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Health First Colorado in 2026:
The Impact of Federal Changes on Medicaid and Actions for State Policymakers

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KEY TAKEAWAYS

Major federal policy changes in H.R. 1 created unprecedented administrative and coverage challenges for Colorado's Medicaid program. These changes and funding cuts, combined with rising costs and a constrained state budget, will increase administrative burden and are projected to cause coverage losses.

Key challenges for Colorado include:

- new federal work requirements and more frequent eligibility checks
- federal funding cuts amid rising costs
- new eligibility restrictions for immigrants
- rising demand and costs for long-term services and supports
- growing risks to children's and families' access to care

Targeted policy actions could help Colorado address these challenges, such as:

- improving eligibility systems and outreach
- expanding value-based and pediatric-focused payment models
- supporting alternative coverage options for immigrants
- strengthening community-based long-term services and supports (LTSS) options
- prioritizing retention and care access for children and families

The One Big Beautiful Bill Act (H.R. 1) introduced the most significant changes to the Medicaid program since the Affordable Care Act.

These changes, along with other longstanding challenges in the Medicaid program, create new complexities in the financing, eligibility, and service delivery of Medicaid services for more than 70 million Americans, including 1.2 million Coloradans. In this brief, we highlight five of the most pressing challenges for Health First Colorado in 2026 and examples of actions to address these challenges to best support Medicaid while implementing the changes of H.R. 1.

Five Pressing Challenges for Colorado in 2026

Work requirements and more frequent eligibility checks

Budget cuts and rising costs

Restrictions on eligibility for immigrants

Strain on long-term services and supports

Access to care for children and families

CHALLENGE #1

Preparing for the introduction of work requirements and more frequent eligibility checks.

Starting in 2027, states will be required to verify that members of the expansion population completed 80 hours of work, education, or volunteer activities in a month. Only Arkansas and Georgia have previously experimented with work requirements; in both states, Medicaid enrollment was lower than expected after the introduction of the requirements and member understanding of the requirements was limited.[1,2] Additionally, states will need to recertify these members' eligibility every six months instead of annually, doubling the administrative workload for renewals of expansion adults. These changes represent a notable increase in the administrative complexity of Medicaid applications and renewals for states. In a recent survey of Medicaid budget officials, nearly all states named the implementation of these (and other) H.R. 1 provisions as a significant challenge.[3]

In Colorado, an estimated 377,000 (31%) members will be subject to work requirements or exemption reporting; around 100,000 of those members are expected to lose coverage.[4] The Department of Health Care Policy and Financing (HCPF) estimates work requirements and more frequent eligibility costs will cost the department $57 million in administrative costs, further taxing an already stretched budget.[4] Additionally, recent CMS guidance indicates states will have to begin beneficiary outreach about these new requirements no later than September 2026,[5] leaving Colorado little time to design and implement the systems necessary to reach beneficiaries effectively.

Policy Actions

Learn from states' experiences in the Medicaid "unwinding" to minimize coverage losses. During the COVID-19 public health emergency, states were prevented from disenrolling members from Medicaid. When the emergency ended in May 2023, Congress required states to begin the process of recertifying Medicaid eligibility for all members. As part of this process, states developed innovative methods to assess Medicaid eligibility. Colorado could take inspiration from these states to limit unnecessary coverage losses.

Utilize the implementation of work requirements to develop more timely and efficient eligibility systems. "Churn" is prominent within Medicaid. When members are disenrolled and then re-enrolled within a short period of time, it indicates they were likely eligible for throughout that period. For example, in 2021, 8% of Medicaid beneficiaries disenrolled and re-enrolled within a year.[6] While implementing work requirements will be challenging, it affords Colorado the opportunity to redesign eligibility systems to be more timely and efficient overall, including making use of all available data sources. Greater integration between Colorado Peak (CO's social services application platform) and income, wage, and education data could facilitate these efforts.

Medicaid unwinding "success" stories

Many states adopted innovative strategies to minimize unnecessary coverage loss during the Medicaid unwind. Examples that could be replicated in the context of H.R. 1 include:

Ex parte renewals: Many states were successful at processing large proportions of renewals via "ex parte" processes, meaning the process was completed without member action via existing information (e.g. connecting with existing sources of income data to automatically determine eligibility).[7]

Targeted beneficiary outreach: Louisiana and Maine made individual calls and texts to those who had not completed the re-eligibility determination and provided tailored instructions to those they were able to reach.[8]

Innovative coverage mechanisms: North Carolina placed some disenrolled members on the family planning Medicaid benefit, which has more generous eligibility limits than traditional Medicaid. Doing so "kept them in the system," which allowed the state to more quickly integrate them back into traditional Medicaid if they became re-eligible.[9]

CHALLENGE #2

Federal cuts, rising costs, and budget strains

H.R. 1 cuts nearly a trillion dollars in federal Medicaid spending over the next decade, including a decrease of $12 billion to Colorado. The state will struggle to fill this deficit without reducing Medicaid eligibility, benefits, or provider rates.

