

## **Table of Contents**

**State/Territory Name: Colorado**

**State Plan Amendment (SPA) #: 25-0039**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages

# CO - Submission Package - CO2025MS00060 - (CO-25-0039) - Administration

Summary Reviewable Units Versions Correspondence Log Analyst Notes **Approval Letter** Transaction Logs News Related Actions

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Medicaid and CHIP Operations Group  
601 E. 12th Street  
Room 355  
Kansas City, MO 64106



## Center for Medicaid & CHIP Services

June 25, 2026

Gretchen Hammer  
Executive Director  
Department of Health Care Policy & Financing  
303 E. 17th Avenue Ste 1100  
Denver, CO 80203

Re: Approval of State Plan Amendment CO-25-0039

Dear Gretchen Hammer,

On April 03, 2026, the Centers for Medicare and Medicaid Services (CMS) received Colorado State Plan Amendment (SPA) CO-25-0039 to update delegation of authority to conduct all fair hearings and issue certain final fair hearing decisions to the Office of Administrative Courts (OAC).

We approve Colorado State Plan Amendment (SPA) CO-25-0039 with an effective date(s) of July 01, 2026.

If you have any questions regarding this amendment, please contact Keri Rosenbloom at 312-353-1754 or [keri.toback@cms.hhs.gov](mailto:keri.toback@cms.hhs.gov).

Sincerely,

Nicole McKnight

Acting Director, Division of Program  
Operations

Center for Medicaid & CHIP Services

# CO - Submission Package - CO2025MS00060 - (CO-25-0039) - Administration

[Summary](#) [Reviewable Units](#) [Versions](#) [Correspondence Log](#) [Analyst Notes](#) [Approval Letter](#) [Transaction Logs](#) [News](#) [Related Actions](#)

## Submission - Summary

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

CMS-10434 OMB 0938-1188

### Package Header

<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	4/3/2026
<b>Approval Date</b>	06/25/2026	<b>Effective Date</b>	N/A
<b>Superseded SPA ID</b>	N/A		

### State Information

**State/Territory Name:** Colorado

**Medicaid Agency Name:** Department of Health Care Policy & Financing

### Submission Component

- State Plan Amendment
- Medicaid
- CHIP

## Submission - Summary

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

### Package Header

**Package ID** CO2025MS00060  
**Submission Type** Official  
**Approval Date** 06/25/2026  
**Superseded SPA ID** N/A

**SPA ID** CO-25-0039  
**Initial Submission Date** 4/3/2026  
**Effective Date** N/A

### SPA ID and Effective Date

**SPA ID** CO-25-0039

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Intergovernmental Cooperation Act Waivers	7/1/2026	CO-18-0037
Eligibility Determinations and Fair Hearings	7/1/2026	CO-18-0037
Organization and Administration	7/1/2026	CO-19-0026

# Submission - Summary

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

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<b>Superseded SPA ID</b>	N/A		

## Executive Summary

**Summary Description Including Goals and Objectives** Update delegation of authority to the Office of Administrative Courts (OAC). Updated delegation: OAC has authority to conduct fair hearings and issue final decisions for all types of hearings unless exceptions, request for transcripts, or request for extension to the Initial Decision are filed. HCPF may elect to perform a substantive review and issue final agency decision instead.

## Federal Budget Impact and Statute/Regulation Citation

### Federal Budget Impact

	Federal Fiscal Year	Amount
First	2026	\$0
Second	2027	\$0

### Federal Statute / Regulation Citation

31 U.S.C. § 6504

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

## Submission - Summary

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

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<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
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<b>Approval Date</b>	06/25/2026	<b>Effective Date</b>	N/A
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### Governor's Office Review

- No comment
- Comments received
- No response within 45 days
- Other

**Describe** Governor's letter dated 5 April 2023

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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# CO - Submission Package - CO2025MS00060 - (CO-25-0039) - Administration

Summary Reviewable Units Versions Correspondence Log **Analyst Notes** Approval Letter Transaction Logs News **Related Actions**

## Medicaid State Plan Administration

### Organization

### Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

CMS-10434 OMB 0938-1188

### Package Header

<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
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	System-Derived		

### A. Intergovernmental Cooperation Act Waivers

The state has the following Intergovernmental Cooperation Act Waivers:

