Medicaid Program Expenditures

Medicaid Commission, September 17, 2026

Medicaid Program Expenditures

Medicaid spending has grown substantially from FY 2020-21 through FY 2025-26

Total Funds (TF): $10.7B → $17.6B

General Fund (GF): $2.6B → $5.6B

Much of the growth has occurred in three service areas:

+$3.0B (54%) TF / +$1.1B (77%) GF — Acute Care Services

+$733M (93%) TF / +$202M (117%) GF — Behavioral Health

+$2.5B (124%) TF / +$1.26B (149%) GF — Community-Based Long-Term Care

Policy Changes & Investments

Acute Care

- Expansion of payment of covered pharmacy services (2021)
- Expansion of family planning benefits, including 12 month postpartum continuous eligibility (2021)
- Removal of copays for Pharmacy and outpatient services (2023)
- Easing of PAR requirements for antipsychotic medications (2024)

Behavioral Health

- Providers accepting Medicaid more than doubled (2018-2025)
- SUD residential & 1115 waiver expansions (2022-2026)
- Peer and recovery support services expanded (2021-2025)
- Prior authorization removed for outpatient psychotherapy (2022)
- Safety net provider and public provider expansion (2021-2023)
- Colorado System of Care for high-acuity youth (2024 - present)

Community Based Long Term Care

- Increased home care wages (2019)
- Expanded who may provide paid care – including parents of children and family caregivers
- Expanded benefits, such as skilled respite & remote supports
- Transition to Community First Choice with a 6 percentage point enhanced federal match (2025)

National Context

Medicaid costs are rising across the country – even as enrollment is flat or declining.

- HCPF is talking with other state Medicaid agencies and national organizations that report similar patterns of growth in expenditures and service utilization.
- In KFF's 2025 survey of state Medicaid officials, states reported rising costs driven by: higher health care needs and service utilization, long-term care, pharmacy, behavioral health, and provider and managed care rate increases.
- A recent article Health Affairs outlined that nationally Medicaid spending per enrollee rose 16.6% in 2024, up from 6.5% the year before. Enrollment fell as states resumed redetermination and the members who remained have higher needs and higher utilization.

Accountability

- The Department takes accountability for the cost growth and responsibility for the previous fiscal year over expenditure and the forecasted increased expenditure in this fiscal year.

- We are committed to working collaboratively with members, the General Assembly and stakeholders to craft solutions to ensure sustainability.

FY 2025-26 Over Expenditure

$157.9M General Fund over expenditure key drivers:

- Increased service utilization:
  - Acute Care primarily driven by Pharmacy expenditure growth, lower than expected and changes to drug rebates ($38.5M)
  - Community Based Long Term Care (CBLTC) growth, primarily driven by personal care and homemaker services ($14.1M)
  - Behavioral Health payments made to the RAEs through capitation ($9.8M)
  - Other service utilization trends ($19.9M)
- Lower than forecasted recoveries ($33.1 M)
- Inaccurate fund source estimates resulting in under-forecasting General Fund expenditures ($35.2M)
- Other adjustments ($7.3M)

Preliminary FY 2026-27 Nov. 1 Forecast Changes

Main drivers of $1.03B Total Fund, $442.5M General Fund increase in the preliminary November 1 forecast:

- Increases in **Acute Care** to account for manual claims reprocessing and drug rebate / pharmacy changes ($314.6 M TF / $195.1 M GF)
- Increases in **Behavioral Health Capitation Rates** amongst General Funded Populations ($8.1 M TF / $10.7 M GF)
- Continued growth in **Community Based Long Term Care** ($488.6 M TF / $244.6 M GF)
- **Decreases in Recoveries** expectations due to recent experience with RAC program ($0 M TF / $14.6 M GF)

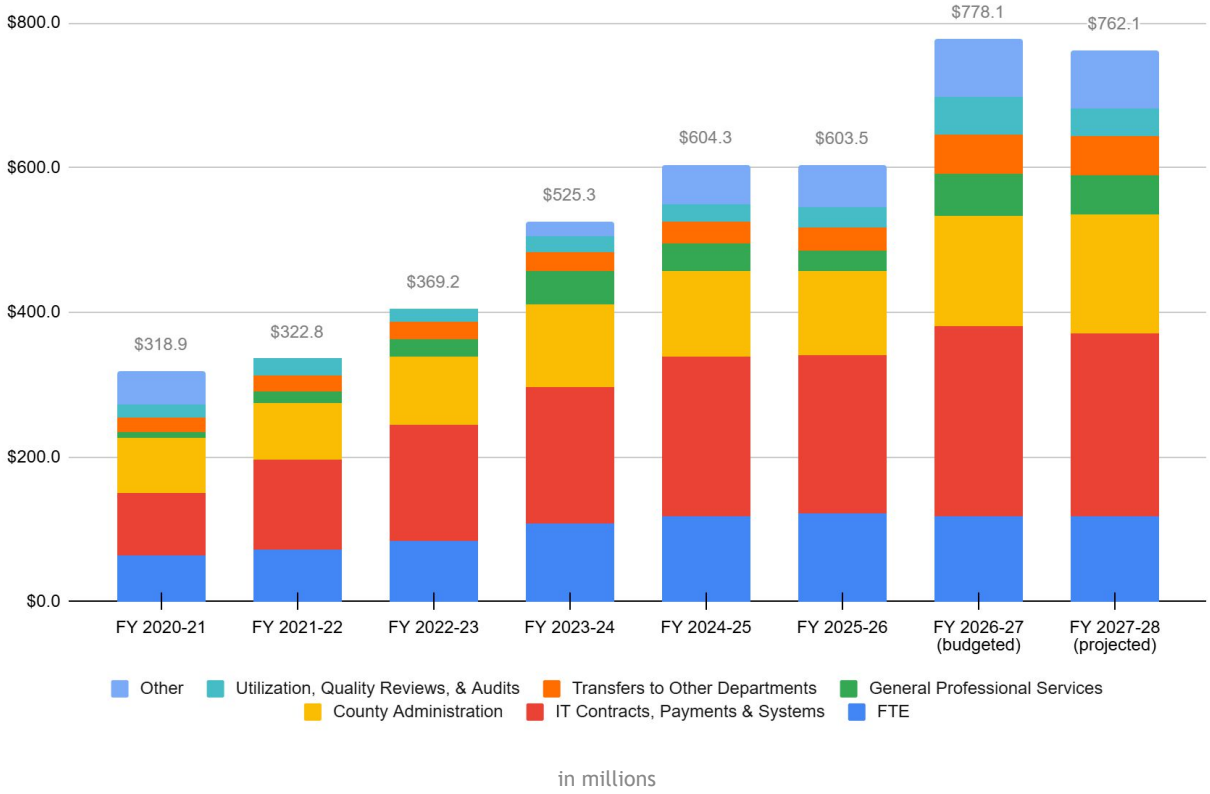
Action Plan

As we work to address the growth in expenditures and to bring spending in line with our appropriation we will be guided by the core commitment to **protect the health and safety of members**.

The Department is focusing our work in four areas:

1. Driving administrative efficiencies
2. Aligning benefits and services to maximize impact and value
3. Ensuring program integrity and fiscal accountability
4. Maximizing federal and non-general fund resources

Administrative Spending



- In FY 2025-26, HCPF administrative spending was 2.96% of total HCPF expenditures
- IT Contracts, Payments & Systems and County Administration equal approximately 55% of HCPF's administrative spending
- Increases in FYs 2026-27 and 2027-28 are driven by HR 1-related needs for systems, county admin, and eligibility determinations

Sustainability Actions in Administration

The Department is taking action to reduce administrative costs.

