Joint Budget Committee Hearing
Health Care Policy & Financing

Introductory Remarks

January 5, 2026

Kim Bimestefer, HCPF Executive Director
Mark Ferrandino, Director OSPB

Fiscal Yr	Year End GF (in millions)	*% Growth*	*GF Actuals Growth*
FY 2014-15	$2,210.6	22%	$404.10
FY 2015-16	$2,364.0	7%	$153.40
FY 2016-17	$2,407.5	2%	$43.50
FY 2017-18	$2,679.6	11%	$272.10
FY 2018-19	$2,824.8	5%	$145.20
FY 2019-20	$2,822.5	0%	($2.30)
FY 2020-21	$2,556.6	-9%	($265.90)
FY 2021-22	$2,865.7	12%	$309.10
FY 2022-23	$3,452.3	20%	$586.60
FY 2023-24	$4,362.0	26%	$909.70
FY 2024-25	$5,082.5	16%	$720.50

Unsustainable Medicaid trends due to increases in medical inflation, increases in our benefits, expansion of our coverage programs, outlier trends in certain areas, and outlier increases to our provider reimbursement rates.

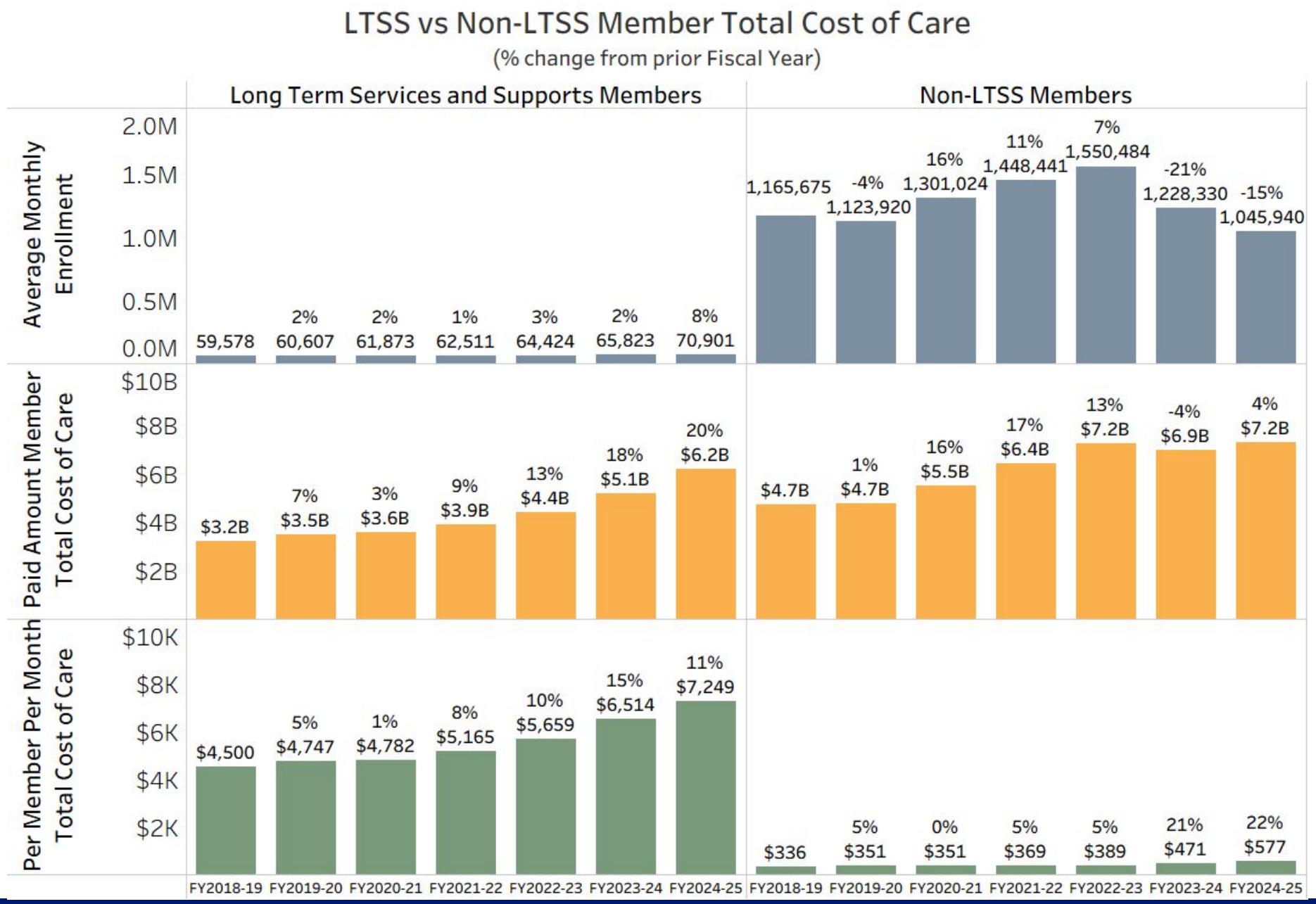
Medicaid General Fund cost trends averaged 6% annually (0-11% range) from FY 2015-16 to FY 2018-19, and averaged +19% (12%-26% range) from FY 2021-22 to FY 2024-25.

Long Term Services and Supports

LTSS ~**6**% of members: 45% of spend and per member trend of 11% last year

Non-LTSS ~85% of members: 53% of spend and per member trend of 22% last year (due to PHE unwind)

Taking care of people with disabilities is core to Medicaid programs.



COLORADO
Department of Health Care Policy & Financing

Partial Coverage Members (9% of members and 2% of spending) are excluded above that are in the Budget: Partial Medicare Dual Eligibles, Family Planning, and Non-Citizens.

Our HCPF/Medicaid Federal Fiscal Challenges

- COVID related federal stimulus dollars are gone.
- Federal general perspectives of Medicaid's purpose have changed, threatening funding for already approved programs and care, or creating new risks
- H.R.1 causes state tax revenue reductions & ratchets down fed funding via its Medicaid Provider Tax provisions by 0.5%/yr from FFY 2028 (starts October 2027) to FFY 2032 (ends September 2032), reducing fed revenues by $1B-$2.5B
- Admin burden goes up - work requirements, 6 vs 12 months renewals, FWA, immigration
- Fed funding clawback risk increases with H.R.1 Medicaid Payment Error Ratio Measurement (PERM) audit provisions: every 0.1% over 3% = $9.3M; i.e.: 5%= $186M

H.R. 1 Congressional Budget Office Impact Estimates

- Total 10-year Medicaid deficit reduction: $866.8 billion; increases uninsured by 7.5 million by 2034
- ~76% of Medicaid savings stem from provisions that reduce enrollment — not fraud, waste, or programmatic efficiencies
- Work requirements are the single largest driver: $317 billion in savings, 5.3 million newly uninsured
- ACA enhanced premium tax credits expired 12/31/2025; combined with reconciliation law marketplace provisions, adds 6+ million additional uninsured beyond Medicaid impacts
- Total projected coverage loss across all health provisions: ~14 million by 2034

Congressional Budget Office
Supplemental Cost Estimate

October 28, 2025

Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14
Title VII, Finance, Subtitle B, Health, Chapter 1, Medicaid

As enacted on July 4, 2025

By Fiscal Year, Billions of Dollars

	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2025-2029	2025-2034
Increases or Decreases (-) in Direct Spending												
Budget Authority	-45	-16,452	-46,852	-62,843	-93,011	-111,201	-128,216	-140,352	-150,712	-164,976	-219,203	-914,661
Estimated Outlays	-45	-16,847	-46,747	-62,661	-92,944	-111,441	-128,616	-139,659	-150,708	-164,965	-219,244	-914,634
Increases or Decreases (-) in Revenue												
Estimated Revenues	0	-454	-1,460	-2,020	-2,798	-3,289	-3,899	-4,294	-4,588	-5,078	-6,732	-27,880
Increase or Decrease (-) in the Deficit From Changes in Direct Spending and Revenues												
Effect on the Deficit	-45	-16,393	--45,287	-60,641	-90,146	-108,152	-124,717	-135,365	-146,120	-159,887	-212,512	-886,754

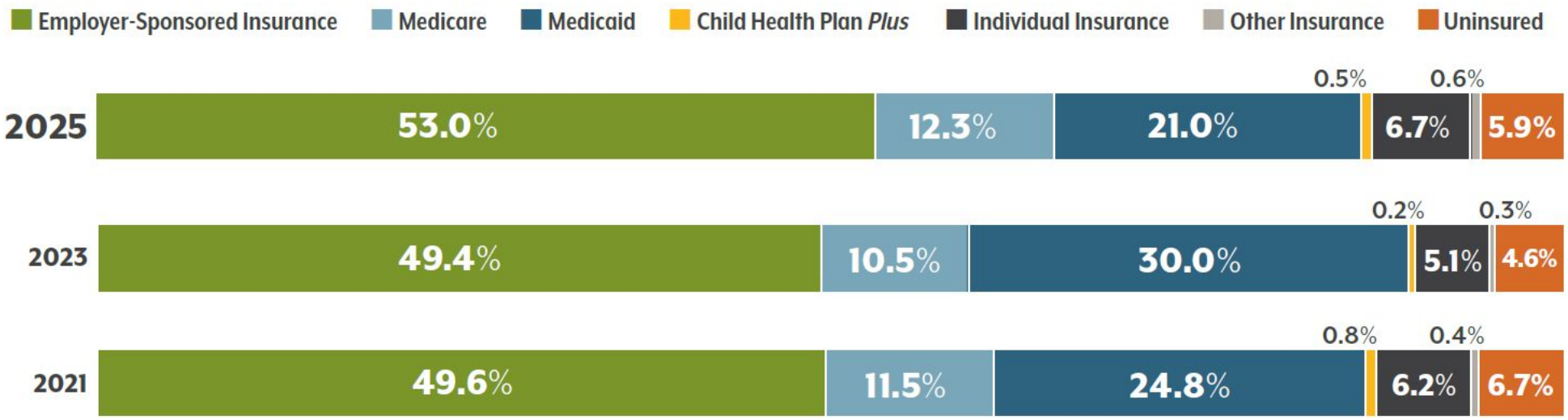
Budget authority includes estimated and specified amounts.

Changing Landscape: Uninsured Rate

Colorado 2025 5.9% uninsured rate is lower than pre-pandemic 6.7%

The end of the public health emergency shifted Colorado's insurance landscape.

Topic: Type of insurance coverage. **Population:** All Coloradans. **Years:** 2019 to 2025.



Source: Colorado Health Access Survey, November 2025, p.7
https://www.coloradohealthinstitute.org/research/colorado-health-access-survey-2025

<u>Fed Risk:</u>

2026 Individual marketplace & 2027 H.R. 1 Medicaid Expansion Work Requirements

Colorado Department of Health Care Policy and Financing (HCPF)

Medicaid Innovation, Sustainability, and Opportunities Project

Joint Budget Committee (JBC) Testimony

January 5, 2026

JBC Testimony Agenda

- **Project Purpose and Approach**
- **The Big Health Care Picture**
- **Colorado Medicaid Landscape Analysis**
- **Developing Policy Strategies**

manatt

Project Purpose and Approach

manatt

Project Purpose

Purpose

Identify **immediate and long-term cost-saving solutions** that will better enable Colorado to **improve the effectiveness and efficiencies of its Medicaid and CHP+ programs**, while **achieving quality and access goals**

manatt

Project Approach

This project, through a phased approach, is seeking to identify, evaluate, and prioritize potential Policy Actions to address cost drivers in the Colorado Medicaid program.

This work is being executed as the Governor and the Department of Health Care Policy and Financing concurrently enact immediate Medicaid program changes in response to a rapidly changing federal and state policy and budget environment.

manatt

Landscape Analysis Approach

The Landscape Analysis identified where Colorado Medicaid is an outlier in program costs and outcomes compared to national and Comparator State trends.

Landscape Analysis

Comparator States *included those with like and unlike delivery systems, based on data availability.*

Comparative State Analysis

Public data were used to compare Colorado to national and Comparator State trends.*

CO Driver Analysis

State data were used to identify drivers of Colorado's cost growth trends.

Opportunities

"Policy Action" opportunities were identified with state leaders to address cost trends.

Policy Assessment

Potential Policy Actions will be further evaluated and prioritized through financial and implementation analyses.

Policy Actions Approach

This project seeks to identify specific, cost-saving and value-enhancing Policy Actions that are aligned with the state's "Guiding Goals."

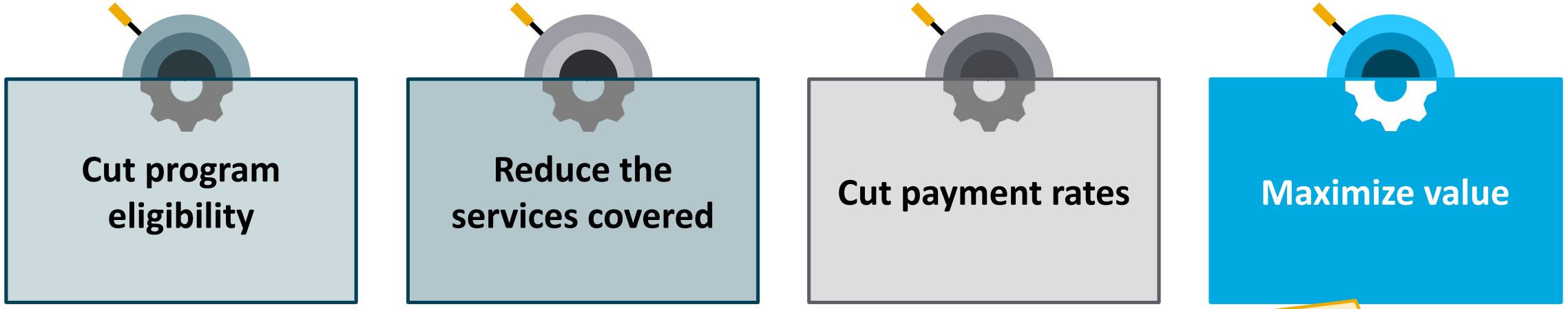
Guiding Goals

- **Produce cost savings:** Slow cost growth and increase program efficiency
- **Emphasize feasibility:** Optimize actionability, minimize state burden, build on and learn from current Colorado initiatives
- **Support long-term sustainability:** Promote value-driven solutions over more expedient, but potentially short-sighted, cost-reduction measures
- **Prioritize member health and experience:** Improve or sustain member access/coverage, quality of care, and experience
- **Minimize adverse impacts on the delivery system:** Confirm delivery system readiness, minimize administrative and financial burden and align delivery system incentives with state goals

manatt

Policy Levers Available to Colorado to Manage Medicaid Costs

States have four major levers to manage Medicaid costs and produce savings.