#### View Waiver Office of Administrative Courts

**1. Name of state agency to which responsibility is delegated:**

Office of Administrative Courts

**2. Date waiver granted:**

5/25/1995

**3. The type of responsibility delegated is (check all that apply):**

- a. Conducting fair hearings
- b. Other

**4. The scope of the delegation (i.e. all fair hearings) includes:**

The delegation for conducting and issuing final decisions after fair hearing at the Office of Administrative Courts (OAC) is limited to provider appeals. Department of Administration, Division of Administrative Hearings, is the predecessor name of the Office of Administrative Courts. OAC is Colorado's centralized administrative court system and resides within the Department of Personnel and Administration (DPA). The state Medicaid agency retains the right to seek judicial reversal of OAC final decisions affecting providers when the final decision is not consistent with law or regulation. This arrangement ensures that provider appeals are processed in an impartial and expeditious manner, while preserving the State's right to challenge any decisions which are not consistent with law or regulations.

**5. Methods for coordinating responsibilities between the agencies include:**

- a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.
- b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.
- c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.
- d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.
- e. The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:
- i. A written agreement between the agencies.
  - ii. State statutory and/or regulatory provisions.

**Statutory/regulatory citation(s):**

10 CCR 2505-10 Sections 8.050 and 8.057; C.R.S. § 25.5-1-107 and C.R.S. § 25.5-4-207

**6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.**

Yes

No

The Medicaid agency only reviews fair hearing decisions issued by the delegated entity with respect to the proper application of federal and state law regulations and policies. The review process is conducted by an impartial official not involved in the initial determination.

**7. Additional methods for coordinating responsibilities among the agencies (optional):**

Both in Colorado's state law and in the approved waiver under section 6504 of the Intergovernmental Cooperation Act, the State Medicaid agency explicitly retains the right to challenge and seek reversal of final decisions from the Office of Administrative Courts on provider appeals when that final decision is not consistent with law or regulations.

**8. Date waiver terminated:**

Jun 30, 2026

## View Waiver Office of Administrative Courts

**1. Name of state agency to which responsibility is delegated:**

Office of Administrative Courts

**2. Date waiver granted:**

6/22/2026

**3. The type of responsibility delegated is (check all that apply):**

a. Conducting fair hearings

b. Other

**4. The scope of the delegation (i.e. all fair hearings) includes:**

The Department of Health Care Policy and Financing (DHCPF) delegates its authority to conduct fair hearings and issue final decisions to the Department of Personnel and Administration's Office of Administrative Courts (OAC). OAC's authority to conduct and issue final decisions is for all types of fair hearings but does not include expedited fair hearings, cases in which one of the parties has filed a timely request for an exception to an Initial Decision, a request for transcripts of the Initial Decision, or an extension of time to file exceptions with DHCPF's Office of Appeals. Additionally, this delegation does not apply where the DHCPF Office of Appeals elects, within the established timeframes, to perform a substantive review of an Initial Decision for which no exceptions have been filed. Parties have 20 days to file exceptions, a request for transcripts, or a request for an extension of time to file exceptions to the Initial Decision issued by OAC Administrative Law Judges (ALJs). An exception is a written filing seeking to reverse, modify, or remand the Initial Decision and must include the specific grounds for reversal, modification, or remand of the Initial Decision. If no exceptions, requests for transcripts, or requests for additional time to file exceptions are filed, the DHCPF Office of Appeals has ten (10) days to perform an administrative review of the Initial Decision and may elect to perform an additional substantive review of the Initial Decision and issue a Final Agency Decision. If no exceptions, requests for transcripts, or requests for extension of time to file exceptions are filed, and the Office of Appeals does not elect to perform a substantive review, the Initial Decision automatically becomes the Final Agency Decision thirty (30) calendar days after the mailing of the Initial Decision. The Final Agency Decision serves as the official final action of the Colorado single state agency for Medicaid.

**5. Methods for coordinating responsibilities between the agencies include:**

a. The Medicaid agency retains oversight of the state plan, as well as the development and issuance of all policies, rules and regulations on all program matters.

b. The Medicaid agency has established a process to monitor the entire appeals process, including the quality and accuracy of the hearing decisions made by the delegated entity.

c. The Medicaid agency informs every applicant and beneficiary in writing of the fair hearing process and how to directly contact and obtain information from the Medicaid agency.

d. The Medicaid agency ensures that the delegated entity complies with all applicable federal and state laws, rules, regulations, policies and guidance governing the Medicaid program.

e. The Medicaid agency has written authorization specifying the scope of the delegated authority and description of roles and responsibilities between itself and the delegated entity through:

i. A written agreement between the agencies.

ii. State statutory and/or regulatory provisions.