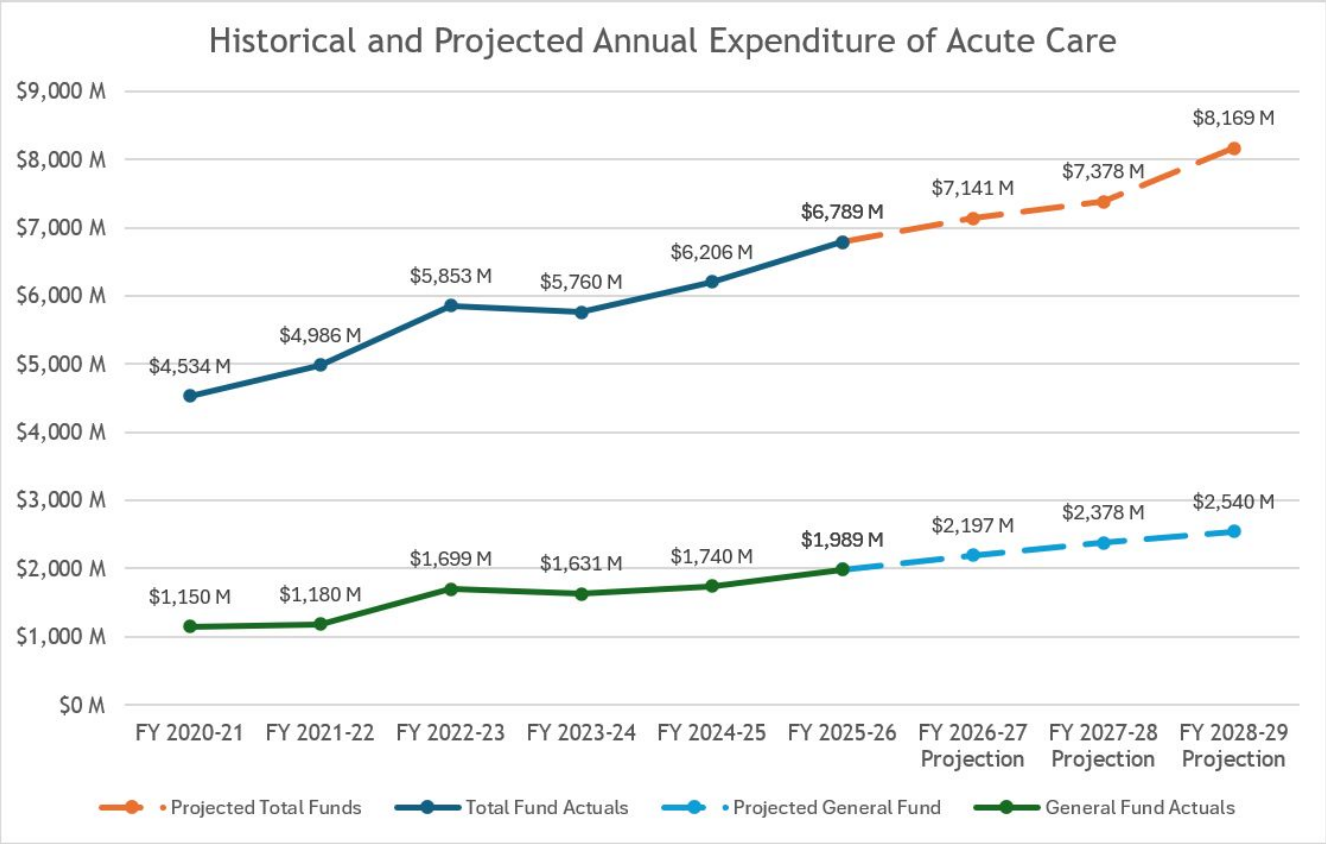
- Changes have already been implemented regarding Department hiring practices and compensation.
- All operational contracts are being reviewed to identify areas where scope can be limited or non-essential work and deliverables can be eliminated.
- All Programmatic Partner contracts are being reviewed for federal and state mandated activities and then evaluated for any additional areas of work that can be limited or ended.
- Action Plans are being developed by sections of the Department to immediately address areas of growth and improve efficiencies.

Acute Care Services

Access to Acute Care

- Acute care services include: Physician and clinic services, Inpatient and Outpatient Hospital, Laboratory and X-Ray, Pharmacy, Emergency Transportation, Non-Emergency Medical Transportation, Dental, Durable Medical Equipment (DME), Acute Home Health.
- Most commonly used services are: Pharmacy, physician and clinic services including FQHC and RHC, Dental, Inpatient Hospital, DME and transportation.