Focus of this Project

While there is no magic bullet to contain Medicaid costs, states can take more nuanced, but also more complex, actions to maximize program value while producing savings.

manatt

The Big Health Care Picture

manatt

The American Health Care System in Context

Inefficiencies within the U.S. health care system are well documented.

Up to 25% of all U.S. health care spending may be wasteful, a product of overtreatment or low-value care, poor care coordination, pricing failures, fraud and abuse, and undue administrative complexities.

Pricing: The U.S. spends up to twice as much per person on medical care compared to other high-income countries.

- U.S medical spending is disproportionately concentrated in inpatient and outpatient hospital care, prescription drugs, and administration.
- U.S. price regulation/negotiation is more fragmented across federal, state, and private payers than comparable countries.

Social Spending: Chronic underinvestment in and siloing of social services in the U.S., relative to comparable nations, can exacerbate health inequities and increase clinical spending.

Administrative Complexity: Up to 30% of excess health care spending in the U.S. can be attributed to administrative costs associated with insurance and administrative burden for providers.

manatt

Structural Challenges to Reconciling Medicaid Growth with TABOR

Colorado, like every state, is facing structural challenges in managing Medicaid health care cost growth. TABOR compounds these challenges.

Health care is expensive – and costs are growing across all states and all private and public coverage types, including Medicaid.

Medicaid cost growth has been driven by a combination of medical price growth and program enrollment growth.

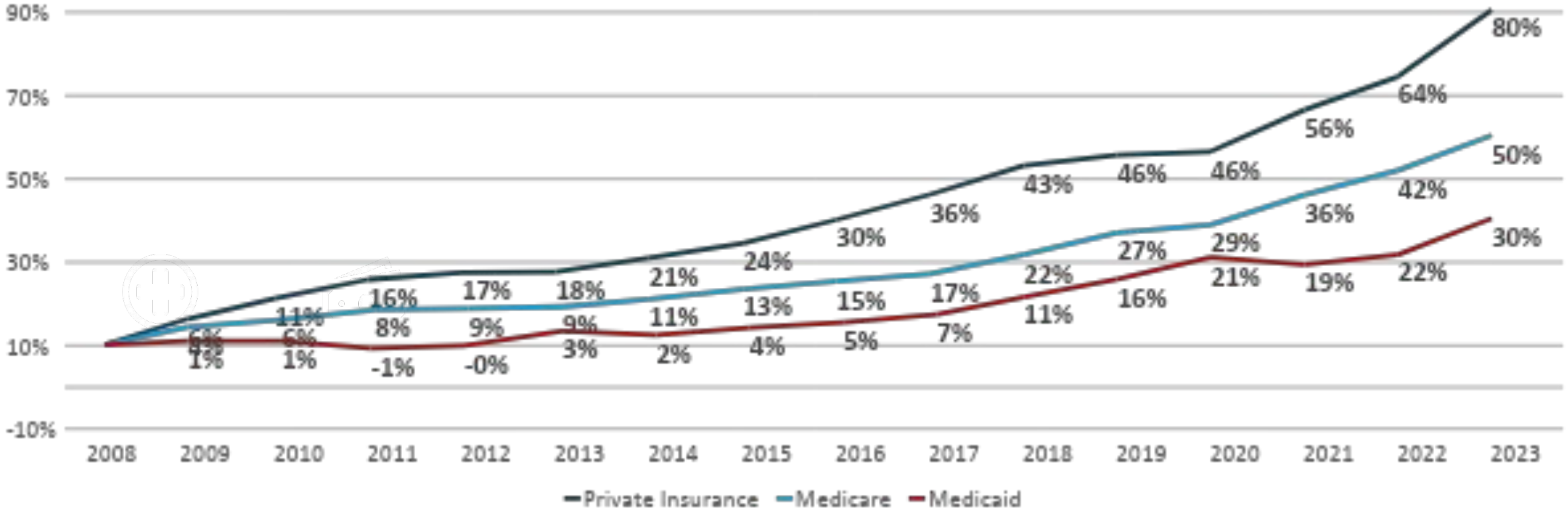
The federal passage of the "One Big Beautiful Bill Act" (H.R. 1) will add new cost pressures to Medicaid agencies across the country, including Colorado.

manatt

National Context: Health Care Cost Growth

Medicaid member costs have grown at half the rate of those with private insurance.

Nationwide Growth in Health Care Spending per Enrollee Relative to 2008,
2008 – 2023

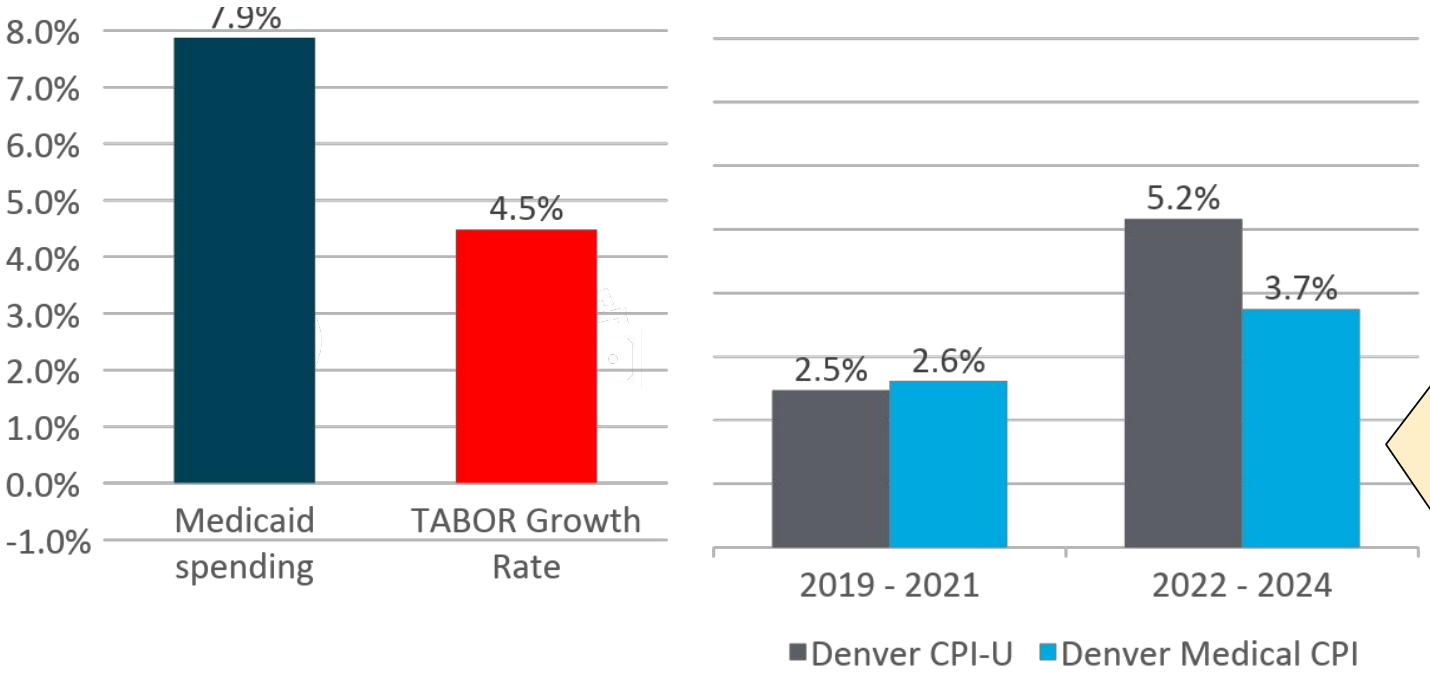


Source: Kaiser Family Foundation, 2025

National Context: Medicaid Cost Growth (Cont.)

Medicaid cost growth has been driven by a combination of medical price growth and program enrollment growth over time.

Colorado Average Annual Growth in Medicaid Spending, TABOR, and Inflation, 2019 – 2024



Key Considerations

The Consumer Price Index for Urban Consumers (CPI-U) and Medical CPI (MCPI) are measures of price inflation.

- Historically, MCPI has tended to outpace CPI-U nationally, but it can be unpredictable over shorter time horizons.
- These measures do not account for changes in the population.
- Medical inflation does not reflect the mix of services and populations covered by Medicaid and has varied considerably relative to general inflation pre- and post-COVID-19.

Medicaid spending (or cost) growth is driven by both medical price inflation, as well as the volume, acuity, and service mix of its population.

- Medicaid enrollment tends to grow during economic downturns, when tax revenues also go down.

Source: Medicaid spending: CMS-64 reports, FFY 2018 - 2024; Denver CPI-U: BLS; Denver Medical CPI: BLS; TABOR: The average growth rate identified from 'Schedule of TABOR Revenue Fiscal Year' reports from the Colorado Office of the State Auditor from 2019 - 2024.

Colorado Medicaid Landscape Analysis

manatt

Landscape Analysis Data Sources

Manatt reviewed over 75 reports, datasets, and materials from the State – and conducted nearly twenty interviews with state SMEs – to identify and contextualize Landscape Analysis findings.

State-Provided Data

- HCPF Premiums, Expenditures and Caseload Reports
- Joint Budget Committee Appropriation Reports and Governor's Office Budget Projections
- Re-priced behavioral health encounter data
- Adjusted CMS-64 reports
- Research memos developed by the HCPF Research & Analysis Team
- Legislative Request for Information Reports
- HCPF Billing Manuals, Medicaid Provider Rate Review Advisory Committee (MPRRAC) Reports and RAE Contracts
- Additional reports and ad hoc data requests

Federal and National Data Sources

- MACStats Medicaid and CHIP Data Books,
- CMS-64 Reports
- Kaiser Family Foundation (KFF) State Health Facts
- CMS Adult and Child Core Set
- American Association of Retired Persons (AARP) Scorecards
- Additional reports and data sources

State Interviews

- 17 state subject matter expert (SME) interviews

manatt

Public Data Challenges & Mitigation Strategies

The Landscape Analysis leveraged publicly available data to support its cross-state comparisons. While these data offer standardized cross-state comparisons, they also have limitations.

- **Data Timeliness:** Public data for many of metrics-of-interest may be lagged by several years (e.g., some Outcome metrics may only have data available through 2022 or 2023), limiting timely current state comparisons.
- **Data Availability:** Public data are not always available for metrics of interest (e.g., spending by service category across populations).
- **Data Accuracy:** Public data are often secondary sources, based on other source reporting; to the extent that the primary source analyses or reporting is inaccurate, the public data will also be inaccurate (e.g., Colorado's CMS-64 LTSS reporting during FFY 2018 and 2019).
- **Data Comprehensiveness:** Public data do not reflect individual state environments, including differences across populations, delivery systems, policies, and programs.
- **Anomalous Trends:** Data from 2020 through 2022 reflect an anomalous time in our health care system, with the COVID-19 Public Health Emergency (PHE) impacting how individuals interacted with the health care system and broader health care system financing.

manatt

Colorado Medicaid/CHP+ Total Expenditures Over Time

Colorado Medicaid/CHP+ spending has increased by nearly 60% since SFY 2018 - or around 8% growth per year. HCPF projects similar growth rates to persist in the coming years.