**Statutory/regulatory citation(s):**

10 CCR 2505-10, Sections 8.050 and 8.057; C.R.S. §§ 25.5-1-107 and 25.5-4-207

**6. The single state agency has established a review process whereby the agency reviews fair hearing decisions made by the delegated entity.**

Yes

No

The Medicaid agency only reviews fair hearing decisions issued by the delegated entity with respect to the proper application of federal and state law regulations and policies. The review process is conducted by an impartial official not involved in the initial determination.

**7. Additional methods for coordinating responsibilities among the agencies (optional):**

Before Initial Decisions that have no exceptions, requests for transcripts, or requests for extension of time to file exceptions convert to Final Agency Decisions under this process, they receive an administrative review by the Department's Office of Appeals. The administrative review checks the Initial Decision to ensure it includes findings of fact, conclusions of law, and an order granting or denying relief, and includes reviewing the Initial Decision for the proper application of federal and state law regulations and policies. After completing the administrative review, the Department's Office of Appeals may elect to perform a substantive review of the Initial Decision and issue a separate Final Agency Decision, rather than allow it to convert to a Final Agency Decision automatically.

# Intergovernmental Cooperation Act Waivers

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

## Package Header

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<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	4/3/2026
<b>Approval Date</b>	06/25/2026	<b>Effective Date</b>	7/1/2026
<b>Superseded SPA ID</b>	CO-18-0037		
	System-Derived		

## B. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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- Summary
- Reviewable Units
- Versions
- Correspondence Log
- Analyst Notes
- Approval Letter
- Transaction Logs
- News
- Related Actions

## Medicaid State Plan Administration

### Organization

### Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

CMS-10434 OMB 0938-1188

### Package Header

<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
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### A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- a. The Medicaid agency
- b. Delegated governmental agency
  - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - iii. Other

**Name of entity:**  
Denver Health and Hospital Authority

- c. Local governmental entities

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- a. The Medicaid agency
- b. Delegated governmental agency
  - i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - iii. The Social Security Administration determines Medicaid eligibility for:
    - (1) SSI beneficiaries
    - (2) Optional state supplement recipients
  - iv. Other

**Name of entity:**  
Denver Health and Hospital Authority

c. Local governmental entities

3. Assurances:

a. The Medicaid agency is responsible for all Medicaid eligibility determinations.

b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.

d. The delegated entity is capable of performing the delegated functions.

# Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

## Package Header

<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
<b>Submission Type</b>	Official	<b>Initial Submission Date</b>	4/3/2026
<b>Approval Date</b>	06/25/2026	<b>Effective Date</b>	7/1/2026
<b>Superseded SPA ID</b>	CO-18-0037		
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## B. Fair Hearings (including any delegations)

- The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.
  - The Medicaid agency is responsible for all Medicaid fair hearings.
1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:
- a. Medicaid agency
  - b. State agency to which fair hearing authority is delegated under an Intergovernmental Cooperation Act waiver.
  - c. Local governmental entities
  - d. Delegated governmental agency
3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):
- All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

# Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

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## C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- Yes  
 No

## D. Additional information (optional)

The State assures that it has addressed any potential conflict of interest that Denver Health and Hospital Authority may have when it is delegated the authority to determine Medicaid eligibility and provides ongoing oversight specific to this issue. Specifically, Denver Health and Hospital Authority eligibility staff are established as a separate and distinct unit, unrelated and independent of any provider's unit, staff or processes. The eligibility staff is separate from any staff responsible for billing or claims for services.

Agencies delegated by the State to perform Medicaid determinations must initially agree to contracted language that directs the agency on the appropriate actions required to avoid an actual, or the appearance of a perceived, conflict of interest. After entering into a contract with the State, a dedicated contract manager is assigned to the agency for the purposes of monitoring the agency's contractual compliance.