Acute Care

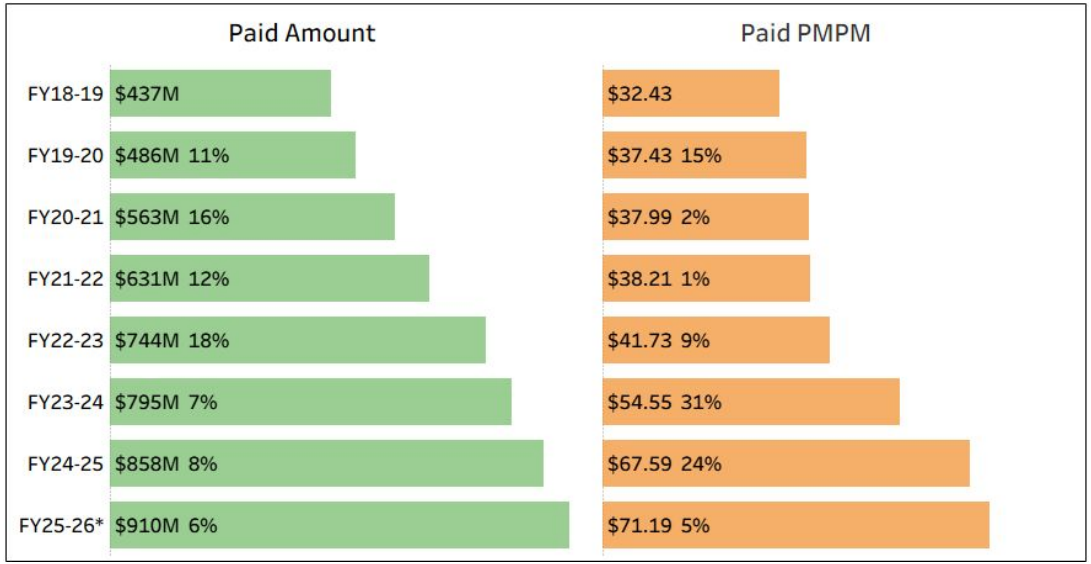


Growth in Acute Care is primarily driven by the Pharmacy benefit

Access to Pharmacy Benefits

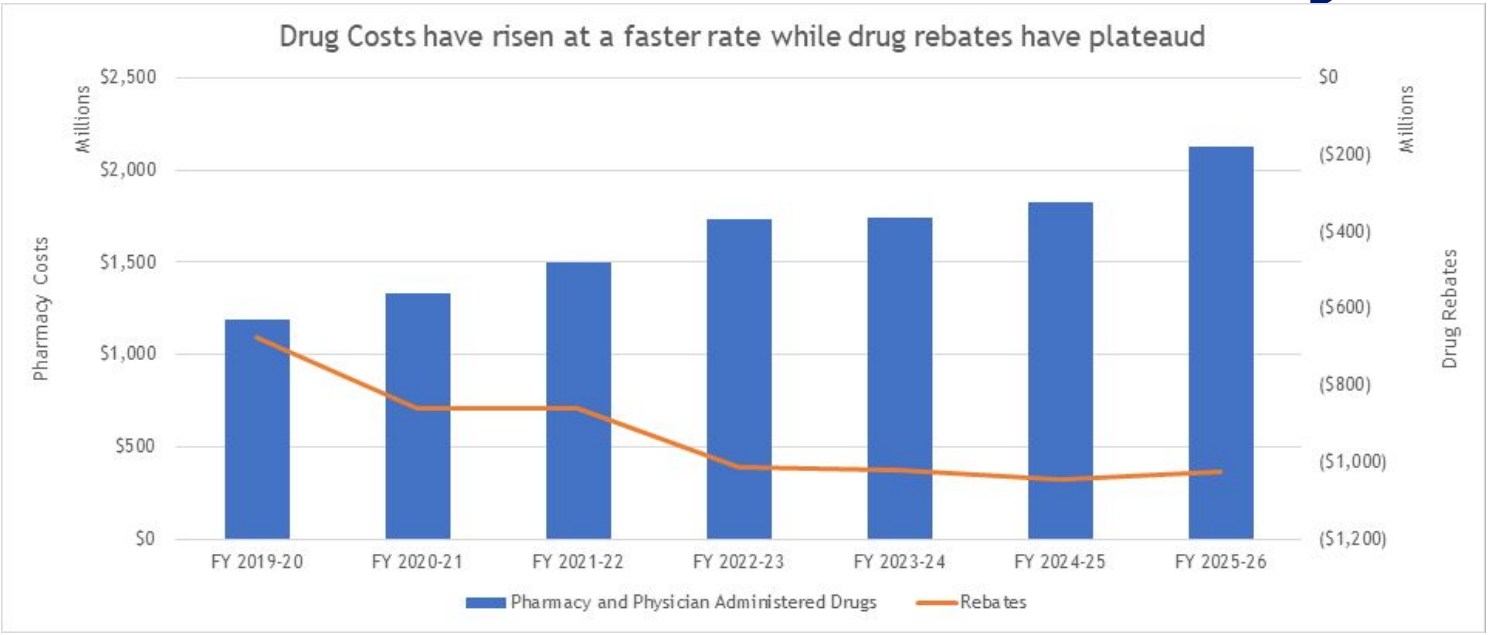
- Roughly 685,000, Medicaid members access the pharmacy benefit
- The most common prescriptions include: inhalers, antidepressants, anticonvulsants, insulin
- Specialty drugs are drugs that require special handling, complex administration and/or are limited distribution drugs. These are rarely prescribed, but very expensive

Acute Care: Pharmacy



- Nationally, the average cost of a brand drug rose nearly 50% from 2018 to 2021, driven by new high-cost specialty drugs. Specialty care drug spending accounts for large amounts of spending even with low drug utilization.
- Colorado mirrors this trend — specialty pharmacy spending grew from $437M in FY 2018-19 to $910M in FY 2025-26, and specialty PMPM more than doubled from $32.43 to $71.19

Acute Care: Pharmacy



- Drug costs have risen faster than rebates from drug manufacturers, and rebate growth has plateaued. The federal Inflation Reduction Act and American Rescue Plan Act implementation have reduced the rebates HCPF collects through the Medicaid Drug Rebate Program.

Sustainability Actions in Pharmacy

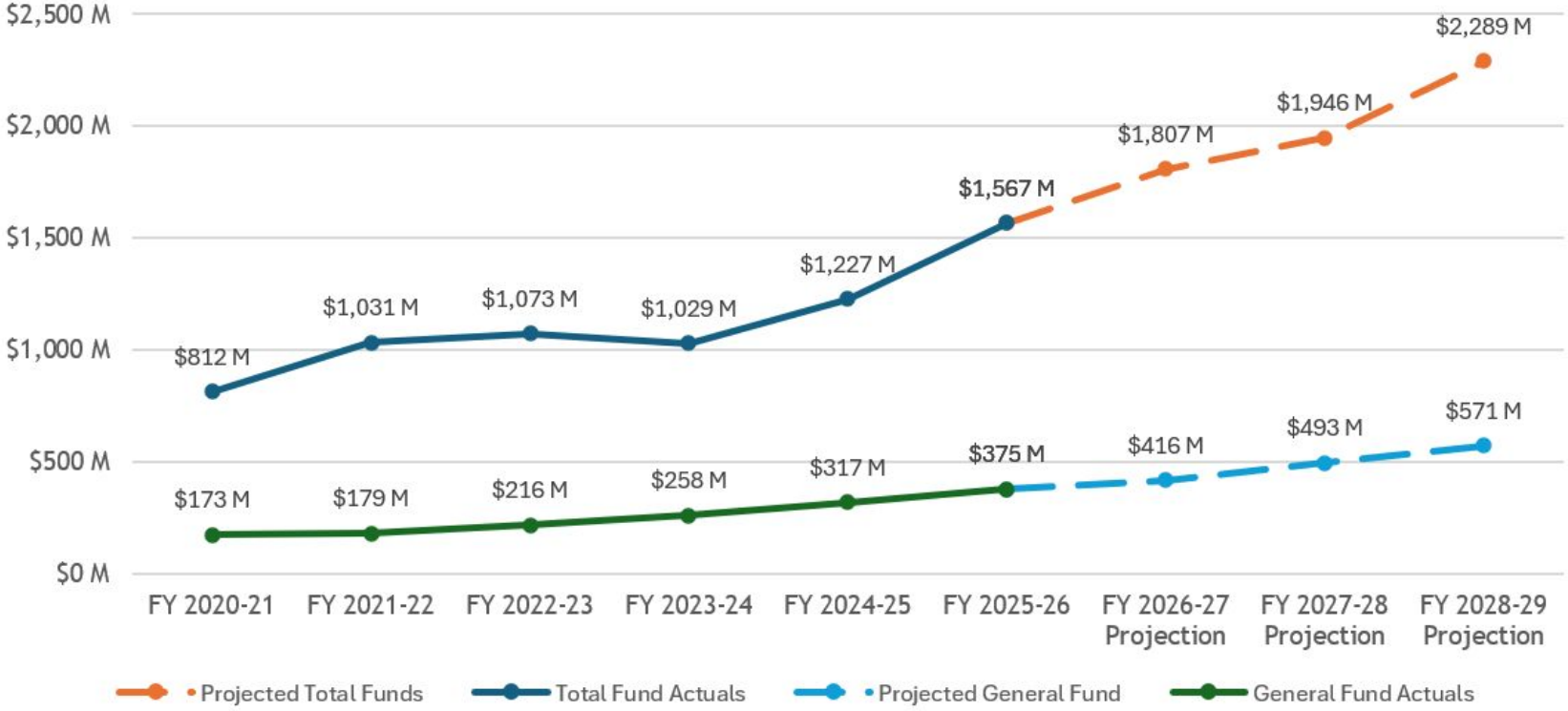
- HCPF's ability to reduce prescription drug expenditures is limited by federal Medicaid rules governing the pharmacy benefit and the Drug Rebate Program
- Prescription drug coverage is technically optional under Medicaid — but all 50 states cover it, and it is a standard benefit in both public and private insurance
- HCPF leverages PBM vendor best practices and partners with the Medicaid Fraud, Abuse and Neglect Unit at the Attorney General's Office on: pharmacy outlier billing, out-of-state pharmacy billing analysis, outlier BOTOX claims, and ALIVIA modeling