Total Medicaid / CHP+ Appropriations (millions),

SFY 2018 – 2025

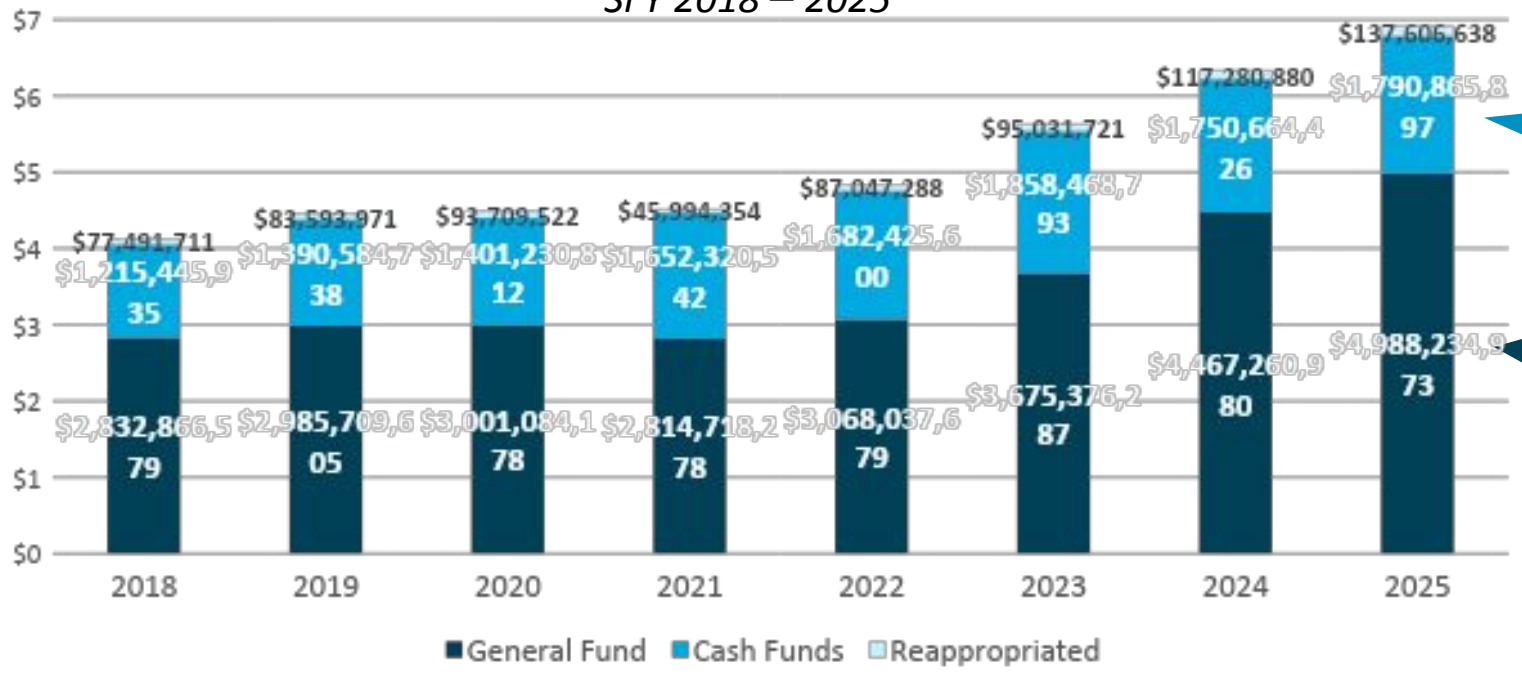
Note: State Funds include General Fund, Cash Funds, and Reappropriated Funds.
Source: 2024 Appropriations History Report FY 2015-16 through FY 2024-25

manatt

Source of State Share for Colorado Medicaid / CHP+

Colorado's ability to support a growing Medicaid/CHP+ state share will likely be further strained by new challenges for raising General Fund and Cash Fund revenues.

Source of State Share for Medicaid / CHP+ Appropriations (billions),
SFY 2018 – 2025



H.R. 1 will limit Colorado's ability to collect new **Cash Fund** provider fees (while increasing program administrative costs).

Colorado's ability to increase **General Fund** contributions will be limited by TABOR, which restricts the growth of state revenue to a formula based on inflation and population growth.

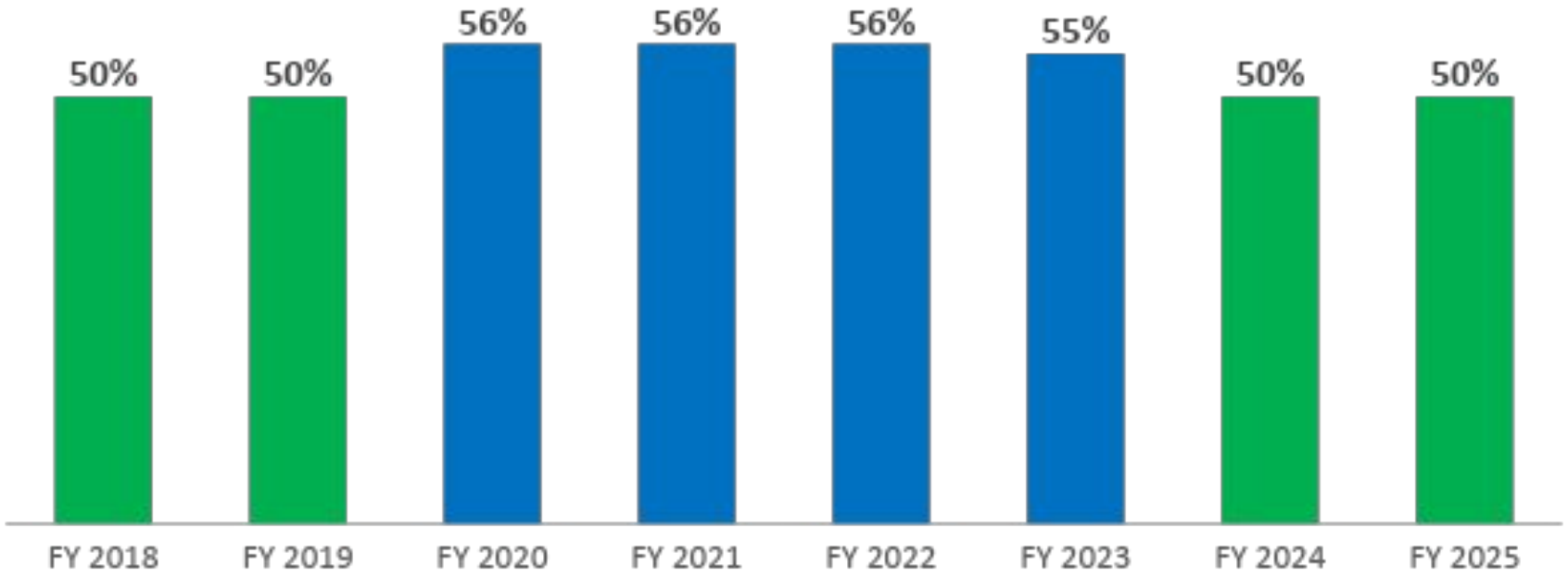
Source: 2024 Appropriations History Report FY 2015-16 through FY 2024-25

manatt

Challenge: Colorado's Federal Medical Assistance Percentage (FMAP)

Colorado is among the states with the lowest FMAP nationally (50%), limiting its ability to draw down federal matching funds for certain populations and services.

Colorado FMAP, FFY 2018 – 2025



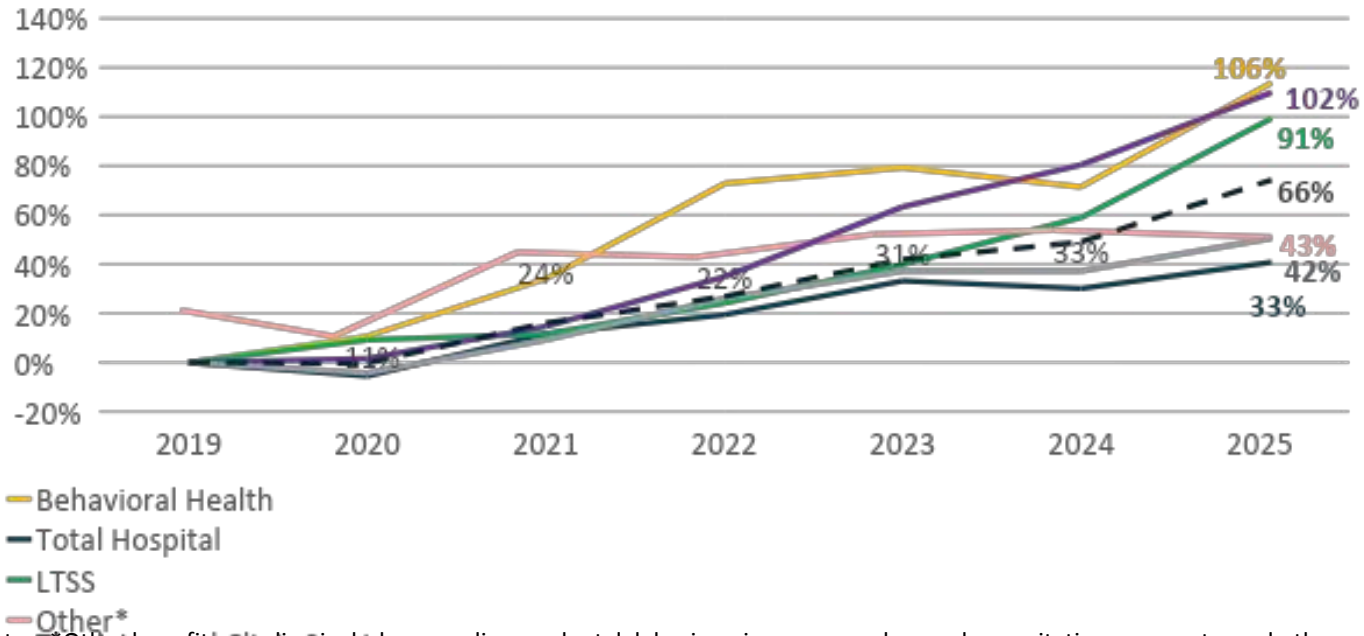
60.1%
Average State FMAP
in FFY 2025

Note: During the public health emergency, states received an enhanced FMAP that phased out by FY 2024. The average FMAP includes all 50 states and Washington D.C.
Source: MACStats (Exhibit 6), Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages by State, FY 2018 – 2025

Colorado Medicaid Cost Growth Drivers

Colorado's spending growth associated with LTSS, behavioral health services, and prescription drugs outpaced overall Medicaid spending growth between SFY 2019 and 2025.

Growth in Total Medicaid Benefit Spending by Category,
SFY 2019 – 2025



Total Medicaid Benefit Spending and Benefit Spending Growth by Category

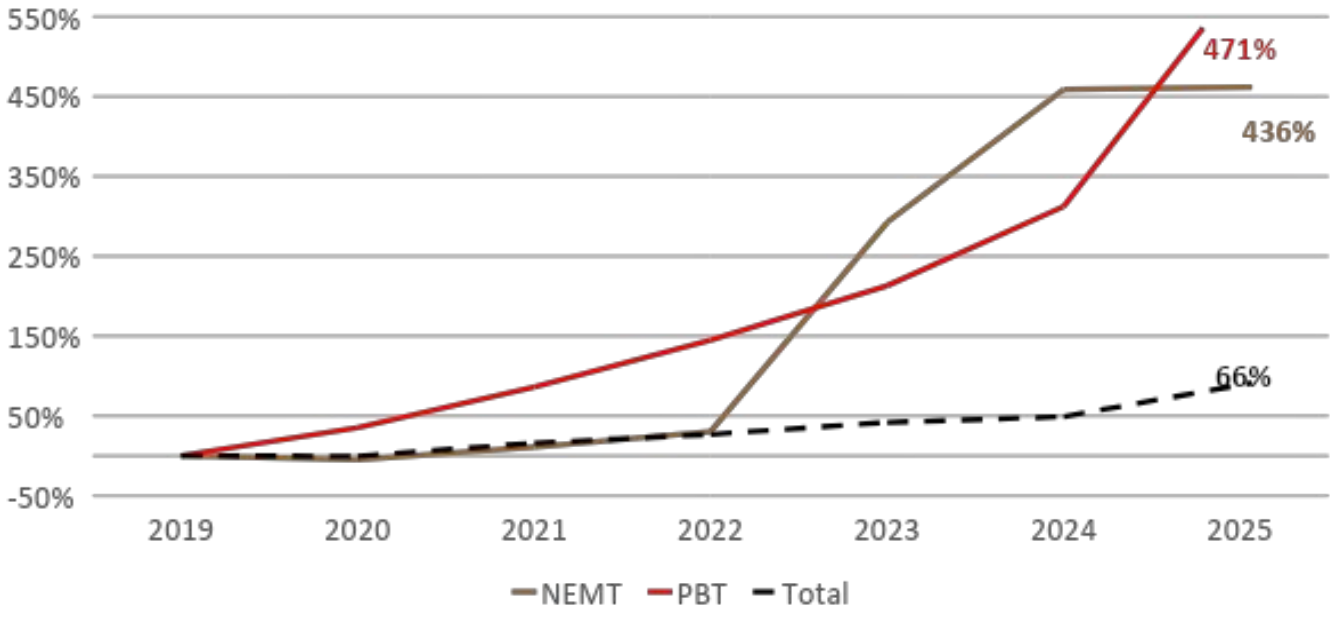
	% Change in Spending, SFY 2019 – 2025	Total Benefit Spending (Millions), SFY 2025
Long Term Services and Supports (LTSS)	91%	$5,316
Total Hospital	33%	$3,313
Inpatient Base Payments	33%	$1,062
Outpatient Base Payments	45%	$724
Supplemental Payments	27%	$1,527
Other*	43%	$2,790
Behavioral Health	106%	$1,241
Physician and Clinic Services	42%	$1,106
Pharmacy	102%	$781
Non-Emergency Medical Transportation (NEMT)	436%	$289
Pediatric Behavioral Therapy (PBT)	471%	$287
Total	66%	$15,122

Notes: *Other benefit spending includes spending on dental, labs, imaging, managed care plan capitation payments, and other benefits. Total Medicaid benefit spending calculated from monthly caseload reports; which may result in differences from prior reporting. Pharmacy spending does not include physician-administered drugs. Pharmacy spending and total spending include drug rebates. HCPF provided adjusted drug rebate data excluding rebates on physician administered drugs to align with pharmacy spending captured in Caseload reports. Estimated rebates for CY 2024 used as a proxy for rebates in SFY 2025 due to data lag. Hospital supplemental payments include inpatient and outpatient supplemental payments.
Source: Data on PBT spending and drug rebates provided by HCPF; all other data from Colorado Caseload reports from SFY 2019-2025

Colorado Medicaid Cost Growth Drivers (Continued)

Colorado's PBT and NEMT spending has increased over four-fold between SFY 2019 and 2025, far outpacing overall Medicaid spending growth.