Some of the largest cuts will come from H.R. 1's changes to provider taxes. Currently, all states except for Alaska use provider taxes to finance part of their Medicaid program. Starting in Fiscal Year 2028, the maximum provider tax rate will progressively decrease from the current max of 6% to 3.5%.[10] In total, this provision is expected to result in a $191 billion reduction in federal funding, and HCPF is projecting an annual decrease of $900 million to $2.5 billion in federal funding by 2032.[4]

These cuts come in the context of Medicaid cost increases and a strained Colorado state budget. In recent years, Colorado Medicaid spending has increased by an average of 8.8% per year.[11] This challenge is not unique to Colorado; many states cite growing Medicaid cost growth as a significant challenge in balancing state budgets while continuing to provide the same Medicaid benefits.[3] However, the Taxpayer Bill of Rights (TABOR) makes this challenge particularly salient for Colorado. Medicaid spending growth is well above TABOR's typical growth cap of 3-4%, and TABOR limits the state's ability to implement new taxes to cover HCPF's costs without voter approval.

Policy Actions

Design new payment mechanisms to support overall health while lowering health care costs. The goal of value-based payment (VBP) in health care is to lower overall costs while maintaining or improving quality. Often, these payment models reward providers for improving overall health (via functions such as care coordination and integrating behavioral health) while avoiding costly events such as hospitalizations. While Colorado is already a leader in VBP within Medicaid, the state could strengthen and grow these models in the future, drawing on experience from current programs and inspiration from other states.

Prioritize supporting the primary care system when determining budgets and reimbursement rates. Primary care is the backbone of a well-functioning health care system. High-quality primary care helps patients manage chronic conditions, prevents costly hospitalizations and emergency department (ED) visits, and promotes long-term health. These services are likely particularly important for Medicaid recipients, who report worse health status than those insured by other payers.

State Alternative Payment Models to Support Overall Health

State Medicaid programs are increasingly experimenting with new payment models that promote overall better health, while controlling total costs of care. Some examples include:

Colorado's Accountable Care Collaborative (ACC) Phase III: In Colorado, the ACC is Medicaid's primary delivery mechanism.[12] Regional Accountable Entities are responsible for administering the capitated behavioral health benefit, establishing and supporting networks of providers and coordinating medical and community-based services for their members.

Oregon's Coordinated Care Organizations (CCOs): Similar to Accountable Care Organizations, Oregon's CCOs are accountable for access, quality, and spending for their Medicaid enrollees.[13] Members served by these CCOs report better access to care and better quality care.[14]

North Carolina's Healthy Opportunities Pilots (HOP): This pilot program tested the impact of providing non-medical interventions to Medicaid enrollees.[15] The pilots used Medicaid funding to provide social needs related services for five years in housing, transportation, food, interpersonal safety, and toxic stress. Recent research indicates the program reduced total Medicaid spending and emergency department visits.[16]

CHALLENGE #3

Restrictions on Medicaid eligibility and benefits for lawfully present immigrants