Behavioral Health

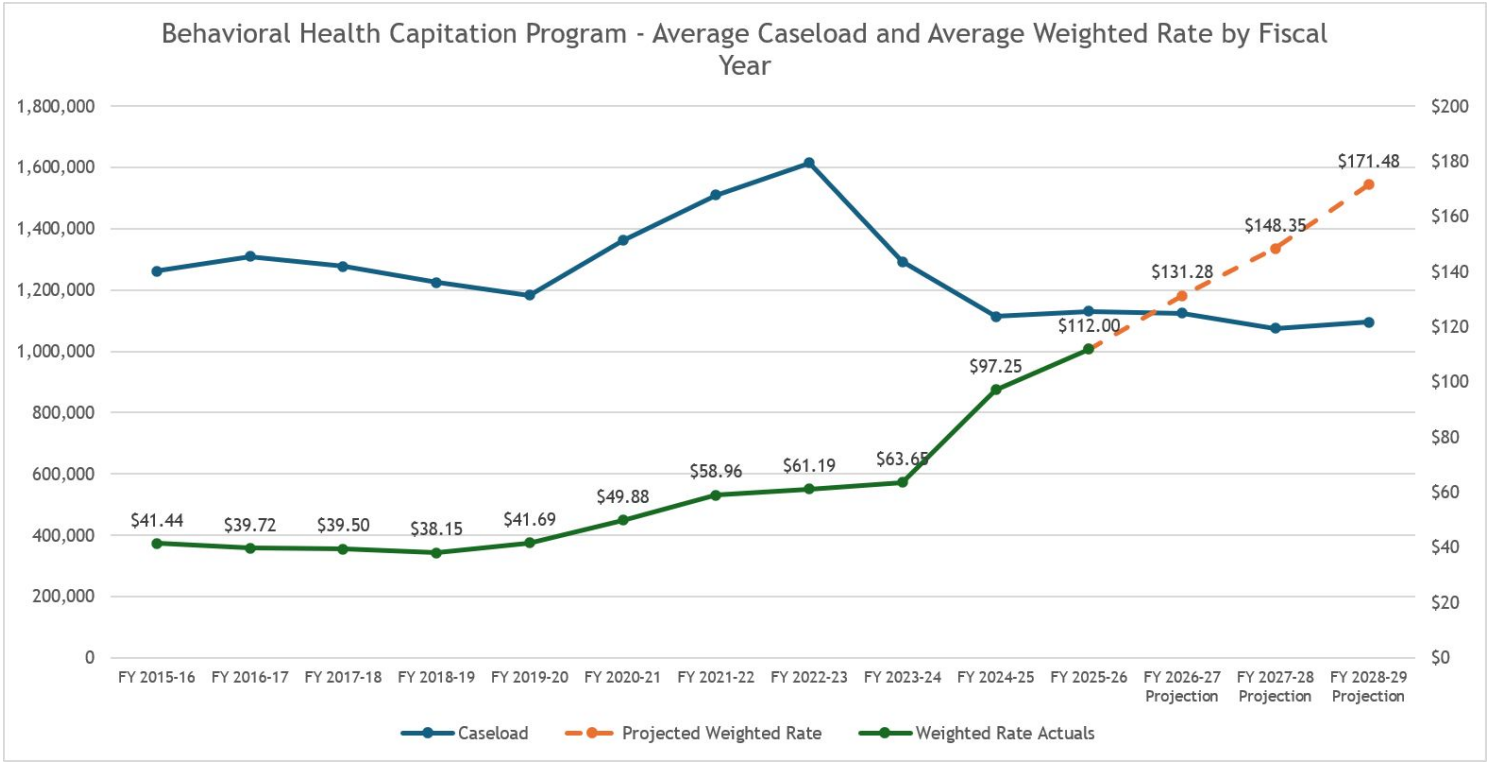
Behavioral Health Access

- Roughly 240,000, Medicaid members accessed behavioral health services in FY 2024-25.
- Behavioral Health services include mental health and substance use disorder services such as:
  - individual, family & group psychotherapy
  - crisis and intensive outpatient services
  - residential and inpatient care
  - medication assisted treatment
  - support services (i.e. peers, case management, outreach, life skills, education, and housing supports)

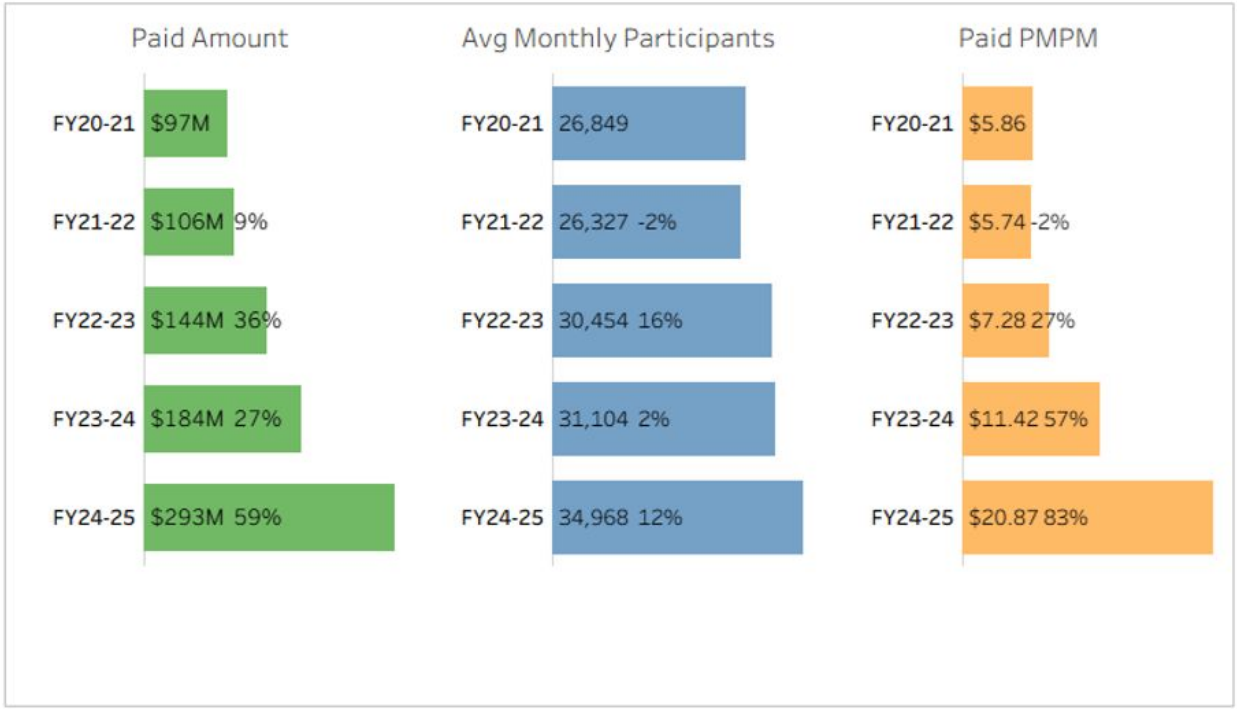
Historical and Projected Annual Expenditure of the Behavioral Health Capitation Program