Growth in Total Medicaid Benefit Spending by Category,
SFY 2019 – 2025



Notes: *Other benefit spending includes spending on dental, labs, imaging, managed care plan capitation payments, and other benefits. Total Medicaid benefit spending calculated from monthly caseload reports; which may result in differences from prior reporting. Pharmacy spending does not include physician-administered drugs. Pharmacy spending and total spending include drug rebates. HCPF provided adjusted drug rebate data excluding rebates on physician administered drugs to align with pharmacy spending captured in Caseload reports. Estimated rebates for CY 2024 used as a proxy for rebates in SFY 2025 due to data lag. Hospital supplemental payments include inpatient and outpatient supplemental payments.
Source: Data on PBT spending and drug rebates provided by HCPF; all other data from Colorado Caseload reports from SFY 2019-2025

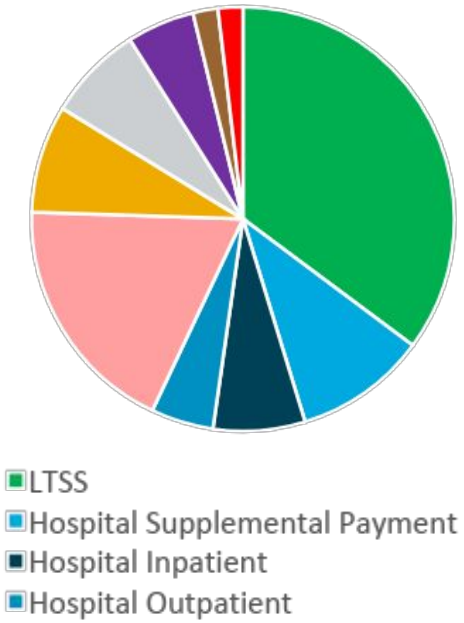
Total Medicaid Benefit Spending and Benefit Spending Growth by Category

	% Change in Spending, SFY 2019 – 2025	Total Benefit Spending (Millions), SFY 2025
Long Term Services and Supports (LTSS)	91%	$5,316
Total Hospital	33%	$3,313
Inpatient Base Payments	33%	$1,062
Outpatient Base Payments	45%	$724
Supplemental Payments	27%	$1,527
Other*	43%	$2,790
Behavioral Health	106%	$1,241
Physician and Clinic Services	42%	$1,106
Pharmacy	102%	$781
Non-Emergency Medical Transportation (NEMT)	436%	$289
Pediatric Behavioral Therapy (PBT)	471%	$287
Total	66%	$15,122

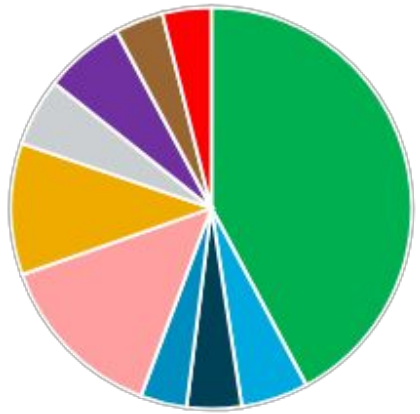
Cost Centers vs. Cost Growth Drivers

LTSS, behavioral health, and pharmacy spending disproportionately drove growth in Colorado's total Medicaid benefit spending between SFY 2019 and 2025.

Share of Total Medicaid Benefit Spending by Category, *SFY 2025*



Share of Total Medicaid Benefit Spending Growth by Category, *SFY 2019 – 2025*



Total Medicaid Benefit Spending and Benefit Spending Growth by Category

	% of Total Spending in SFY 2025	% of Total Spending Growth, SFY 2019 - 25
LTSS	35.2%	42.1% (+6.9 pct pts)
Hospital Supplemental Payments	10.1%	5.4% (-4.7 pct pts)
Hospital Inpatient	7.0%	4.4% (-2.6 pct pts)
Hospital Outpatient	4.8%	3.7% (-1.1 pct pts)
Other*	18.4%	13.9% (-4.5 pct pts)
Behavioral Health	8.2%	10.6% (+2.4 pct pts)
Physician and Clinic Services	7.3%	5.5% (-1.8 pct pts)
Pharmacy	5.2%	6.5% (+1.3 pct pts)
NEMT	1.9%	3.9% (+2 pct pts)
PBT	1.9%	3.9% (+2 pct pts))

Notes: *Other benefit spending includes spending on dental, labs, imaging, managed care plan capitation payments, and other benefits. Total Medicaid benefit spending calculated from monthly caseload reports; which may result in differences from prior reporting. Pharmacy spending does not include physician-administered drugs. Pharmacy spending and total spending include drug rebates. HCPF provided adjusted drug rebate data excluding rebates on physician administered drugs to align with pharmacy spending captured in Caseload reports. Estimated rebates for CY 2024 used as a proxy for rebates in SFY 2025 due to data lag. Hospital supplemental payments include inpatient and outpatient supplemental payments.

Source: Data on PBT spending and drug rebates provided by HCPF; all other data from Colorado Caseload reports from SFY 2019-2025

Landscape Analysis Findings: Behavioral Health Spending

Key Findings

Behavioral health capitation spending per member more than doubled from SFY 2018 to 2025.

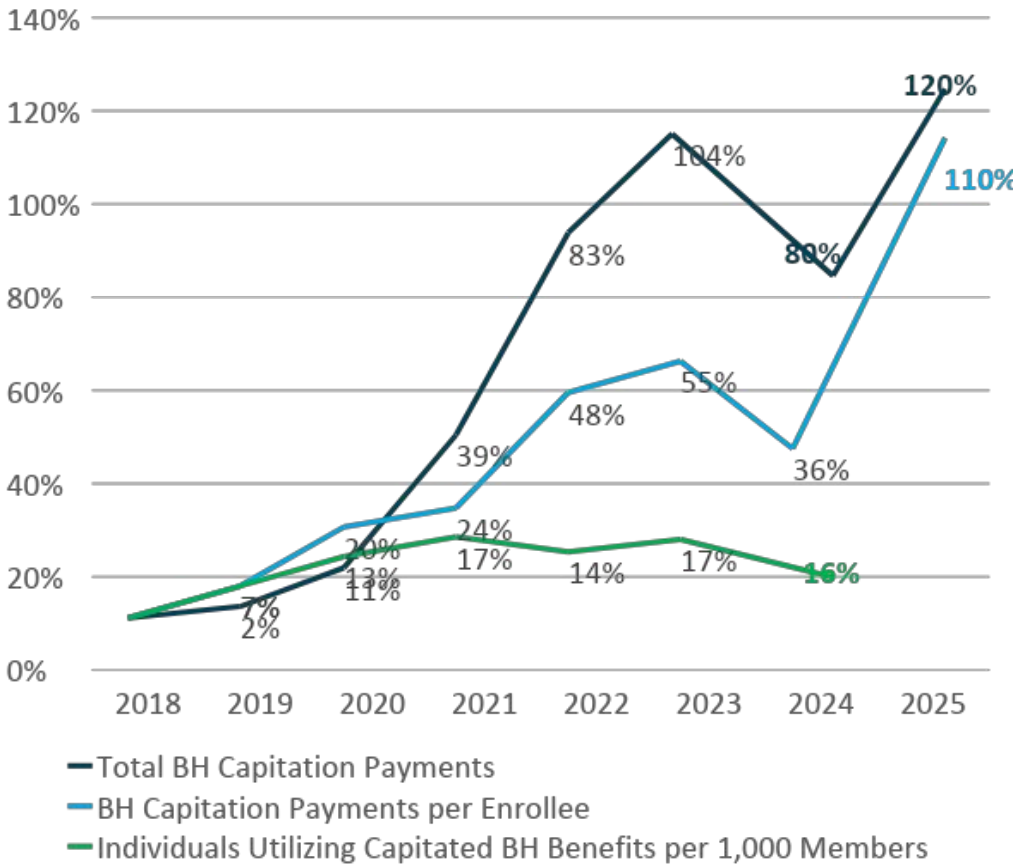
Over the past decade, Colorado prioritized expanding access to behavioral health services for low-income Coloradans.

Behavioral health spending now accounts for approximately **8% of total Medicaid benefit spending** ($1.24 billion).

Increased behavioral health capitation spending has been **driven by the volume and costs of services** being utilized. **Services and providers** driving spending growth include:

- Spending on **outpatient prevention and treatment** and **community and peer supports**.
- Spending attributable to the **independent provider network increased 75%** from SFY 2022 to 2024.

Growth in Behavioral Health (BH) Capitation Payments and Utilizers of Capitated BH Services, *SFY 2018 – 2025*



Source: Data provided by HCPF; Behavioral Health Legislative Request for Information Reports. Data on number of individuals utilizing capitated BH benefits per 1,000 members in SFY 2025 is not yet available.

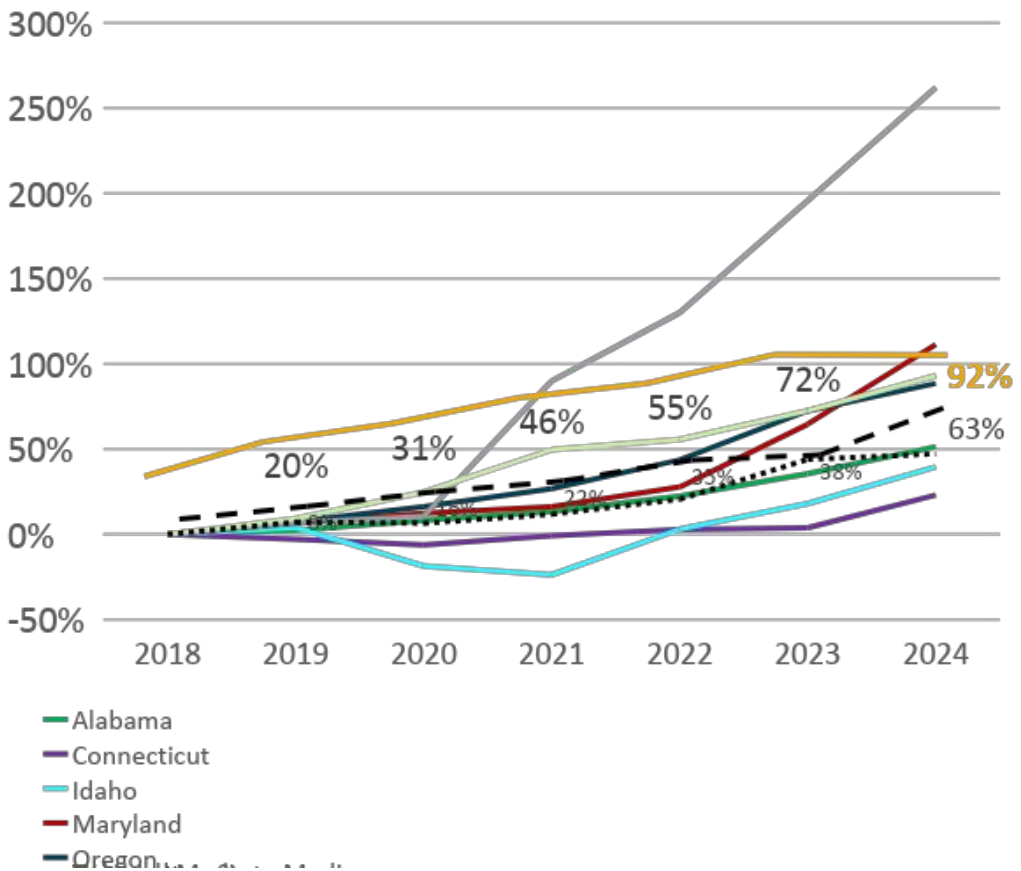
Landscape Analysis Findings: LTSS Spending

Key Findings

Colorado's LTSS spending growth from FFY 2018 to 2024 outpaced most Comparator States.

- Colorado has made **significant and intentional investments** in LTSS to expand **access**, improve **equity**, and strengthen the direct care **workforce** over the past decade.
  - Colorado's LTSS spending growth has primarily been driven by increases in LTSS base **wages** and provider **rates**.
- Colorado's LTSS spending <u>levels</u> in FFY 2024 were generally ***on par*** **with Comparator States** in terms of spending as a share of total benefit spending and per recipient.
- LTSS spending increased **20%** from SFY 2024 to 2025, accounting for **more than half** of benefit spending growth over this time.
- Spending on select **waivers** (e.g., Developmental Disabilities, Children's Extensive Supports, Elderly, Blind and Disabled) and state plan benefits (e.g., Long Term Home Health) are driving cost growth.

Growth in LTSS Spending Across Comparator FFS LTSS States,
FFY 2018 – 2024



Note: This analysis focuses on states with FFS LTSS programs because CMS-64 data do not accurately capture LTSS spending in states with managed care LTSS programs.
Source: CMS Scorecard, FY 2018 – 2023; Analysis of CMS-64s, FY 2024.