Oversight of the agency includes ongoing biweekly or monthly meetings to address issues such as potential process changes, client concerns, performance, and contract compliance. The contract manager also performs regular site visits, including no-notice visits to ensure the agency is meeting contractual expectations. The meetings and site visits conducted by the State, of the delegated agency, allows the State to address any identified processes or concerns that may present a conflict of interest.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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## Medicaid State Plan Administration

### Organization

#### Organization and Administration

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

CMS-10434 OMB 0938-1188

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### A. Description of the Organization and Functions of the Single State Agency

#### 1. The single state agency is:

- a. A stand-alone agency, separate from every other state agency
- b. Also the Title IV-A (TANF) agency
- c. Also the state health department
- d. Other:

**2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)**

#### a. Eligibility Determinations

The Colorado County Departments of Human/Social Services (counties) conduct Medicaid eligibility determinations. The Medicaid agency also delegates the authority to conduct eligibility determinations to Denver Health and Hospital Authority, and the Social Security Administration. The staff designated to make such determinations are the eligibility technicians hired by Denver Health and Hospital Authority and the Colorado County Departments of Human/Social Services to perform eligibility for Colorado State Medicaid programs. The Medicaid agency supervises the administration of the state plan by counties, including the counties' responsibility to conducting eligibility determinations. The counties and Denver Health and Hospital Authority accept applications and renewals, conduct, and determine eligibility for all Medicaid eligibility groups (MAGI and Non-MAGI populations). For Supplemental Security Income (SSI) recipients, the Social Security Administration determines Medicaid eligibility for SSI beneficiaries. The counties and Denver Health and Hospital Authority, under oversight of the State Medicaid agency, conduct final Medicaid eligibility determinations.

#### b. Fair Hearings (including expedited fair hearings)

An applicant or member may request an expedited hearing if the appeal involves an issue where the application of the standard timeframe for making a decision may seriously jeopardize the applicant/member's life, health, or ability to regain, attain, and maintain maximum function. The Office of Appeals must determine within 1 day whether the application of the standard timeframe for making decision may seriously jeopardize the applicant/member's life, health or ability to regain, attain, and maintain maximum function. If an expedited appeal is granted, a hearing must be scheduled no later than the end of the day after the decision to grant the hearing was made, and the hearing decision must be made by a three-person panel including the Executive Director, the Medicaid Director, and the Medical Director, or their designees. Final administrative action must be taken no later than 3 business days after the Office of Appeals received the request for an expedited fair hearing, except for expedited hearings concerning eligibility issues, for which final administrative action must be taken no later than 7 business days after the Office of Appeals receives the request. The hearing decision constitutes the Final Agency Decision (final administrative action) for purposes of requesting judicial review.

All fair hearings, except for expedited hearings, are conducted by Administrative Law Judges (ALJs) at the Office of Administrative Courts (OAC). OAC ALJs issue Initial Decisions and some of those decisions become Final Agency Decisions (FAD) in accordance with the state's Intergovernmental Cooperation Act Waiver.

The Office of Appeals resides in the Legal Division of the Department of Health Care Policy and Financing (DHCPF), and, as a designee of the Executive Director, substantively reviews Initial Decisions when one of the parties has filed a timely request for an exception to an Initial Decision, a request for transcripts of the Initial Decision, or an extension of time to file exceptions with DHCPF's Office of Appeals. Additionally, the DHCPF Office of Appeals conducts an administrative review of each Initial Decision to ensure it includes findings of fact, conclusions of law, and an order granting or denying relief; and to review for the proper application of federal and state law regulations and policies. Based on its administrative review, the DHCPF Office of Appeals may elect to perform a full substantive review of an Initial Decision for which no exceptions, requests for transcripts, or requests for extension to file exceptions have been filed.

When the DHCPF Office of Appeals substantively reviews an Initial Decision, the DHCPF Office of Appeals issues the Final Agency Decision (FAD). The FAD is based on substantive review of applicable laws and regulations; the record, which consists of the written transcript of testimony and exhibits; all papers and requests

filed in the OAC hearing; Initial Decision of the administrative law judge at OAC; and any exceptions and responses. The Office of Appeals' FAD affirms, modifies, or reverses the Initial Decision based upon the entire hearing record that was before the ALJ, plus any exceptions and responses. If any new material concerning matters related to findings of fact is discovered through the exception process, the Office of Appeals may remand the case back to the ALJ to consider the new evidence for findings of fact. The FAD serves as the official final action of the Colorado single state agency for Medicaid.