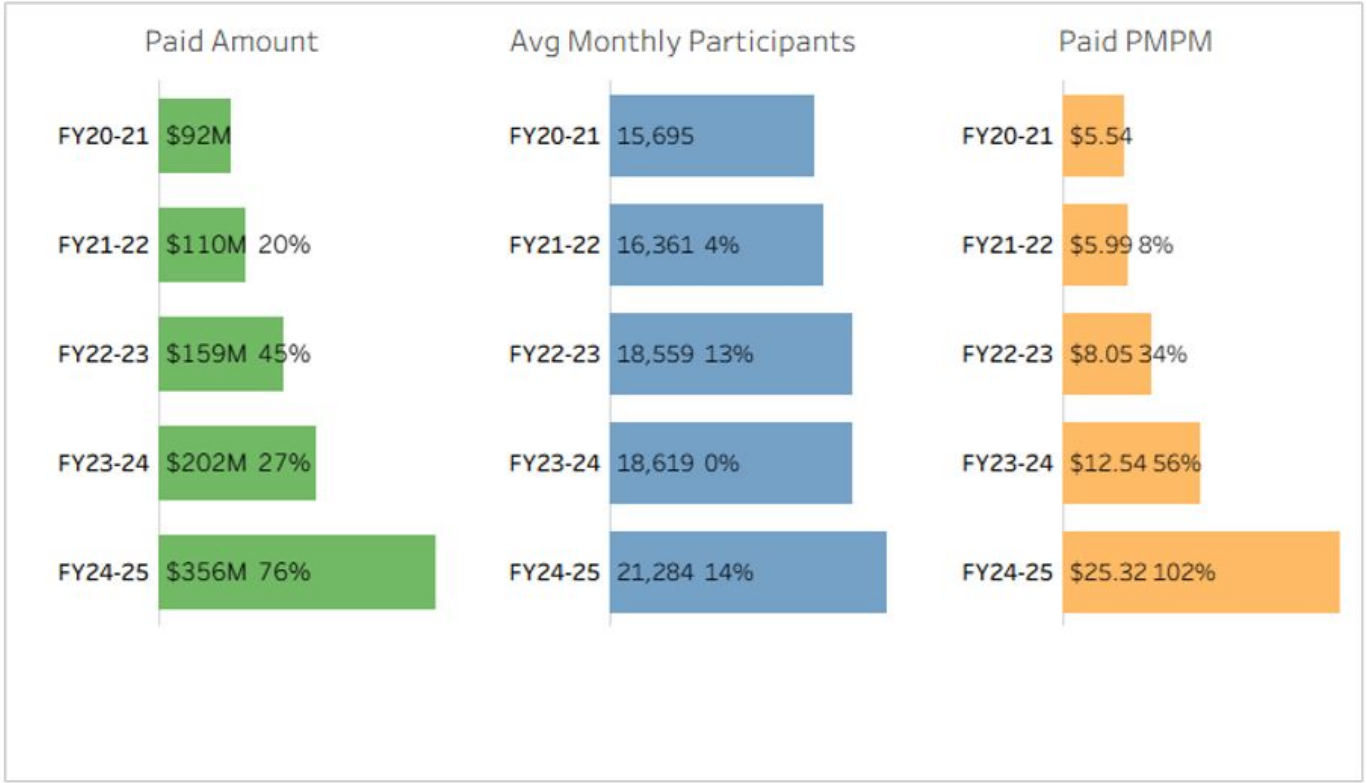
Behavioral Health Cost Projection



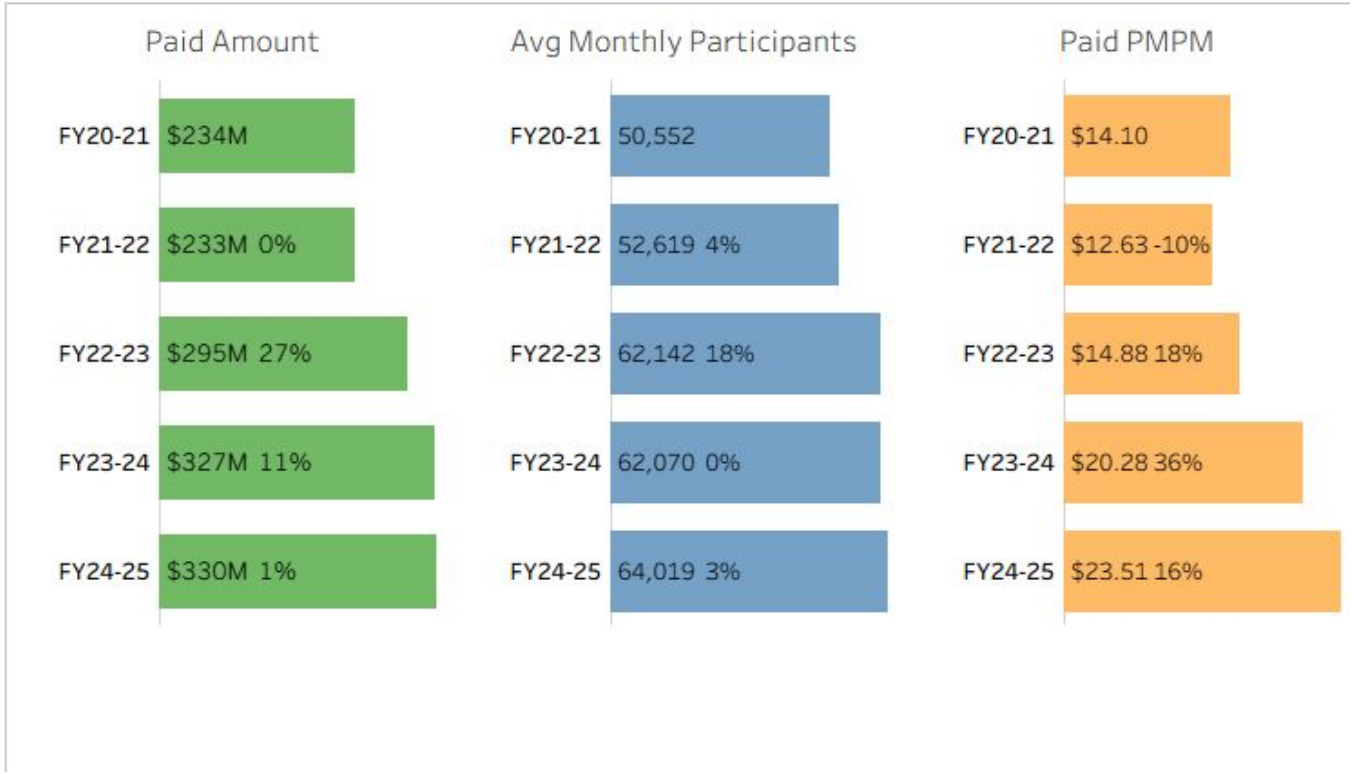
Peer and Support Services



Residential SUD



Outpatient Psychotherapy



Sustainability Actions in BH

- Network management activities by RAEs including review of outlier billing and prioritizing contracts providers that can demonstrate outcomes
- Monitoring and retroactive review of outpatient therapy
- Billing and coding national standards in all claims
- Guidelines on the Prospective Payment System (PPS) for Comprehensive Providers
- Limiting allowable place of services and provider type that can provide support services, increasing clinical oversight requirements
- Coordination with Program Integrity, MFANU

Long Term Services and Supports

Bonnie Silva, Director

Fact Sheet Overview

1. Eligibility for Long-Term Services and Supports (LTSS)
2. Case Management for LTSS Members
3. Medicaid Service Package for Members Receiving LTSS
4. Due Process for LTSS
5. Weekly Caregiver Cap
6. Adding PETI to the DD Waiver

Access to Long Term Services & Supports

- Roughly 100,000 people access Long Term Services & Supports through Community Based Services and Institutional Care
  - The Members accessing LTSS have a range of disabilities including, physical, cognitive, and mental health; as well as extensive chronic conditions
  - LTSS Members access services across the lifespan: 16% are children/youth, 41% are adults (21-64), and 43% are older adults (65 or older)

Eligibility for Long-Term Services & Supports

Individuals enter the LTSS system through a series of eligibility steps. Different programs serve different populations, which is why pathways may vary.

Member Begins Eligibility Process at a Case Management Agency (CMA) or County Human Services

FINANCIAL ELIGIBILITY

Determined by County Human Services

For HealthFirst CO:

- Income up to 138% FPL ($1,769/single) or 450% FPL ($5,869/single) for buy-in.

For HCBS/PACE/SNF:

- Income below 300% of SSI; resources for one person below $2,000/$3,000 for couple.

LEVEL OF CARE REQUIREMENT

Determined by the CMA

- Must meet nursing facility level of care.
- Determined through a standardized functional assessment.