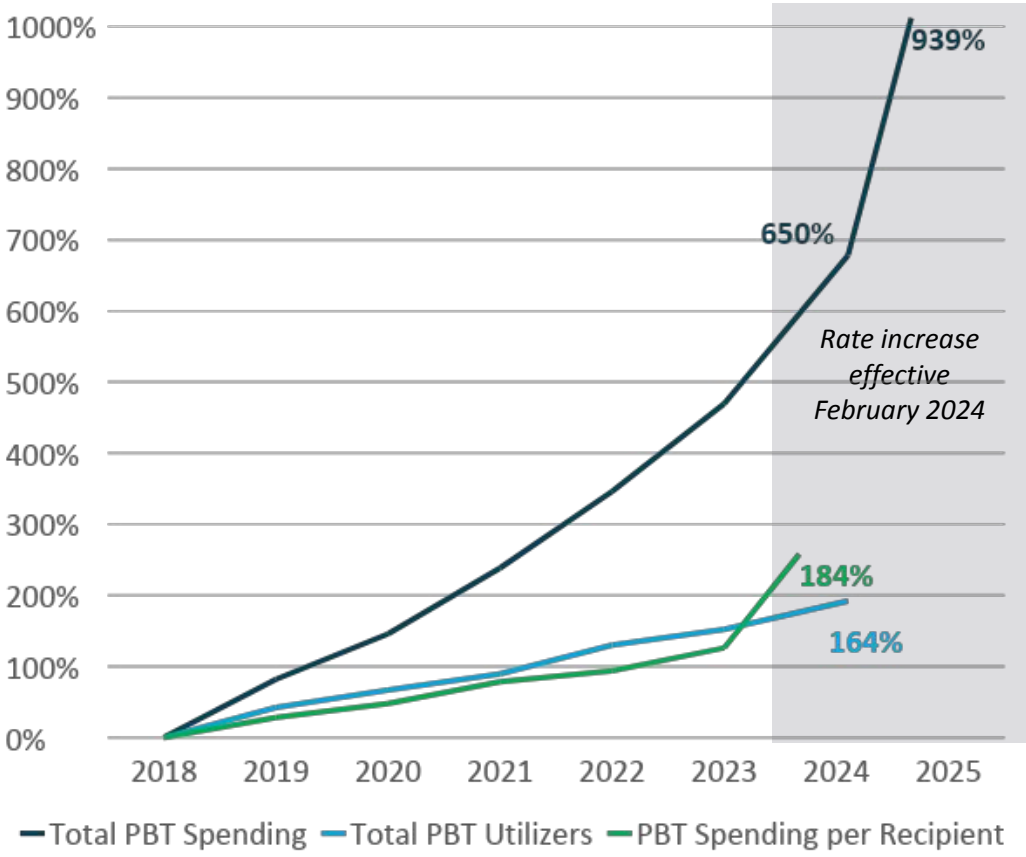
Landscape Analysis Findings: PBT Spending

Key Findings

PBT spending per service recipient nearly tripled from SFY 2018 to 2025.

- Colorado - like many other states - is experiencing significant increases in **utilization** and **spending** on PBT.
- **PBT service spending now comprises approximately 2% of Colorado Medicaid benefit spending** ($287 million) – a nearly ten-fold increase since SFY 2018.
- Increased PBT spending is **primarily driven by increased rates** and **the average number of hours utilized** per week.
- State PBT utilization and spending are **not evenly distributed** across providers, raising concerns about consistency in medical necessity of the services being delivered, and the financialization of the service by private equity.

Growth in PBT Spending and Members Utilizing PBT
SFY 2018 – 2025



Source: Data provided by HCPF. Data on number of individuals utilizing PBT services in SFY 2025 not yet available.

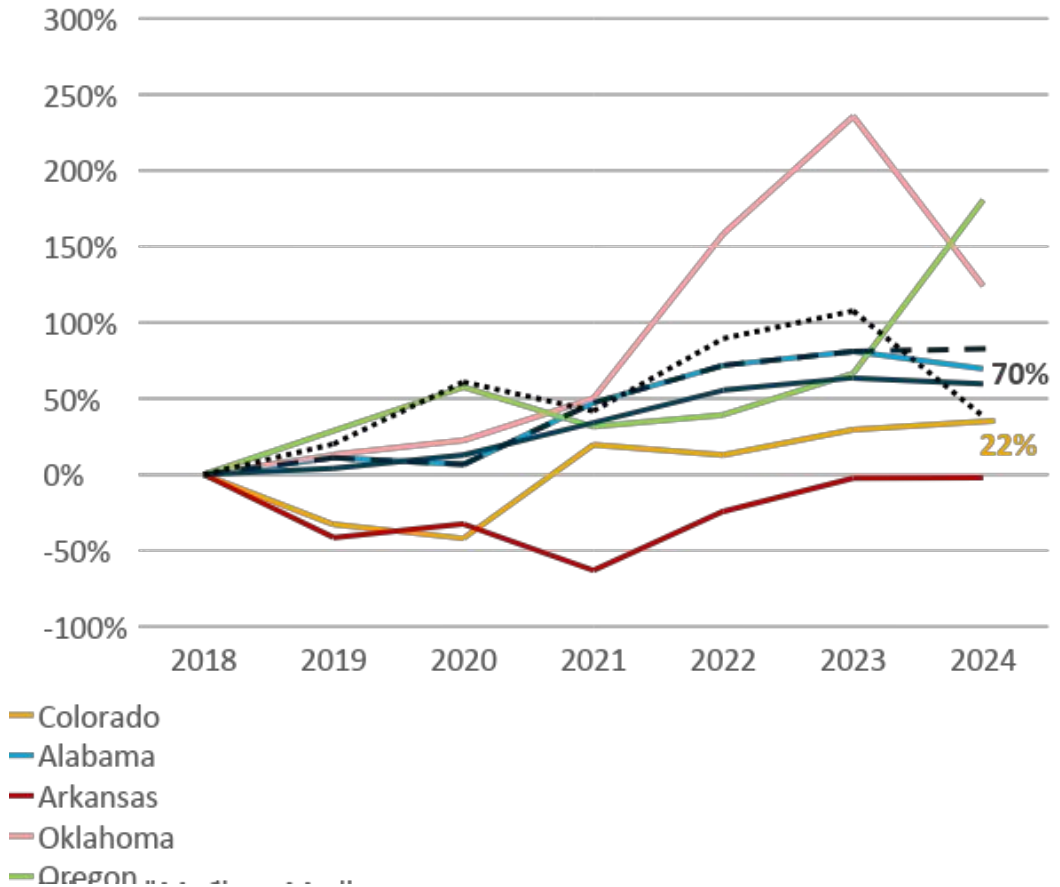
Landscape Analysis Findings: Pharmacy Spending

Key Findings

Specialty drug spending drove pharmaceutical spending in Colorado Medicaid.

- Post-rebate prescription drug (Rx) spending in Colorado exceeded $780 million in SFY 2025 (**5.2% of benefit spending**).
- Colorado post-rebate Rx spending increased more **slowly** than most FFS Comparator States (FFY 2018 – 2024).
- The cost of **specialty drugs** has been identified as an area of concern for most Medicaid programs across the country.
  - Colorado post-rebate spending on specialty drugs **increased 121%** between SFY 2019 and 2024.
  - Specialty prescription drugs account for only **2% of drugs dispensed**, but nearly **60% of post-rebate Rx spending.**

Growth in Post-Rebate Prescription Drug Spending Across FFS Comparator States, FFY 2018 – 2024



Note: This analysis focuses on states with FFS pharmacy benefits because CMS-64 data do not accurately capture pharmacy spending in states with managed care pharmacy benefits.
Source: CMS Scorecard, FY 2018 – 2023; Analysis of CMS-64s, FY 2024

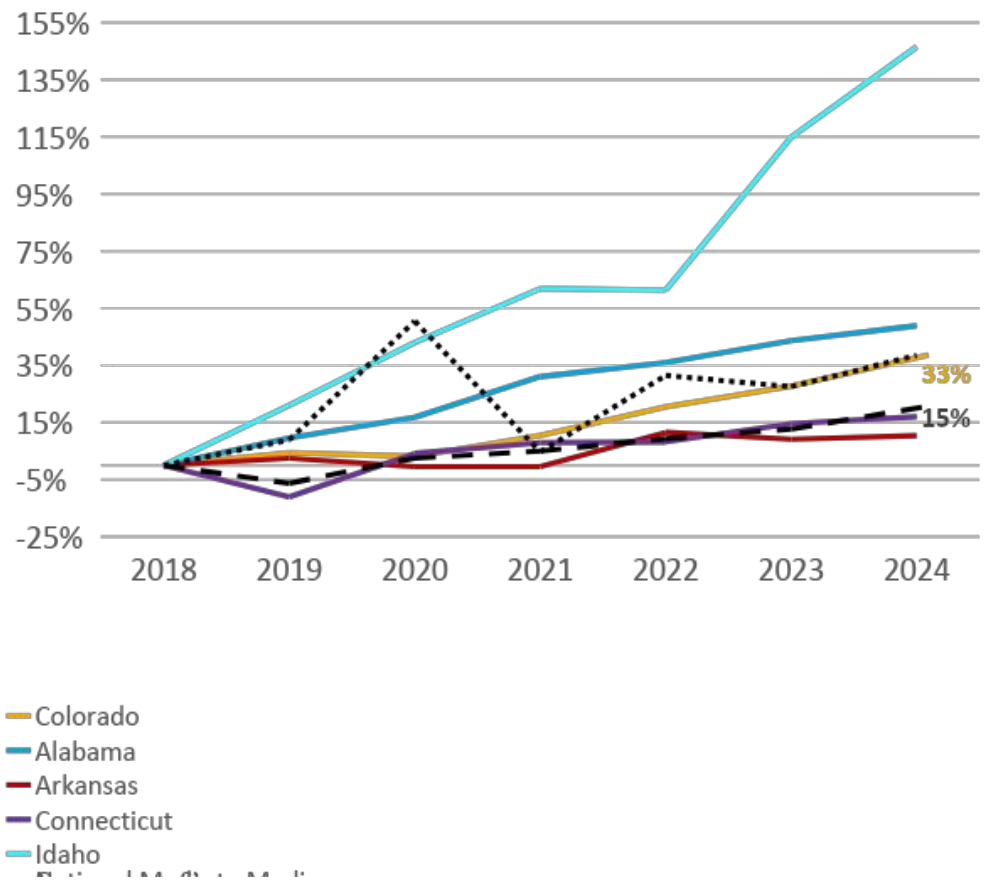
Landscape Analysis Findings: Hospital Spending

Key Findings

Hospital spending in Colorado Medicaid has grown slower than overall Medicaid spending.

- Colorado's **total hospital spending grew 33%** between SFY 2019 and 2025 to exceed **$3.3 billion,** compared with a **67% increase in total Medicaid benefit spending**.
  - Hospital expenditures are the second largest cost center for Colorado Medicaid.
- Total hospital spending is comprised of inpatient and outpatient base payments as well as supplemental payments.
  - Inpatient hospital base **rates were rebased on July 1, 2023**.
  - **Supplemental payments are TABOR exempt** and funded by provider fees rather than the General Fund. H.R. 1 will prevent Colorado from implementing new or increased provider fees.
- Colorado's inpatient hospital spending growth between FFY 2018 and 2024, including inpatient base and supplemental payments, was **on par with FFS Comparator States** (see figure on right).
  - Colorado's inpatient hospital **spending per enrollee** is also in-line – or lower than – that in other FFS states.

Growth in Inpatient Hospital Base and Supplemental Payments Across FFS Comparator States, *FFY 2018 – 2024*



Note: This analysis focuses on states with FFS delivery systems because CMS-64 data do not accurately capture hospital spending in states with managed care delivery systems.
Source: CMS Scorecard, FY 2018 – 2023; Analysis of CMS-64s, FY 2024

Landscape Analysis Findings: Administrative Services Spending

Key Findings

Administrative Service spending growth in Colorado has outpaced national and most Comparator State increases.

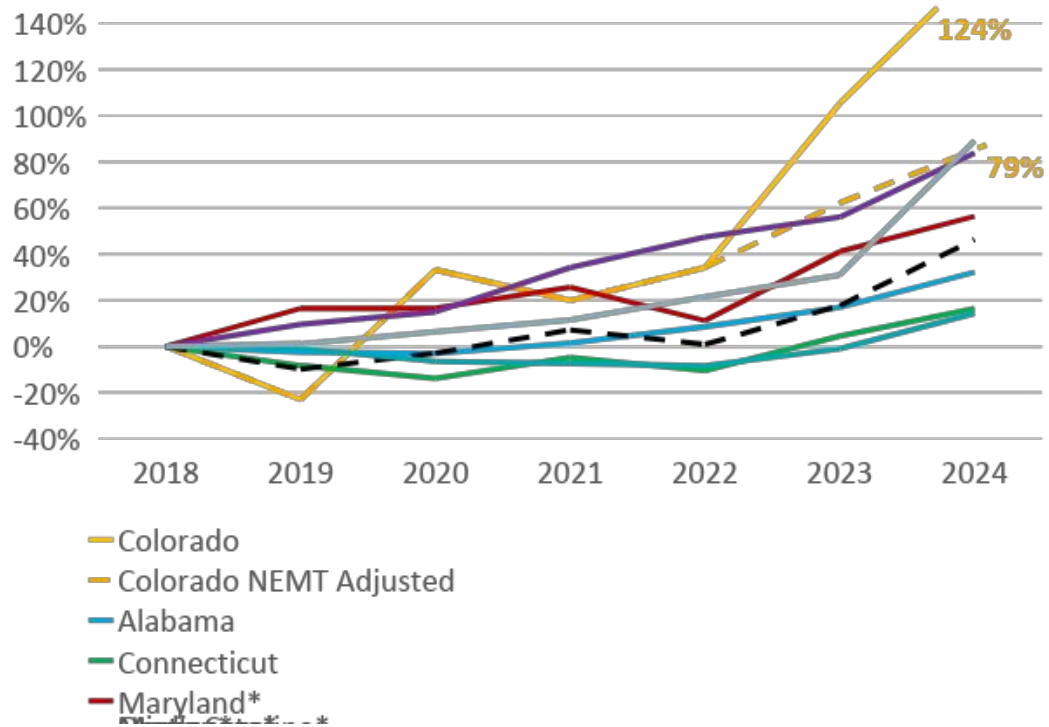
Excluding NEMT spending, Colorado's **administrative spending as a share of total Medicaid spending (~4.7%) was on par** with national and Comparator State measures in FFY 2024.