**c. Health Care Delivery, including benefits and services, managed care (if applicable)**

The Health Policy Office designs, implements, administers, monitors and improves Medicaid acute care and the Children's Basic Health Plan (CHP+) programs. The Office is made up of the Children and Families Division and the Policy and Benefits Delivery System Division.

The Pharmacy Office oversees access to medication for Medicaid fee-for-service and Medicare-Medicaid enrollees, and administers the Rx Review Program (drug therapy counseling sessions for Medicaid clients).

The Office of Community Living manages Colorado Medicaid's programs, services, and supports for older adults and persons with disabilities. The Office is working to transform the Long-Term Services and Supports system into a person-centered system that ensures responsiveness, flexibility, accountability, and person-centered supports for all eligible persons of Colorado. The Office is comprised of 5 divisions: Benefits and Services Management; Case Management and Quality Performance; Operations and Administration; Strategic Outcomes and Compliance & Innovation.

The Medicaid Operations Office includes the Eligibility Division, Provider and Fiscal Agent Division, Chief Client Officer, and Client Services Division. The Operations Office manages the client call center and provides oversight and contractual direction for the fiscal agent. The Office is working on customer service and operational excellence goals to improve client and provider satisfaction.

**d. Program and policy support including state plan, waivers, and demonstrations (if applicable)**

The Policy, Communications, and Administration Office manages Department functions associated with government affairs, communication and media relations, client services, legal affairs and internal operations. It provides leadership and guidance regarding external communication and relations, legal affairs, and organizational development. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press. The work of the Policy, Communication and Administration Office crosses the Department and facilitates and supports the work of all staff. The Office is comprised of the Legal Division, Communications, and the Government & Partner Relations Division.

**e. Administration, including budget, legal counsel**

The Policy, Communications, and Administration Office manages Department functions associated with government affairs, communication and media relations, client services, legal affairs and internal operations. It provides leadership and guidance regarding external communication and relations, legal affairs, and organizational development. Office staff represent the Department before external stakeholders that include policy makers, county partners, advocates, and the press. The work of the Policy, Communication and Administration Office crosses the Department and facilitates and supports the work of all staff. The Office is comprised of the Legal Division, Communications, and the Government & Partner Relations Division.

**f. Financial management, including processing of provider claims and other health care financing**

The Finance Office consists of the Chief Financial Officer, Deputy Finance Office Director, the Budget Division, Contoller Division, Managed Care Rates Division, Fee for Service Division, Special Financing Division, Purchasing and Contracting Services Section, Audits and Procurement Division, and the Payment Reform Division. The Chief Financial Officer (CFO) is accountable for the financial and risk management operations of the Department, and oversees control systems that report financial results and maintain Department compliance. The CFO is responsible for the Department's financial data and reporting, and its use of data analytics to define value and measure quality with regard to Department operations. The CFO develops the Department's financial and operational strategy, and generates actionable analytics tied to that strategy.

**g. Systems administration, including MMIS, eligibility systems**

The Health Information Office develops, implements, and maintains the Department's Health Information Technology (HIT) and related Information Technology (IT) infrastructure, while coordinating with the Governor's Office of Information Technology and other stakeholders on HIT and IT projects that impact the Department. The Health Information Office is comprised of the Business Solutions Division, the Medicaid Health IT Director, the Contracts & Quality Assurance Division, the ESI Division, and the Project Management Division.

**h. Other functions, e.g., TPL, utilization management (optional)**

The aims of the Cost Control & Quality Improvement Office are to propel Medicaid claim cost-control solutions towards industry standards and payer best practices; prepare for volatility; build a sustainable approach to controlling claims costs; and contain costs while improving member health outcomes. The Office is comprised of the Chief Medical Officer, ACC/Delivery System Division, Clinical Operations Division and the Data & Analytics Division.