DISABILITY DETERMINATION

Determined by ARG

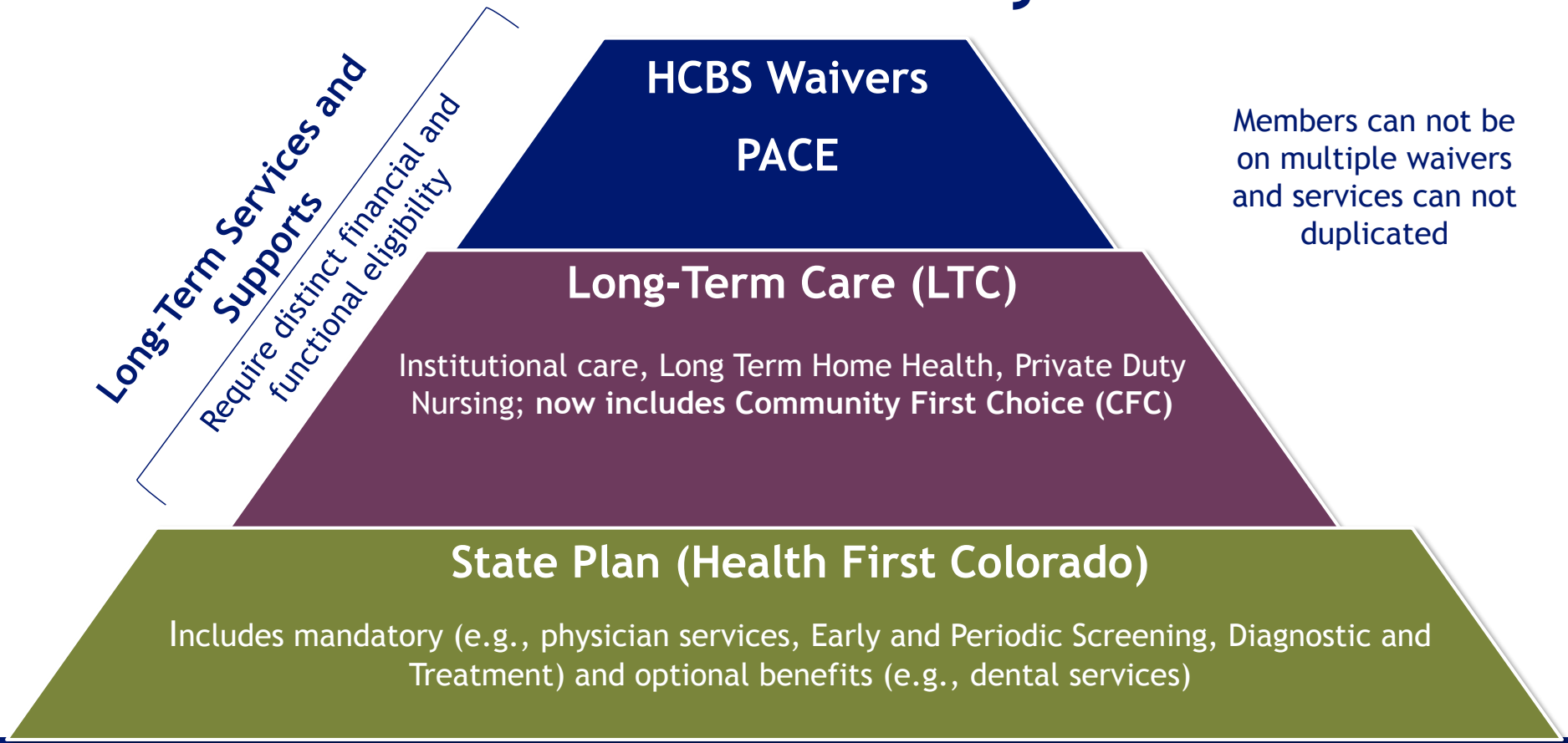
- Members may require a Disability Determination Must have a physical, intellectual/ developmental disability or be 65+.

PROGRAM ELIGIBILITY

- Individuals enroll in the waiver and/or program that best fits their age, disability, and needs (targeting criteria).*

*LTSS enrollment is contingent and based on functional, financial, and programmatic eligibility and funding availability.

Medicaid Benefits Pyramid



Members can not be on multiple waivers and services can not duplicated

LTSS Programs Available Across Medicaid

Nine HCBS Waivers
Optional

Adult Waivers

- Brain Injury Waiver (BI)
- Community Mental Health Supports Waiver (CMHS)
- Complementary & Integrative Health Waiver (CIH)
- Elderly, Blind & Disabled Waiver (EBD)
- Supported Living Services Waiver (SLS)

Children's Waivers

- Children with Complex Health Needs Waiver (CwCHN)
- Children's Extensive Support Waiver (CES)
- Children's Habilitation Residential Program Waiver (CHRP)

Other LTSS Services
Optional

- Program for All Inclusive Care for the Elderly (PACE)
- Community First Choice (CFC)
- Private Duty Nursing (PDN)
- Intermediate Care Facilities
- Case Management

State Plan LTSS
Required

- Long-Term Home Health (LTHH)
- Nursing facilities

How Services Are Received

Agency-Based:

- Members work with a provider agency
- The agency is responsible for staffing the caregivers to meet the member's specific service needs

In-Home Support Services (IHSS):

- The member can select their own caregiver and direct their daily tasks
- An agency is involved to provide support with employee responsibilities

Consumer Directed Attendant Support Services (CDASS):

- Member oversees all hiring, training, scheduling, and directing of their caregiver's responsibilities
- A financial management agency is involved to handle taxes and payroll

LTSS Member Service Package Examples

Member A: 13 year old child with an intellectual disability, autism, and a tracheostomy tube.

Program	Services Received
Children's Extensive Support (CES) Waiver	Community Connector, Massage Therapy, & Respite
Community First Choice (CFC)	Personal Care
State Plan Medicaid	Private Duty Nursing, Pediatric Behavioral Therapy, Medical Services, & Pharmacy

Member B: 52 year old with a spinal cord injury.

Program	Services Received
Complementary & Integrative Health Waiver (CIH)	Massage & Chiropractic Care
Community First Choice (CFC)	Homemaker & Personal Care
State Plan Medicaid	LTHH CNA, Medical Services, & Pharmacy

Shared Investments into the LTSS System

A top LTSS system in the nation

- Colorado scores 5th overall for LTSS performance.
- Workforce base wage investments have increased the average hourly wage from $12.41 to $19.28

Community-based care

- The share of Medicaid LTSS members receiving services in community settings increased from 78% to 84%
  - 10,000 members outreached to transition from nursing facilities to the community.

Investment in IDD Waivers

- Enrollment into IDD waivers increased 58% from FY2017-18 to FY2024-25.

Improved waiver access

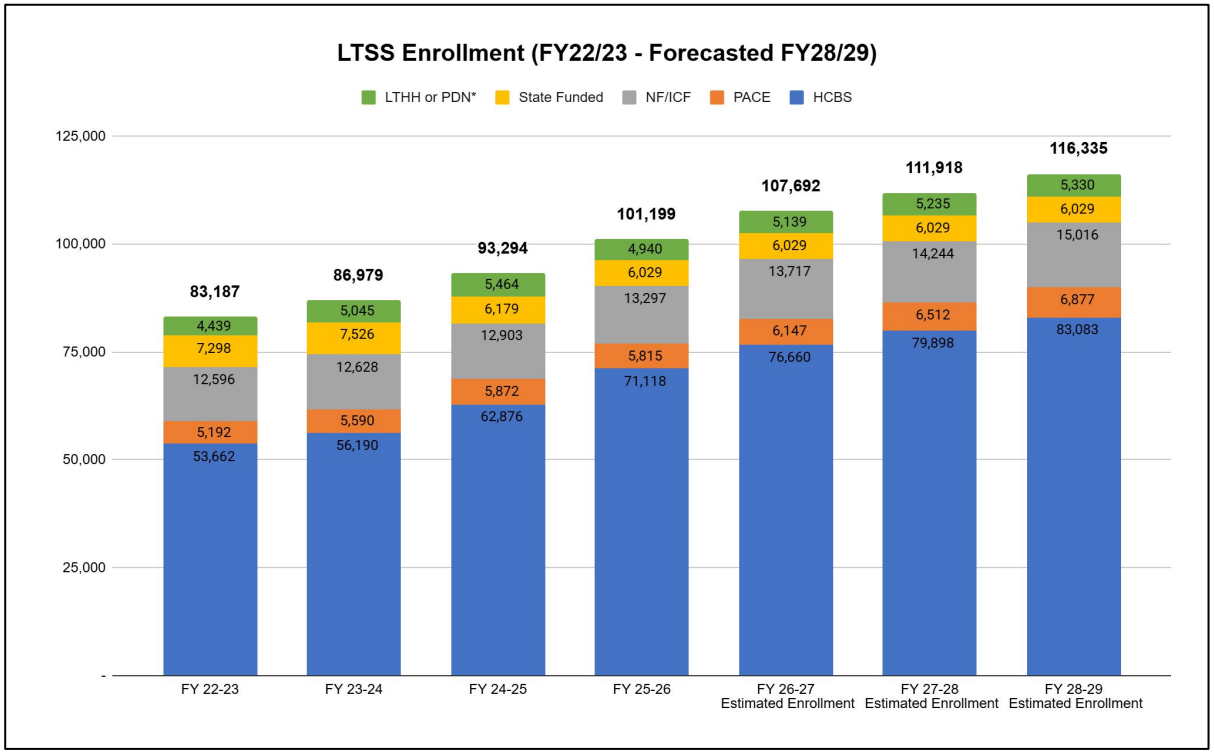
- Added residential options for children and adults with significant mental health needs to access waiver services.