Administrative service spending is **matched at rates** ranging from 1:1 to 9:1 by the federal government depending on expenditure type.

- Nearly 60% of Colorado's administrative spending was covered by the federal government in FFY 2024, on par with Comparator States.

- Colorado includes NEMT services within its administrative service reporting to CMS. Colorado Medicaid's NEMT service spending grew considerably between FFY 2018 and 2024 (+732%).
  - HCPF has taken recent **action to respond to the increase in NEMT spending** (e.g. moratorium on new providers).

Medicaid Administrative Spending Relative to FFY 2018 Across Comparator States, *FFY 2018 – 2024*



Note: Asterisks denote high managed care states. Colorado NEMT Adjusted represents Colorado administrative spending growth, holding NEMT spending at FY 2022 levels in FY 2023 and 2024. CHP+ administrative spending is not included. Administrative spending by RAEs and managed care plans is not included. Median reflects national median across all states. Colorado NEMT spending ($millions): ($152)-2018, $34-2019, $49-2020, $63-2021, $93-2022, $270-2023, $280-2024.
Source: CMS Scorecard, FY 2018 – 2023; Analysis of CMS 64s, FY 2024

Landscape Analysis Findings: Administrative Services Cont.

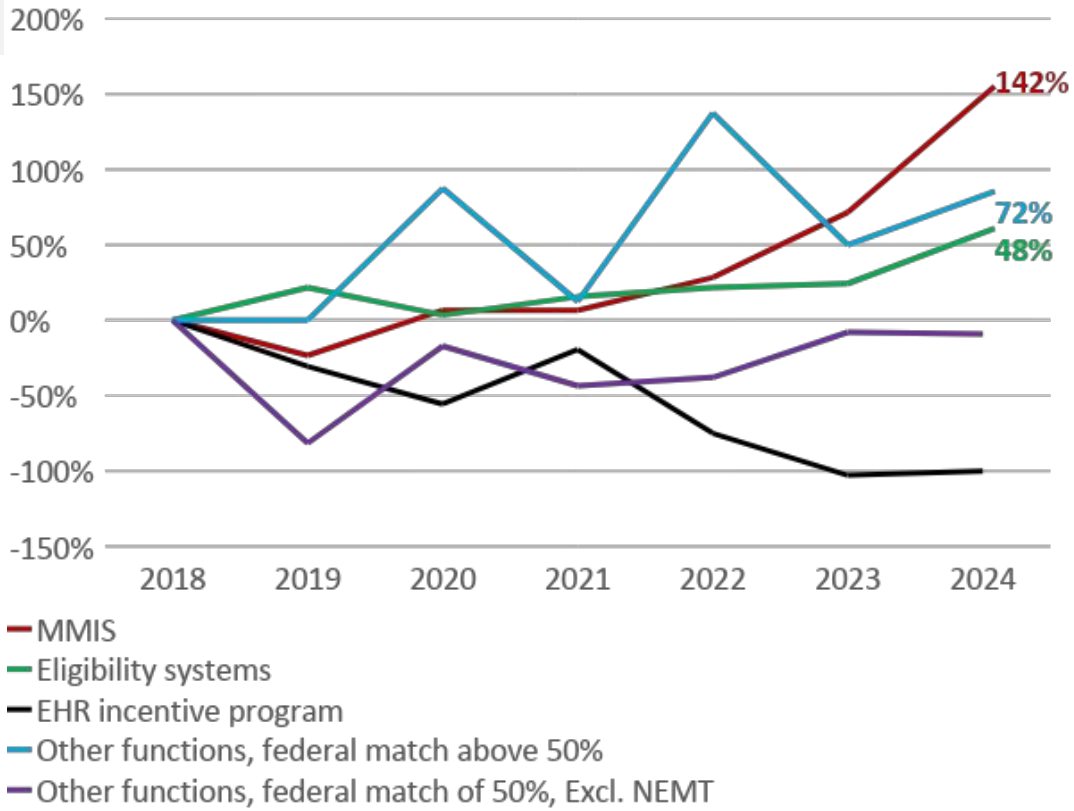
Key Findings

MMIS spending has been a core driver of (non-NEMT) Administrative Service spending in recent years.

Colorado spent **$641** million on Medicaid administrative services other than NEMT in FFY 2024.

- **"Other functions"** (matched at 50% FMAP) and **eligibility systems** accounted for the largest portions of non-NEMT administrative spending in FFY 2024 (49% and 27% respectively).
- While only comprising 23% of non-NEMT administrative service spending, **MMIS spending growth accounted for the majority of spending growth** between FFY 2023 and 2024.
    - This increase may reflect recent state investments to meet federal **modularity** requirements.

Colorado Total Administrative Spending by Category Relative to FFY 2018, *FFY 2018 – 2024*



Note: CHP+ spending is not included. NEMT spending is not included.
Source: MACStats (Exhibit 31), Total Medicaid Administrative Spending by State and Category, FY 2018 – 2023, CMS 64 Reports, FY 2024

Key Question: Colorado's Medicaid Delivery System

The Landscape Analysis assessed whether Colorado should consider shifting its Medicaid delivery system to comprehensive Medicaid managed care (MMC).

Managed Care Impact: Evidence from the Field

- ✔ MMC is positively associated with **lower hospital spending** (inpatient and outpatient) and rates of preventable emergency department (ED) utilization
- x No evidence of significant impact on **budget predictability**
- x Little evidence of decreases in **overall state Medicaid spending**
- x Mixed evidence MMC's impact on **drug spending and quality**
- ✔ Opportunities to **control costs** through population health management (risk assessments, care management) and utilization management (PARs, step therapy)

manatt

Key Question: Colorado's Medicaid Delivery System

After evaluating available evidence, Manatt determined that transitioning to managed care is not likely to generate significant savings for Colorado at this time.

Colorado Current State

- ✔ **Not an outlier in its inpatient hospital spending** growth or inpatient hospital spending per enrollee relative to other fee-for-service states
- ✔ **Performs at or better** than the national median on metrics of costly avoidable care
- ✔ Invested in **population health management** through the ACC program by aligning payment and outcomes
- ✔ Colorado's administrative spending compares favorably to managed care states*

Conclusion

- The RAEs perform **key, value-generating functions** under the current delivery system.
- Core **methods and interventions** of managed care are already in place.
- Sustained utilization management authorities are critical to support medical necessity and program sustainability.

*Medicaid administrative spending in Colorado is estimated to total ~5.7% (~4.2% in direct state administrative spending and ~1.5% in RAE administrative spending); this compares favorably to estimates from managed care states of ~9.4% (~3.5% in state administrative spending and ~5.9% in managed care administrative spending). Colorado state/HCPF estimates of Medicaid administrative spending may differ due to methodological and data source differences.

Developing Policy Strategies

manatt

Policy Guiding Goals

This project seeks to identify specific, cost-saving and value-enhancing Policy Actions that are aligned with the state's "Guiding Goals."

Guiding Goals
Produce cost savings: Slow cost growth and increase program efficiency
Emphasize feasibility: Optimize actionability, minimize state burden, build on and learn from current Colorado initiatives
Support long-term sustainability: Promote value-driven solutions over more expedient, but potentially short-sighted, cost-reduction measures
Prioritize member health and experience: Improve or sustain member access/coverage, quality of care, and experience
Minimize adverse impacts on the delivery system: Confirm delivery system readiness, minimize administrative and financial burden and align delivery system incentives with state goals

manatt

Identifying Areas for Policy Actions

Opportunities Selected for Immediate Policy Actions

Manatt, the Governor's Office, and HCPF collectively identified the following areas as key opportunities for Policy Actions under this project, based on Landscape Analysis findings:

Behavioral Health	**Long Term Services & Supports (LTSS)**	**Pediatric Behavioral Therapy (PBT)**	**Pharmacy**

Colorado is actively developing policy solutions outside of this project to address factors driving cost growth in other areas.

manatt

Preview of Preliminary Colorado Policy Actions

1. Withdrawal Management Update	Inpatient withdrawal management is not clinically indicated for all substance use; Colorado would shift to more effective outpatient alternatives where appropriate.
2. Tiered Pricing for Select Behavioral Health Services	Colorado pays for a higher level of care/intensity for some services than is appropriate for all members; tiered prices would better reflect the costs of services provided.
3. Mobile Health Services	Colorado would expand mobile health, which is evidence-supported as both saving costs and improving access and health outcomes.
4. LTSS Program Integrity	Provider behavior, including direct to consumer advertising leading to a high reliance on family caregiving models, is making it harder to ensure members get the right level of care for their needs; Colorado would address through multiple strategies that oversee providers and educate members
5. PBT Standardized Assessments	Standardized assessments for PBT would help support clinically-informed individual treatment planning, ensuring members get the right level of service.
6. Modify Protected Drug Classes	Colorado would implement responsible utilization management strategies for select drugs, increasing rebates and addressing recent cost growth, while ensuring continued access to medically necessary drugs.

manatt

Policy Action #1 Overview: Update Withdrawal Management Policies

Policy Action

Update **inpatient withdrawal management (WM) policies** by:

- Strengthening **medical necessity and settings requirements** to reflect clinical best practices, requiring outpatient WM when appropriate
- Requiring RAEs to align their **prior authorization procedures** with these best practices
- Requiring RAEs to increase frequency of levels of care **assessments**
- Updating **RAE capitation rates** accordingly

Rationale

- Inpatient WM has **grown significantly** since its introduction in 2021. For example, from CY 2022 to 2024,
  - Medicaid spending on **residential treatment** increased by 90% and drove 23% of behavioral health capitation growth.
- However, inpatient WM is **not clinically indicated** for some substances (e.g. for opioid and stimulant use disorder).

Evidence & Examples

- Evidence suggests that individuals who frequently receive WM are a particularly **costly** population.
- This Action aligns with clinical consensus; multiple studies reinforce that outpatient opioid use disorder care results in **better outcomes** than inpatient care.

- Many states similarly **manage intensive SUD services**, by requiring:
  - Prior authorization (17 states)

SUD services to be rendered in “least intensive level of care” medically necessary (CA)

Frequent updates to stabilization plans (OR)

manatt

Policy Action #2 Overview: Tiered Pricing

Policy Action

Implement a tiered pricing model for **select behavioral health services** including:

- Outpatient therapies
- Outpatient crisis stabilization, and/or
- Hospital inpatient mental health

Prices/rates for these services could be tiered based on patient **acuity**, **service costs and intensity**, or **geographic** variations in cost.

Rationale

- Recent behavioral health capitation growth was driven most substantially by **outpatient services** (41% of the overall growth).
- Currently, pricing does not always accurately **reflect the appropriate cost** of these services; for example, crisis stabilization units, an alternative to hospitalization, are often reimbursed at a higher rate than hospitalization.
- Tiered pricing may help to ensure members are getting **the right level of care in the right setting** and reduce costs.

Evidence & Examples

- Tiered pricing models are **encouraged** by CMS and can be designed to **generate cost savings**.
- Tiered pricing models can be **complex** to design and implement and HCPF will need to **monitor** providers closely to ensure savings are sustained.

- Many states use **tiered pricing** in BH services, for example by:
  - Stratifying many BH rates by provider type and county (CA)
  - Tiering rates for inpatient psychiatric care by level of care and patient acuity (FL)
  - Tiering rates for crisis services based on patient acuity and geography (NY)

Policy Action #3 Overview: Mobile Health Services

Policy Action

Expand **non-crisis mobile health services**, for example, through expansion and investment in **community paramedicine** or mobile health units.

Rationale

- Hospital spending is a substantial cost center; data suggests that **behavioral health needs** are also contributing to **inpatient hospital costs** and increases in the behavioral health capitation rate.
- Mobile health services can expand access to **preventive** outpatient access and **reduce avoidable inpatient care.**
- Colorado already has mobile health provider **infrastructure** to build on.
- The state could **expand** some non-crisis, behavioral health services (e.g., post-hospitalization or post-overdose follow-up) and scale **infrastructure and payment** to address physical health.

Evidence & Examples

- A significant body of evidence suggests that mobile health units and community paramedicine programs result in **net cost savings** and improve **access to care** and **health outcomes.**
- Scaling mobile health would carry **up front costs** both to build provider capacity and in some use cases, reimburse for the service.

- Many states are leveraging these services effectively:


Broad **community paramedicine** programs (MN and NV)


Post-overdose mobile response teams (NC and CA)

manatt

Policy Action #4 Overview: Increase Program Integrity

Policy Action

Increase program integrity in LTSS by strengthening and enforcing rules and regulations related to:

- **Direct-to-consumer** (DTC) **advertising**
- The role of **Case Management Agencies** (CMAs) in managing appropriate **assessment, authorization, and monitoring** of services
- **Educating** providers and caregivers/members on **fraud prevention**

And, **developing a comprehensive family caregiver strategy** to support this essential workforce while ensuring long term fiscal sustainability

Rationale

- Colorado spent **$5.3 billion** on LTSS in SFY 2025, where it accounted for ~35% of total Medicaid benefit spending.
- HCPF is concerned that **provider behavior**, including direct-to-consumer advertising and coaching on waiver eligibility and assessments, is driving **increased waiver enrollment** and **service utilization** that do not always align with level of need, as well as a high reliance **on family caregiving**.

Evidence & Examples

- Program integrity efforts broadly can support the successful and appropriate allocation of limited resources to address members' needs.
- Federal and state audits and investigations have validated the **risk** and evidence of **improper payment** and quality control failures in HCBS programs.