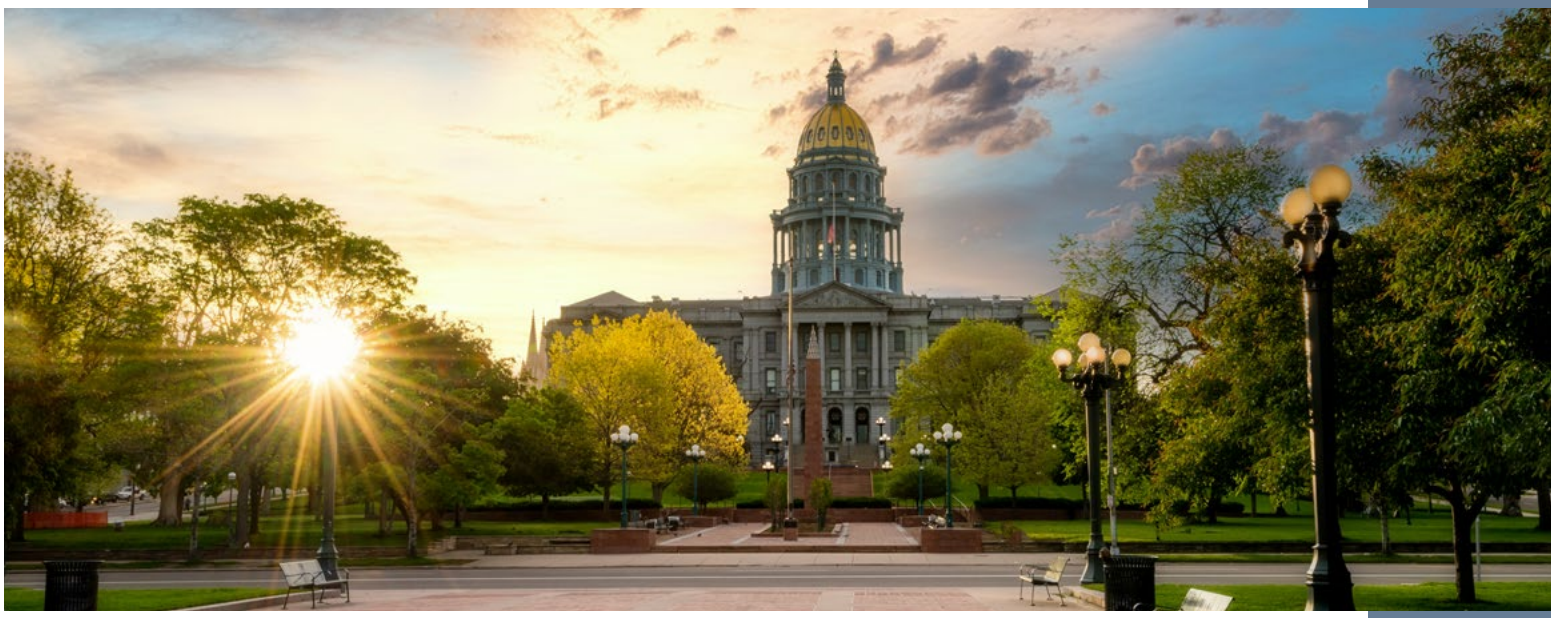
H.R. 1 changes which categories of lawfully present immigrants are eligible for traditional Medicaid coverage and emergency Medicaid. Starting in October 2026, most refugees, asylees, and DACA (Deferred Action for Childhood Arrivals) recipients will no longer be eligible for Medicaid or subsidies in the ACA Marketplace.[17] HCPF estimates that about 7,000 lawfully present immigrants in Colorado will lose Medicaid due to these changes.[4] These new limitations are in addition to Colorado's population of unauthorized immigrants, who were already prohibited from receiving Medicaid (around 200,000 people).[18]

Even lawfully present immigrants may feel apprehension around applying for Medicaid benefits or other social services given the recent activity by Immigration and Customs Enforcement (ICE). In July 2025, the Centers for Medicare and Medicaid Services reached an agreement with the Department of Homeland Security to allow ICE to access Medicaid enrollee data, including names and addresses.[19] Although Medicaid eligibility was already restricted to immigrants with legal status, applicants may be wary of providing Medicaid with the personal information necessary to process an application, especially in mixed immigration status households.

Policy Actions

Continue offering and funding alternative coverage options for these populations using state-only funding. In Colorado, OmniSalud provides undocumented immigrants an opportunity to purchase private health insurance via a secure platform, with some financial assistance available to help enrollees cover premiums and cost-sharing.[20] However, demand for this program has outpaced the state's availability to provide financial assistance slots for all applicants. In 2025, 12,000 financial assistance subsidies were available while only 7,000 are available in 2026.[21] Without additional funding, demand is likely to continue to exceed the supply of financial assistance subsidies, especially given the additional 7,000 immigrants expected to lose Medicaid coverage.

When possible, protect the privacy of information provided by immigrants and communicate these privacy measures to communities. While Colorado must follow federal data sharing requirements, the state could refuse voluntary data requests that threaten personal privacy. Additionally, providing full transparency around what data is required to be disclosed and continuing to communicate the data privacy safeguards in place for OmniSalud could help immigrants feel more comfortable applying for coverage.



CHALLENGE #4

Strain on long-term services and supports (LTSS)

Medicaid is the primary payer of long-term services and supports (LTSS), which are used by adults and children with disabilities, especially those needing medically complex care. LTSS include both Home and Community-Based Services (HCBS), which cover services like in-home assistance or day programs, and institutional care.

Costs for LTSS are growing faster than other parts of Medicaid. From 2021-2024, LTSS costs rose 44% in Colorado, and enrollment in these services increased by 11%.[22] These services also make up a large part of total Medicaid spending; in Colorado, only 4-5% of Medicaid members use LTSS, yet they account for 42% of total Medicaid spending.[23] This trend is only expected to worsen as the population ages.