**3. An organizational chart of the Medicaid agency has been uploaded:**

Name	Date Created	
<a href="#">CO-25-0039_HCPF ONE ORG CHART_TITLES ONLY_May 2026</a>	5/18/2026 6:04 PM EDT	

## Organization and Administration

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

### Package Header

**Package ID** CO2025MS00060  
**Submission Type** Official  
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**SPA ID** CO-25-0039  
**Initial Submission Date** 4/3/2026  
**Effective Date** 7/1/2026

## B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
Denver Health and Hospital Authority	<p>Denver Health and Hospital Authority is designated to make determination of Medicaid eligibility for all Medicaid eligibility groups for the Colorado Department of Health Care Policy and Financing.</p> <p>The State assures that it has addressed any potential conflict of interest that Denver Health and Hospital Authority may have when it is delegated the authority to determine Medicaid eligibility and provides ongoing oversight specific to this issue. Specifically, Denver Health and Hospital Authority eligibility staff are established as a separate and distinct unit, unrelated and independent of any provider's unit, staff or processes. The eligibility staff is separate from any staff responsible for billing or claims for services.</p> <p>Agencies delegated by the State to perform Medicaid determinations must initially agree to contracted language that directs the agency on the appropriate actions required to avoid an actual, or the appearance of a perceived, conflict of interest. After entering into a contract with the State, a dedicated contract manager is assigned to the agency for the purposes of monitoring the agency's contractual compliance.</p> <p>Oversight of the agency includes ongoing biweekly or monthly meetings to address issues such as potential process changes, client concerns, performance, and contract compliance. The contract manager also performs regular site visits, including no-notice visits to ensure the agency is meeting contractual expectations. The meetings and site visits conducted by the State, of the delegated agency, allows the State to address any identified processes or concerns that may present a conflict of interest.</p>
The Social Security Administration	<p>Pursuant to a written 1634 agreement, the Department for Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.</p>

## Organization and Administration

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

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## D. Supervision of the Administration of the State Plan through Local Government Entities

1. The types of the local government entities that administer the state plan under the supervision of the Medicaid agency are:

- a. Counties
- b. Parishes
- c. Other

### a. Counties

2. Are all of the local government entities selected used to administer the state plan?

- Yes
- No

3. The number used to administer the state plan is:

64

4. The functions staff perform in carrying out the entity's responsibilities are described below:

- a. Eligibility Determinations
- b. Fair Hearings
- c. Other

The Colorado County Departments of Human/Social Services (counties) are designated to make the determination of Medicaid eligibility for the Colorado Department of Health Care Policy and Financing. The staff designated to make such determinations are the eligibility technicians hired by the Colorado County Departments of Human/Social Services to perform eligibility for Colorado State Medicaid programs. For the MAGI populations, the counties accept applications and renewals and determine eligibility for all Medicaid eligibility groups. For the non-MAGI populations, the counties make the financial and resource eligibility determinations. The counties, under oversight of the State Medicaid agency, use the compilation of these findings to make the final Medicaid eligibility determination.

# Organization and Administration

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

## Package Header

<b>Package ID</b>	CO2025MS00060	<b>SPA ID</b>	CO-25-0039
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## E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):

- Yes
- No

Name of agency:	Description of the Medicaid functions or activities conducted or coordinated with another executive agency:
The Department of Public Health and Environment	The Department of Public Health and Environment administers programs that seek to improve health outcomes through the promotion of health, wellness and prevention.
The Department of Personnel and Administration	<p>The Office of Administrative Courts (OAC) is Colorado's centralized administrative court system and resides within the Department of Personnel and Administration (DPA). OAC conducts an impartial, third party review of both applicant/beneficiary appeals and provider appeals. For applicant/beneficiary appeals OAC renders an Initial Decision which is subject to a de novo review by the single state Medicaid agency's Office of Appeals for Final Agency Decision. OAC conducts fair hearings and issues final decision for provider appeals under delegated authority from the single state Medicaid agency.</p> <p>DPA provides the infrastructure by which the rest of state government operates. In addition to the Office of Administrative Courts, DPA includes the Division of Finance and Procurement, the Division of Central Services, the Division of Human Resources, and the Office of the State Controller. The Executive Director of the Department of Personnel and Administration is appointed by the Governor and serves at his pleasure as a member of the Cabinet.</p>
Department of Human Services	The Department of Human Services (DHS) administers assistance programs such as food and cash assistance that improve the safety, independence and well-being of Coloradans. DHS also

Name of agency:

Description of the Medicaid functions or activities conducted or coordinated with another executive agency:

works closely with the Department on the coordination of behavioral health and substance abuse benefits.

## Organization and Administration

MEDICAID | Medicaid State Plan | Administration | CO2025MS00060 | CO-25-0039

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### F. Additional information (optional)

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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