
Yuma District Hospital

Hospitals Paying Full Fee Assessments in 2024-25 HPF*

Avista Adventist Hospital
Banner Fort Collins Medical Center
Broomfield Hospital
Castle Rock Adventist Hospital
Children's Hospital Colorado Springs
Community Hospital
Delta County Memorial Hospital
Foothills Hospital
Grandview Hospital
Greeley Hospital
HCA HealthONE Aurora Hospital

HCA HealthONE Mountain Ridge Hospital
HCA HealthONE
Presbyterian St. Luke's Hospital
HCA HealthONE Rose Hospital
HCA HealthONE Sky Ridge Hospital
HCA HealthONE Swedish Hospital
Highlands Ranch Hospital
Intermountain Health
Good Samaritan Hospital
Intermountain Health Lutheran Hospital
Intermountain Health Platte Valley Hospital
Intermountain Health Saint Joseph Hospital
Intermountain Health
St. Mary's Regional Hospital
Littleton Adventist Hospital
Longmont United Hospital
Longs Peak Hospital
McKee Medical Center
Medical Center of the Rockies
Mercy Hospital
Montrose Regional Health
National Jewish Health
North Colorado Medical Center
OrthoColorado Hospital
Parker Adventist Hospital
Parkview Medical Center
Penrose-St. Francis Hospital
Porter Adventist Hospital
Poudre Valley Hospital
San Luis Valley Health Regional Medical Center
St. Anthony Hospital
St. Anthony North Hospital
St. Anthony Summit Hospital
St. Elizabeth Hospital
St. Francis Hospital - Interquest
St. Mary-Corwin Hospital
Vail Health Hospital
Valley View Hospital
Yampa Valley Medical Center

**In June 2025, HCPF submitted a new fee waiver to CMS, included in this fee waiver were changes to hospitals receiving fee discounts beginning in the 2025-26 HPF program.*

APPENDIX C

C.R.S. 25.5-4-402.4