- Many states regulate direct-to-consumer advertising in the LTSS space, for example:

Bars FFS home health providers from influencing member choice (MA)

Requires written approval before advertising personal care services (NM)

Places restrictions on HCBS provider advertising (WI)

Policy Action #5 Overview: PBT Standardized Assessments

Policy Action

Require providers use **standardized assessments** for Pediatric Behavioral Therapy (PBT) **treatment planning** that build upon sound clinical criteria and would be applied at the individual level to improve **care planning** and help ensure services meet individual needs. This Action would complement other strategies HCPF is already pursuing to address PBT spending ~~growth~~.

Rationale

- In SFY 2025, **~2%** of total Medicaid benefit spending was on PBT and from SFY 2018 to 2024, spending on PBT increased 650% while enrollment only increased 164%.
- **A variety of PBT-related assessment tools** are currently used to determine level of need and medically necessary treatment.
- Standardizing assessments could **save costs** by accurately determining the level of need and the **appropriate PBT modality**/intensity, and deterring inappropriate service use.
- Effective **utilization management** could also help reinforce the value of standardized assessments.

Evidence & Examples

- Clinical best practices have **not coalesced** around a single standardized assessment for PBT.
- Clinical evidence does, however, reinforce the **value of standardized assessments** in appropriately allocating treatment and resources, and assessments are recognized as essential to **calibrate treatment** for autism diagnoses, in particular.
- Colorado would be a leader in standardizing PBT assessments, but standardized assessments are common in many states for **HCBS services** (for example: MN, WA, OR, WI, NJ, and CO).

manatt

Policy Action #6 Overview: Modifying Protected Classes of Drugs

Policy Action

- Allow **prior authorizations for select HIV drugs** (consistent with the scheduled expiration of the current prohibition on prior authorizations in July 2027), and
- Return to HCPF's **previous authorization process for antipsychotics**, allowing requirements to step through up to two preferred drugs before initial authorization for a non-preferred drug (policy prohibited by state law in 2024). A member **stabilized** on a non-preferred product would be allowed to continue that product.

Rationale

- Between SFY 2019-2024, post-rebate spending on specialty prescription drugs (which includes some HIV and antipsychotic drugs) increased **121%.**
- Expenditures on antipsychotics increased by **$14.5 million in one year** (from SFY 2023-24 to 2024-25) following the state law change restricting utilization management (UM) on these drugs.
- This Policy Action would result in savings over time by increasing use **of cost-effective drugs** and would immediately increase the state's **leverage** when negotiating supplemental rebates.

Evidence & Examples

- Colorado would need be careful when instituting these policies to ensure **adequate access to drugs** in each class to avoid adverse member impacts that could drive up costs in the long term.
- As of 2019, **the majority of states allowed unrestricted UM** on these classes, only 14 states restricted UM for HIV/AIDS antiretrovirals and 10 for mental health drugs.
- And since 2019, additional states have implemented UM on some of these drugs (e.g. FL, AL, NV, MO).

Project Approach

This project, through a phased approach, is seeking to identify, evaluate, and prioritize potential Policy Actions to address cost drivers in the Colorado Medicaid program.

This work is being executed as the Governor and the Department of Health Care Policy and Financing concurrently enact immediate Medicaid program changes in response to a rapidly changing federal and state policy and budget environment.

manatt

Manatt Subject Matter Experts

Stephanie Anthony
Senior Advisor,
LTSS

Anna Lansky
Senior Advisor,
LTSS

Jocelyn Guyer
Senior Managing Director,
Behavioral Health

Dr. Yngvild Olsen
National Advisor,
Behavioral Health

Tony Fiori
Senior Managing Director,
Pharmacy

Mindy Lipson
Managing Director,
PBT

Alix Gould
Director,
PBT

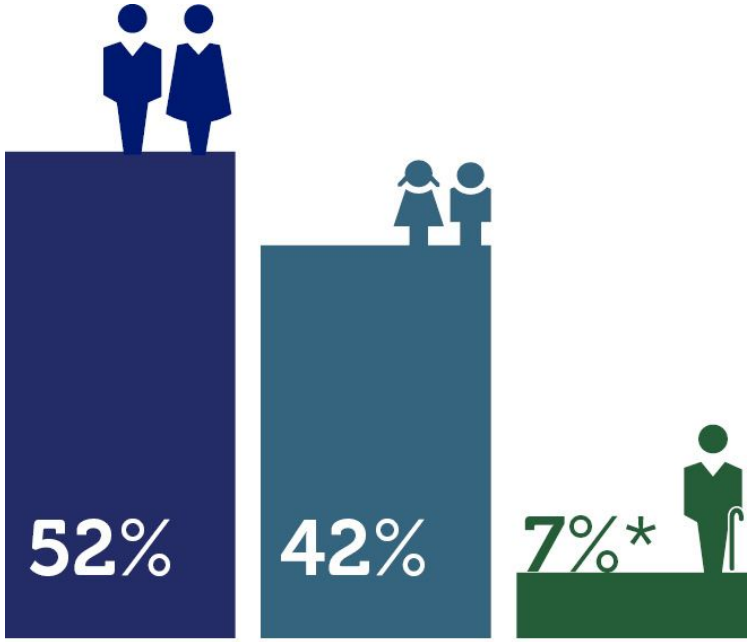
manatt

Joint Budget Committee Hearing
Health Care Policy & Financing

January 5, 2026

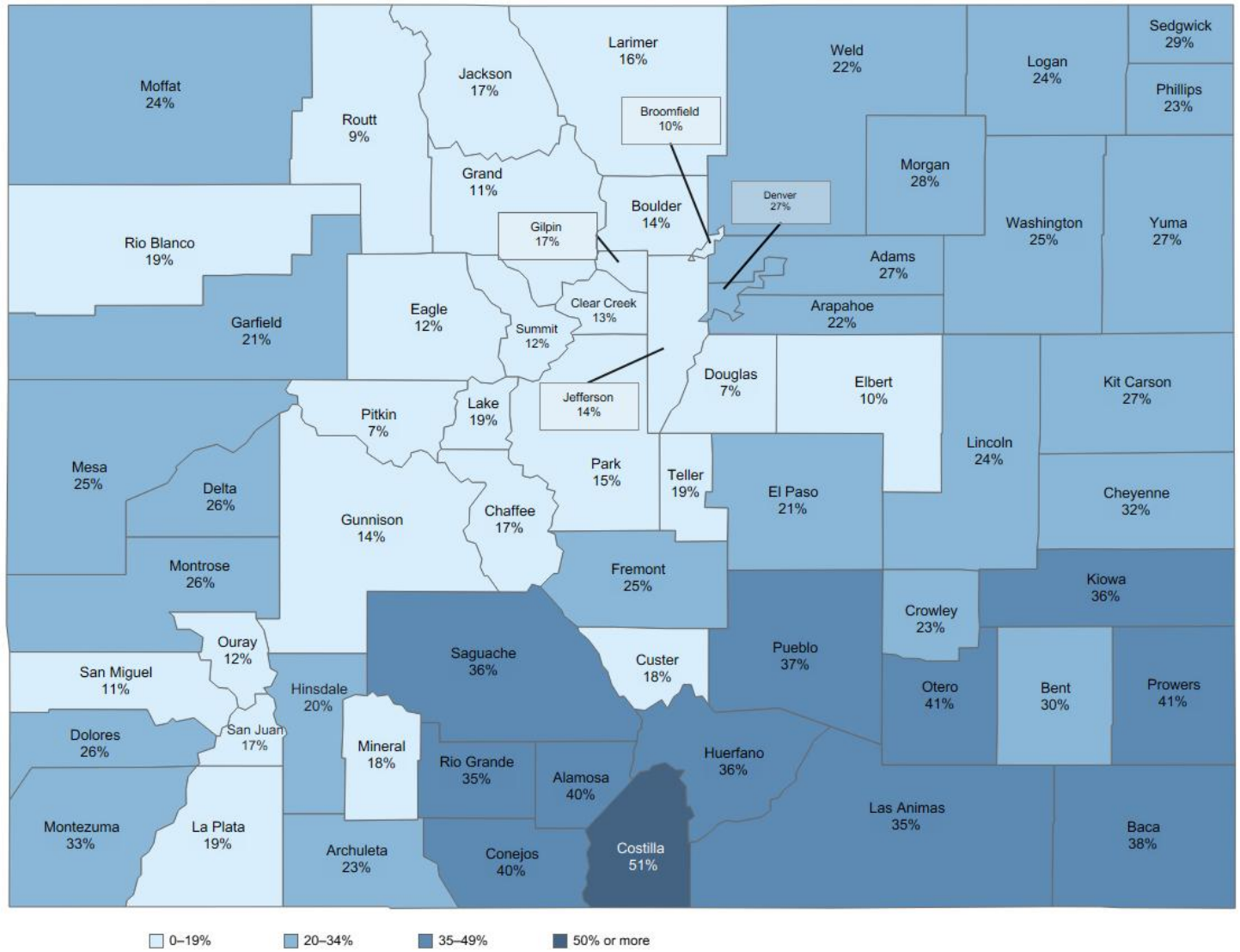
Kim Bimestefer, Executive Director
Cristen Bates, Behavioral Health Initiatives and Coverage Office Director
Joshua Block, Finance Office Director
Adela Flores-Brennan, Medicaid Director
Marivel Klueckmann, Eligibility Division Director
Tom Leahey, Pharmacy Office Director
Joshua Montoya, Partner Relations and Administration Division Director
Rachel Reiter, Policy, Communications & Administration Office Director
Bonnie Silva, Office of Community Living Director

Nov 2025: 1.3M members
1.2M Medicaid & 73k CHP+



*Adults age 65 and older includes people partially eligible for Health First Colorado.

% of enrolled Medicaid & CHP+ members, by county



Source Notes: Figures represent avg. monthly Medicaid & CHP+ enrollment during FY2024-2025.For more info, visit: CO.gov/hcpf/2025-report-to-community

Medicaid Sustainability Framework helps us better manage Medicaid trends **and avoid draconian cuts**

1. **Address Drivers of Trend:** Better address all the controllable factors that drive Medicaid cost trends
2. **Maximize Federal Funding:** Leverage and maximize HCPF's ability to draw down additional federal dollars
3. **Invest in Coloradans:** Continue investing in initiatives to drive a Colorado economy and educational system to reduce the demand for Medicaid over the long term as Coloradans rise and thrive
4. **Make Reasonable Medicaid Cuts or Adjustments:** Identify where programs, benefits, and reimbursements are comparative outliers or designed in such a way that we are seeing - or will experience - higher than intended trends or unintended consequences
5. **Reassess New Policies:** Consider pausing or adjusting recently passed policies not yet implemented
6. **Exercise Caution in Crafting Increases** to the Medicaid program going forward

HCPF August Annual Webinar Poll Result:

In accordance with our Medicaid Sustainability Framework, are you in agreement with our focus on implementing solutions to battle outlier trends?

89% Yes

11% No

HCPF August Annual Webinar Poll Results

Top 5 most important HCPF priorities:

78% Medicaid Sustainability Framework

54% Implement H.R.1

46% Advance LTSS

45% Maximize CHASE

41% Advance fraud, waste, and abuse

Robust HCPF Plan to help navigate our realities

- Discipline to Medicaid Sustainability Framework: Grounded in facts/insights and alignment around shared goals
- Understanding H.R.1 impacts and aligned goals:
  - Eligibility ecosystem and state/county modernizations
  - Fraud, Waste, Abuse enhancements
  - North Star: Shared efforts to help Coloradans comply and stay covered
- Seeking other federal funding
- Leverage ACC Phase III and Innovations (eConsults, Prescriber Tools, Value Based Payments, etc.) to control trends and improve quality
- Prioritize engagement, transparency, partnership, leadership
- **Leverage third-party insights, state comparisons, learnings**

HCPF's FY 2026-27 Budget

Governor's Budget released on October 31, 2025

- HCPF's proposed annual budget for FY 2026-27 is **$20.6 billion** in total funds (TF), including **$5.99 billion** General Fund (GF).
  - Representing an **increase of $2.3 billion** TF including a $413 million increase GF
  - About 96% of total funds allocated to HCPF go to providers to care for members
  - Funding allocated to HCPF in the Governor's FY 2026-27 budget request represents 32% of available General Fund for the entire state budget.
- HCPF budget includes a reduction of $537 million TF, including $217 million GF ($20.6 billion TF is net of the $537 million TF reductions)

Resources: HCPF FY 2026-27 Budget Agenda Summary; FY 2025-26 HCPF Budget Reductions Fact Sheet; FY 2026-27 Budget Requests