Expanded innovative opportunities

- Expanded benefits such as remote supports, skilled respite, home-delivered meals and home modifications.

Community Based Long Term Care Expenditure and Enrollment Growth

Overall Enrollment Growth LTSS



Colorado's LTSS enrollment growth has **increased by 22%** (FY22-23 & FY25-26) and is anticipated to grow **another 15%** (FY25-26 & FY28-29)

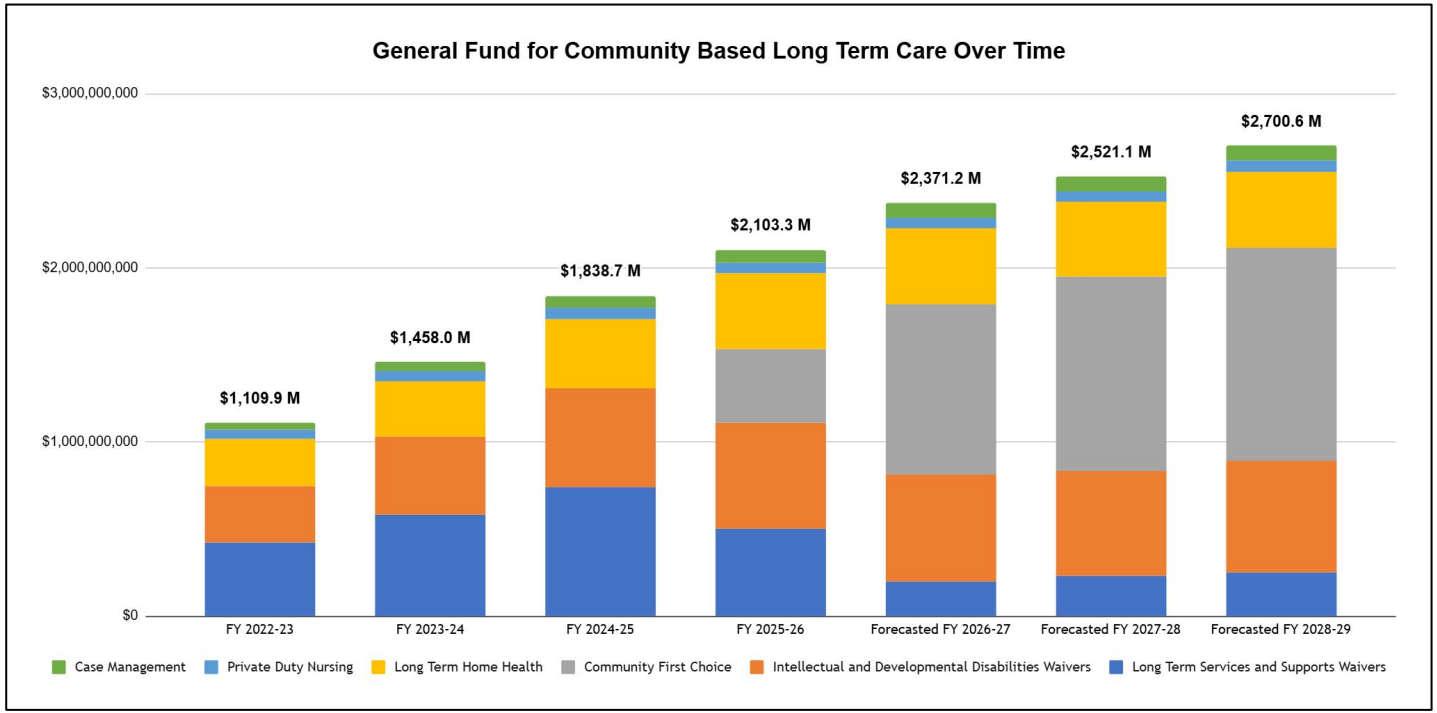
- 11.3% growth in Long Term Home Health & Private Duty Nursing
- 5.6% growth in Nursing Facility and Intermediate Care Facility
- 12% growth in PACE
- 32.5% growth in Home & Community Based Services Waivers & CFC

**State Funded services have seen a 17% decline in enrollment*

**LTHH/PDN only includes those members who receive only those services and no other services listed*

Community Based LTSS Cost Growth

Investments led to expanded access and increased enrollment, resulting in higher expenditures.



All of LTSS accounts for apx. $5.7B TFs/Yr, $2.7B GFs/Yr

- *48% of the Medicaid GF Spend*

100,000 Members Access LTSS

- *Apx. 8% of the Medicaid Population*

Community Based Long Term Care Expenditure Growth

Expenditure Growth

- Continued growth in Community Based Long Term Care requires us to increase our forecast for FY26-27 by apx. $245M
- Previously implemented sustainability efforts are curbing some of the trend but they are not yet fully implemented and are not doing enough in key areas

Primary drivers include:

- Higher participation and utilization of several services, including:
  - Personal Care and Homemaker under CFC
  - Community Connector
  - Long Term Home Health
  - Enrollment

Growth Outpacing Projections

HCPF's assumptions about policy impact and provider behavior under CFC were incorrect; resulting in service and cost growth.

CFC expectations	CFC actual experience
Decrease in higher-cost services	Shift from higher to lower-cost services occurring, but not to the level expected
Some growth in participation; but most members maintaining pre-CFC utilization	Increase in access & utilization of services by members who previously had access
Enhanced 56% match rate	Enhanced match not offsetting the utilization increases

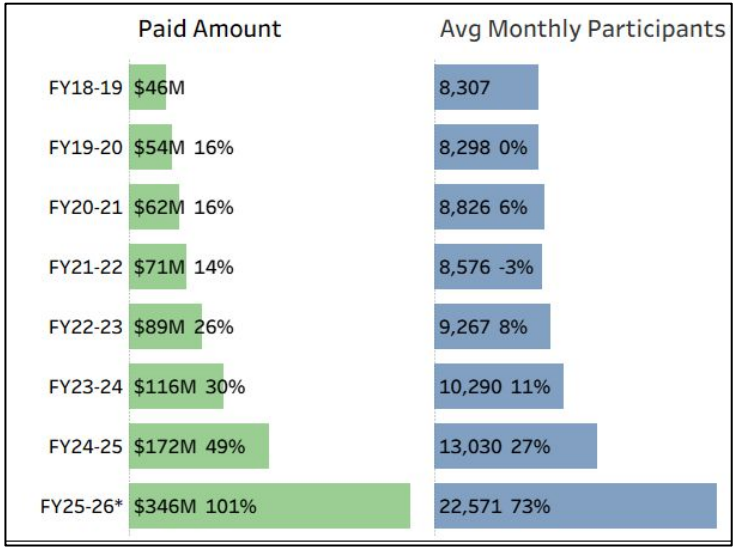
Drivers

- Homemaker: Over 18,000 adults, most on the EBD waiver, newly accessing the service
- Personal Care: Nearly 12,000 children, nearly all on children's waivers, newly accessing the service