While nursing home care is a mandatory Medicaid benefit, other LTSS benefits are optional, such as HCBS. States may choose to start cutting or eliminating these optional benefits to reduce costs in the context of the large, programmatic cuts introduced by H.R. 1. These benefits are not typically covered by other insurers (such as Medicare or employer-sponsored insurance) and are extremely expensive out-of-pocket, meaning those receiving these services may have no other viable option for coverage.

Policy Actions

Explore new payment models for LTSS. Some states are experimenting with new ways to pay for LTSS outside of the traditional Medicaid financial model. For example, in Washington State, the WA Cares fund is a public long-term care insurance program financed through worker payroll taxes.[24] Workers who contribute a mandatory 0.58% of their wages for at least 10 years can receive an annual long-term care benefit when they have a care need.

Prioritize the role of community-based settings in providing LTSS. LTSS provided in community-based settings are much less expensive than institutional care.[25] As Colorado continues to assess what changes need to be made to ensure budget stability, moving more care to community-based settings could decrease some cost concerns.

CHALLENGE #5

Access to care for children and families

While many components of H.R. 1 are targeted towards expansion adults, ripple effects of these changes may affect children and families. Researchers have documented the "welcome mat" effect of Medicaid, where coverage expansion in one group leads to increased coverage in already-eligible groups. H.R. 1 may lead to an "unwelcome mat" effect, where still-eligible children are disenrolled if their parents lose coverage. Parents may assume their children are no longer eligible for Medicaid if they are deemed ineligible, meaning they may not proceed with Medicaid renewals or applications. Some evidence points to this unwelcome mat effect in the context of the Medicaid unwind. Post Medicaid-unwinding, the uninsurance rate for Colorado children rose to its highest level since 2014 (6%).[26]

Additionally, the larger funding cuts to Medicaid, such as provider tax reductions, will affect all Medicaid enrollees, including children. Given that almost half of children in Colorado are insured by Medicaid, these cuts represent a threat to the ability of children to receive adequate and timely care. Children and families may especially struggle to access behavioral health and social support services, as these services are typically reimbursed at lower rates than physical health services, despite their importance to growth and development.

Policy Actions

Prioritize maintaining enrollment for children whose parents are at risk of disenrollment. Conducting outreach to these members to clarify that their children may still be eligible for Medicaid or CHIP (Children's Health Insurance Program), even if they are no longer eligible for coverage, could help Colorado retain coverage for children. Such outreach could include both targeted verbal (e.g. phone calls) and written communications, as well as broader community education efforts to help maximize retention for eligible enrollees.

Develop and implement pediatric-specific Alternative Payment Models (APMs). Most APMs are targeted at adult populations, meaning they may be less able to meaningfully improve care for children. Learning from pediatric-specific APMs, such as CMS' Integrated Care for Kids (InCK) Model, could help Colorado build models to support the integration of physical, behavioral, and social services for children.[27]

Medicaid in Colorado Facts and Figures

Health First Colorado covers

1 in 5 Coloradans

40% of Colorado's children[28]

Colorado Medicaid expansion led to

$4 Billion in economic activity

30,000+ new jobs[29]

36%

of Colorado's total state expenditures in 2023 were allocated to Medicaid; this proportion is growing over time[30]

Summary of Policy Actions

Challenge Area	Policy Actions
Preparing for the introduction of work requirements and more frequent eligibility checks	• Learn from states' experiences in the Medicaid "unwinding" to minimize coverage losses. • Utilize the implementation of work requirements to develop more timely and efficient eligibility systems.
Federal cuts, rising costs, and budget strains	• Design new payment mechanisms to support overall health while lowering health care costs. • Prioritize supporting the primary care system when determining budgets and reimbursement rates.
Restrictions on Medicaid eligibility and benefits for lawfully present immigrants	• Continue offering and funding alternative coverage options for these populations using state-only funding. • When possible, protect the privacy of information provided by immigrants and communicate these privacy measures to communities.
Strain on long-term services and supports (LTSS)	• Explore new payment models for LTSS. • Prioritize the role of community-based settings in providing LTSS.
Access to care for children and families	• Prioritize maintaining enrollment for children whose parents are at risk of disenrollment. • Develop and implement pediatric-specific APMs.

Conclusion

Health First Colorado faces a uniquely challenging time due to federal policy changes, longstanding increasing cost trends, and the state's balanced budget requirement. Maintaining the integrity of Medicaid through these challenges is critical, given the role it plays in providing health care to those most at risk. While policymakers will have to make difficult decisions on coverage, eligibility, and other factors, they can preserve Medicaid to the greatest extent possible.

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