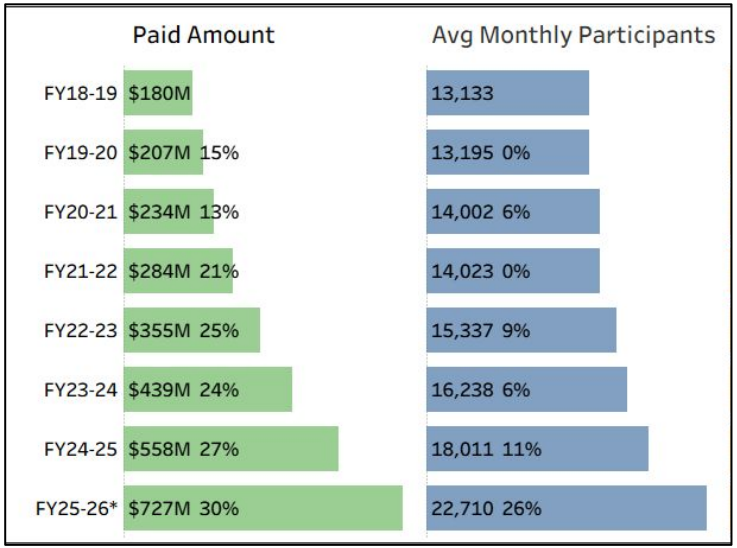
CFC Policy Changed How Services Are Delivered

Aligning services created new allowances for paid family caregivers that have increased member participation.

Homemaker Service



Personal Care Service



- Homemaker & Personal Care services were available previously through the waivers
- When they moved to CFC, new flexibilities, particularly around family caregiving, became available
- Provider behavior targeting family caregivers appears to be driving part of this trend

Action Plan: Align Spending with Appropriation

We must act now to bring spending into alignment with available funding while protecting health, safety, and access.

Targeted Action

- Continue analysis of utilization, participant, and provider data
- Develop a series of policy options with meaningful fiscal impact aimed at addressing sources of spending growth

Engage Before Final Decisions

- Engage members, families, providers, advocates, and partners before policies are finalized
- Use input to identify impacts, unintended consequences, and implementation risks
- HCPF will announce a structured engagement plan next week

Strengthen Accountability

- Monitor spending, participation, utilization, and provider behavior monthly
- Improve forecasting and identify material variances earlier
- Move quickly from analysis to implementation and course-correct based on results

Sustainability Actions Update

Sustainability Actions Underway

Actions approved by the legislature last session, with rolling effective dates.

Rate Actions

- Targeted rate/payment changes to align reimbursement with sustainable service delivery.
- Includes 1.6% rollback, 2% reduction and other adjustments.

LRP Homemaker Limit

- Limit reduced from 10 to 7 hours/week, with no limit on the number of LRPs.
- Members can still access additional hours of Homemaker through other caregivers.

Community Connector

- Annual service limit reduced from 2,080 to 1,040 units.
- Includes an exceptions process.

HCBS Soft Caps

- Limits on annual hours for Homemaker, Personal Care and HMA. without prior approval.
- Includes an exceptions process.

Weekly Caregiver Cap

- Phased limit on hours one caregiver can provide to one member.
- 84 → 70 → 56 hours/week through July 2027.

DD PETI

- Members contribute a portion of their existing income toward the cost of residential services after required protections and deductions.

HCBS Soft Caps

New limits introduced on three services to reign in outliers, while allowing for exceptions for those who need it.

Implementation:

- New limit became effective April 1, 2026; rolling out through November 2026
- Approximately 4,600 members estimated to be impacted
- Limits apply to:
  - Homemaker, Personal Care and Health Maintenance Activities (HMA)
- Case Managers can submit an exception request for members who need hours over the limit

Exception Requests:

- 627 requests have been received*
- Of those, 59% have either been partially or fully approved
- The exception request review includes:
  - Case Management Agency submission → HCPF reviews & requests more information, if needed → Decision is issued
  - This process takes on average, 13.5 days
- Due Process:
  - Because the limit could be decreasing a members services, this is an appealable action

Exception Request data as of September 11, 2026

Weekly Caregiver Cap

The policy is designed to address member health and safety, and support more stable caregiving arrangements over time.

Implementation:

- Phased in limit starting at 84 hours per week July 1, 2026 for a single caregiver providing certain LTSS to a single member; moving to 70 hour/week January 1, 2027; and fully implemented at 56 hours/week July 1, 2027
- Limit applies to specific services:
  - Homemaker, Personal Care, HMA, Long-Term Home Health CNA and Nursing
- Members can still receive additional hours of service from alternative caregivers
- The exception process recognizes extraordinary needs, workforce challenges, transitions and other qualifying circumstances.

Exception Requests:

- Over 2,300 members receiving over 84 hours/week across the services.
  - 176 requests have been received* of those.
- 80% have been fully approved
- The exception request review includes:
  - Provider agency submission → **CMA provides input (if applicable)** → HCPF reviews & requests more information, if needed → Decision is issued
  - This process takes on average, 27 days

Exception Request data as of September 9, 2026

Due Process in LTSS: Protecting Members Who Raise Concerns

Members have multiple ways to question decisions, raise concerns, and seek help.

Raise a Concern

- Members may raise concerns with their Case Management Agency (CMA), Provider or HCPF
- Members can escalate concerns when an issue is not resolved through the CMA

Challenge a Service Decision

- Adverse decisions include reducing, suspending, or terminating an authorized service
- Members receive written notice of the decision and appeal rights
- When applicable, benefits may continue while an appeal is pending

Multiple Safeguards

- Members are not limited to the person or organization involved in the concern
- The HCPF escalation process and formal appeal process provide additional avenues for review
- These processes are intended to ensure members can speak up about their care without losing access to services simply because they raised a concern

PETI for the Developmental Disabilities Waiver

Post-Eligibility Treatment of Income applies after eligibility is established, is based on a member's income, and protects certain funds before a contribution is calculated.

Background:

- PETI is required for other residential programs under the other HCBS waivers.
- Anticipated to impact 40% of DD waiver members (apx. 3,100 people)
- Average monthly contribution anticipated to be $550
- A members contribution depends on their income and allowable protections and deductions

What changed with PETI implementation:

- For some DD waiver members receiving residential services, a portion of their own income will now be used toward the cost of residential services. Medicaid continues to pay the remaining cost.
- The calculation protects certain amounts first, including a Personal Needs Allowance, applicable housing/room-and-board costs, and other allowable deductions.
- The contribution is based on the member's individual financial circumstances.

What did not change with PETI implementation:

- Does not change Medicaid eligibility or eligibility for the DD waiver.
- Does not change the services a member is eligible to receive.
- Does not require a member to contribute all of their income.
- Does not count parents' or other household members' income toward the member's contribution.

Long-Term Sustainability

Long-Term Work Is Already Underway

The immediate work is focused on stabilization. The longer-term work is already beginning.

Multiple Efforts Working Together:

Community Led Work

Foundation funded, community-led cross-system group to develop long-term recommendations for Colorado's LTSS system.

National Partnership

HCPF is working with the Center for Health Care Strategies for support on engaging and developing this work.

Six Areas for Longer-Term Redesign:

1. Eligibility & Enrollment
2. Benefit & Service Design
3. Utilization & Authorization
4. Provider Reimbursement
5. Delivery System & Care Models
6. Provider Participation, Accountability, & Quality

BOTTOM LINE: The goal is not simply to spend less. It is to build an LTSS system that can meet people's needs, protect health and safety, and operate within available resources over time.

Questions