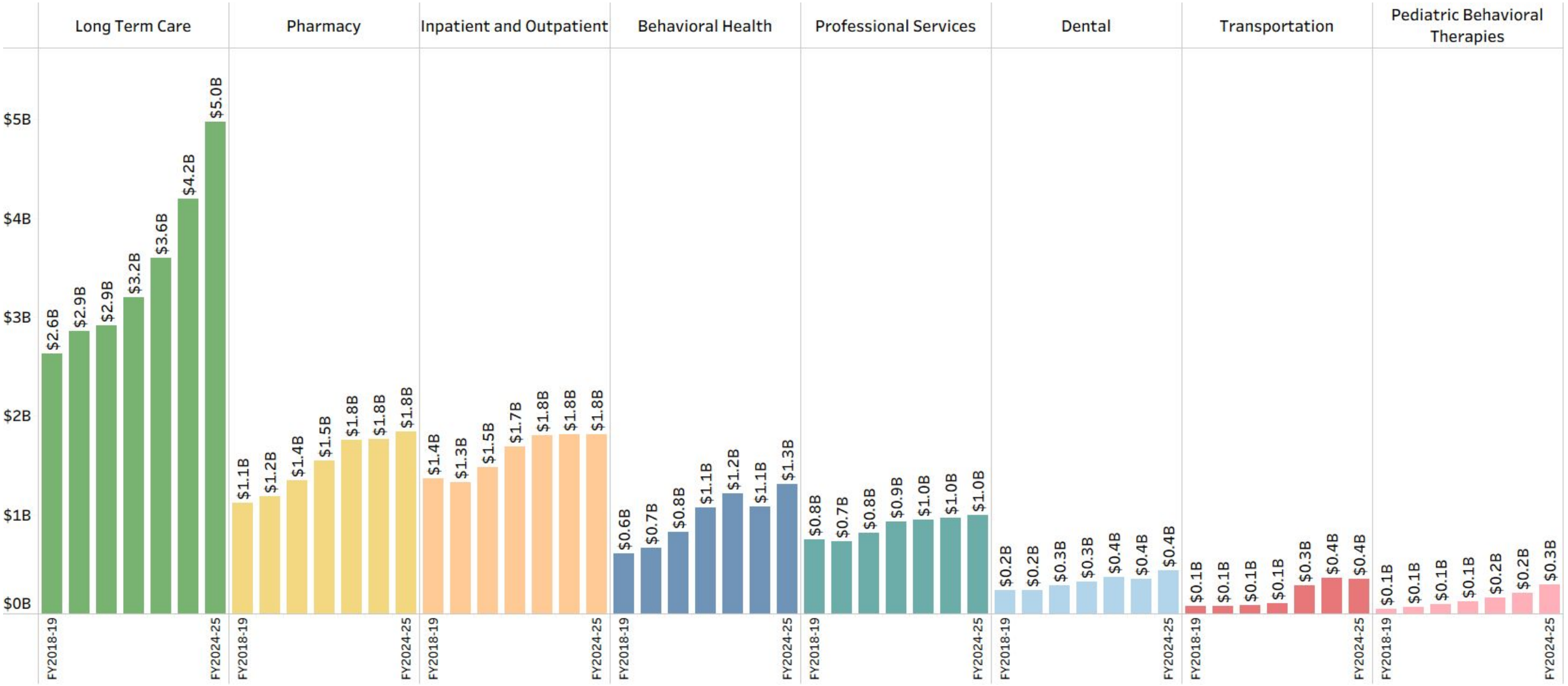
HCPF's FY 2026-27 Budget Amendments

FY 2025-26 Supplementals and FY 2026-27 Budget Amendments submitted Jan. 2, 2026

- HCPF's Jan. 2nd supplemental/budget amendment package includes budget amendments with additional **reductions of $243.9 million** total funds (TF), including **$126.8 million** General Fund (GF), for the FY 2026-27 budget
  - S-7/BA-7 Additional Reductions Package: ($118M) GF
  - S-8/BA-8 Resources for HR 1 Compliance: $5.6M GF
  - S-9/BA-9 New Federal Regulation Compliance: $1.0M GF
  - S-10/BA–10 Housing Vouchers Resources and Savings: ($8.9M) GF
  - BA-11 Certified Community Behavioral Health Clinic Waivers: ($6.5M) GF
- Visit HCPF's Budget page for all FY 2025-26 Supplementals and FY 2026-27 Budget Amendments including an Additional Budget Reductions Fact Sheet

Proposed Reductions Context Questions 1-9

FY18-19 to FY24-25 Medicaid Benefits Trend (Questions 1-7)



Source note: Includes claims and capitation payments only
Pharmacy is before credited rebates (over 50% impact)

Questions 8-9: Reductions & Cost Drivers

HCPF has observed three key drivers of cost increases: utilization, rate increases, and enrollment/eligibility, proposed sustainability actions directly address these cost drivers.

Utilization

- Definitive Drug Testing;
- Reinstate prior authorization outpatient psychotherapy;
- Implement pre- and post- claim review pediatric autism behavioral therapy;
- Delay implementation of Community Health Workers;
- Soft Cap Certain HCBS/CFC Services;
- Cap Weekly Caregiving Hours;
- Cap Weekly Homemaker Hours for Legally Responsible Persons;
- Unit Limitations for Community Connector.

Rates

- Roll back 1.6% rate increase;
- Adjust Community Connector Rate (-15%);
- Eliminate Nursing Facility Minimum Wage Supplemental Payment;
- Reducing Certain Rates to 85% of Medicare Benchmark;
- Outpatient Drug Rate Reduction; and
- Align Community Connector Rate with Supported Community Connections(-23%).

Eligibility/Enrollment

- Ending Continuous Coverage;
- Reduction in Immigrant Family Planning;
- Align IRSS rates;
- Change Auto Enrollment for DD Waiver Youth Transitions;
- Reduce DD Waiver Churn Enrollments; and
- LTSS presumptive eligibility (PE) delay.

R6: Managed Care Rates, ACC and Incentives
Questions 10-14

Question 12: Behavioral Health Capitation Rates and Services

FY 2025-26 Aggregate Average PMPM Capitation Rate

RAE	Average PMPM Capitation Rate
RAE 1 (Rocky Mountain Health Plans)	$113.28
RAE 2 (Northeast Health Partners)	$111.23
RAE 3 (Colorado Community Health Alliance)	$98.08
RAE 4 (Colorado Access)	$119.50

FY 2025-26 Capitation Rate Administrative Percentage

RAE	Administrative Percentage
RAE 1 (Rocky Mountain Health Plans)	6.9%
RAE 2 (Northeast Health Partners)	10.8%
RAE 3 (Colorado Community Health Alliance)	6.5%
RAE 4 (Colorado Access)	9.9%

Question 13: Administration Payments to RAEs

FY 2025-26 Administrative Payments

Payment Category	FY 2025-26 Budgeted Amount
Care management physical health	$191.4 million
Behavioral health (approximate)	$136.7 million

FY 2025-26 Quality Incentive Payments

Payment Category	FY 2025-26 Budgeted Amount
Physical health quality incentive payments	$43.8 million
Behavioral health quality incentive payments	$26.6 million

Payments on this slide are located in the "Medical Services Premiums" and "Behavioral Health Community Programs" Long Bill groups.

Question 14: Provider Rate Differences Between RAEs

FY 2024-25 Select BH Procedure Code Pricing

Procedure Code	Description	Fee for Service Rate (Effective Oct. 1, 2025)	Avg Rate for the RAE with the Lowest Reimbursement	Avg Rate for the RAE with the Highest Reimbursement
90832	Psychotherapy - 30 min	$68.76	$46.36	$72.85
90834	Psychotherapy - 45 min	$91.09	$74.92	$118.00
90837	Psychotherapy - 60 min	$134.51	$98.01	$130.94
H0020	Methadone administration	$16.29	$16.27	$22.27
H2036 U1	SUD residential - ASAM level 3.1	$190.00	$246.56	$270.87
H2036 U5	SUD residential - ASAM level 3.5	$425.00	$476.82	$493.37

R6: Pharmacy
Questions 15-21

Questions 18-21: Biosimilars

What does the FDA say about biosimilar medications:

- “A biosimilar and its original biologic are made from the same types of sources.”
- “Biosimilars are a type of biologic medication that is safe and effective for treating many illnesses.”
- “A biosimilar and its original biologic have the same treatment risks and benefits.”
- “Biosimilars may be available at a lower cost than the original biologics.”

U.S. Food and Drug Administration. *Biosimilar Basics*. Accessed December 23, 2025. https://www.fda.gov/drugs/biosimilars/biosimilars-basics-patients

R6: Specific Reduction Areas Questions 22-25

Question 25: Access Stabilization Funds

There are 271 PCMPs eligible:

- Small: 87 PCMPs (5 or fewer rendering providers)
- Rural: 37 PCMPs (located in a county designated as “Rural” or “Counties with Extreme Access Considerations (CEAC)” by the Division of Insurance)
- Pediatric: 80 PCMPs (80% or more of patients with Medicaid under the age 0-18)

R6: Drug Testing
Questions 26-28

Questions 26-28: Drug Testing

- Different tests
  - *Presumptive* tests (no yearly limit) preferred front-line testing
  - *Definitive* tests (limit 12 per year for adults) should be used infrequently
- Fraudulent and abusive definitive drug testing is driving unnecessary costs
  - Labs commonly perform unnecessary reflex testing (testing used every time) which is driving expenditure without value to the member, clinician, or the state. Often other services are not offered.
- Court-ordered tests are **not covered** unless they are also medically necessary

R6: Cover All Coloradans
Questions 29-30

R6: Pediatric Behavioral Therapy Questions 31-35

Pediatric Behavioral Therapies (PBT/ABA)

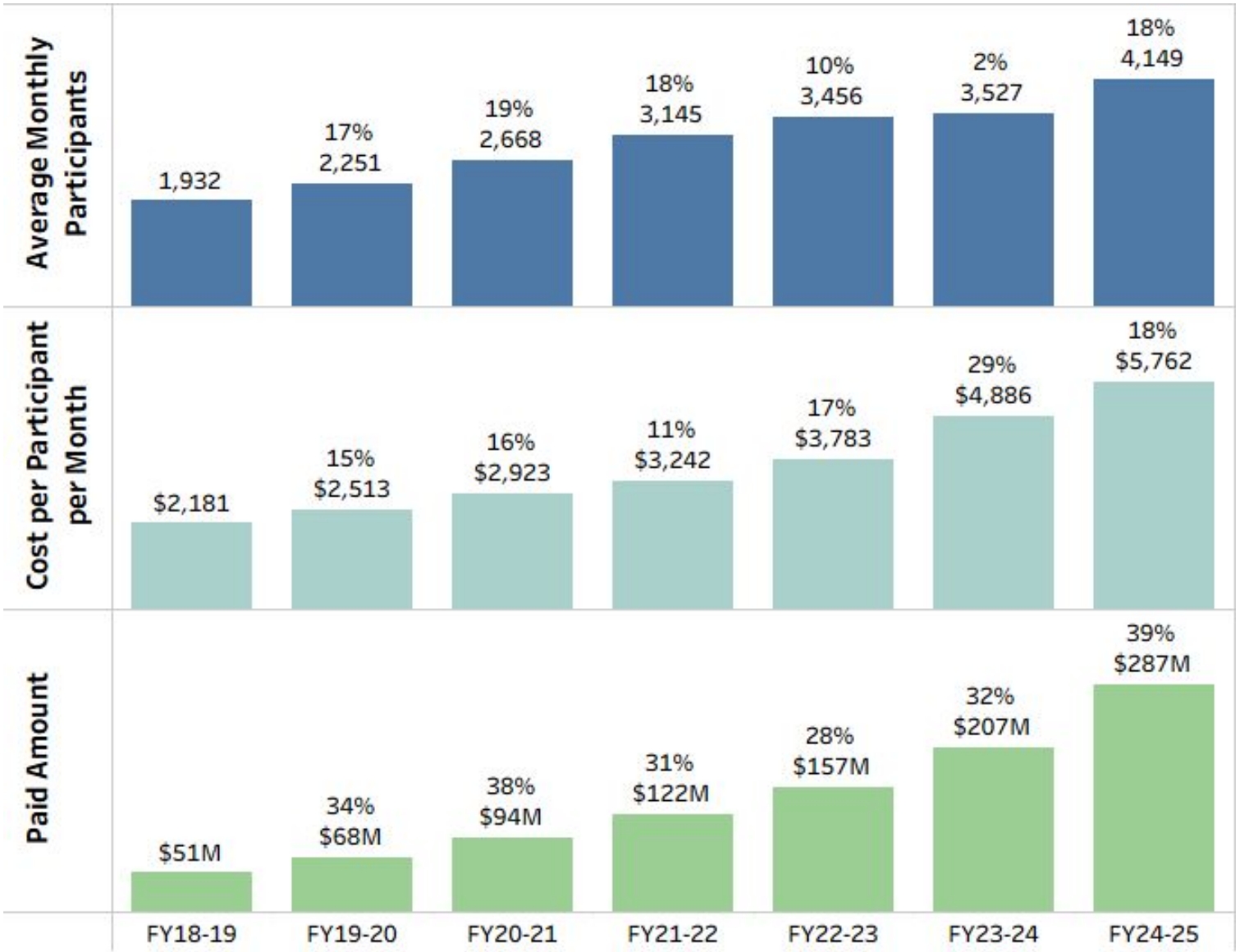
467% increase in paid $ FY18/19 to FY24/25.
+34% paid trend/yr. +18% PMPM trend/yr.

Drivers:

- Private equity provider behavior
- Requiring minimum patient hrs/wk
- Billing for uncredentialed providers
- Billing for nontherapeutic and noncontact hours like naps/playtime

Potential Solutions:

- Policy change
- Address Private Equity Behaviors
- Benefit design changes
- Advancing prior auth criteria
- Pre and post payment review
- Rollback of rate increases
- Additional fraud referrals



https://cepr.net/publications/pocketing-money-meant-for-kids-private-equity-in-autism-services/

Office of Community Living (OCL)

Bonnie Silva,
Director of the Office of Community Living

Overview of OCL, Long-Term Services and Supports (LTSS), and Home and Community Based Services (HCBS)

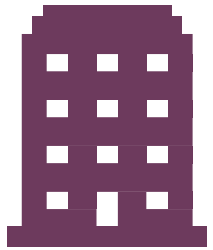
Questions 36-37

Long-Term Services & Supports

Community-Based Care

Including Home- and Community-Based Services (HCBS), Community First Choice (CFC), Long-Term Home Health (LTHH), Private Duty Nursing (PDN), and State General Fund Programs

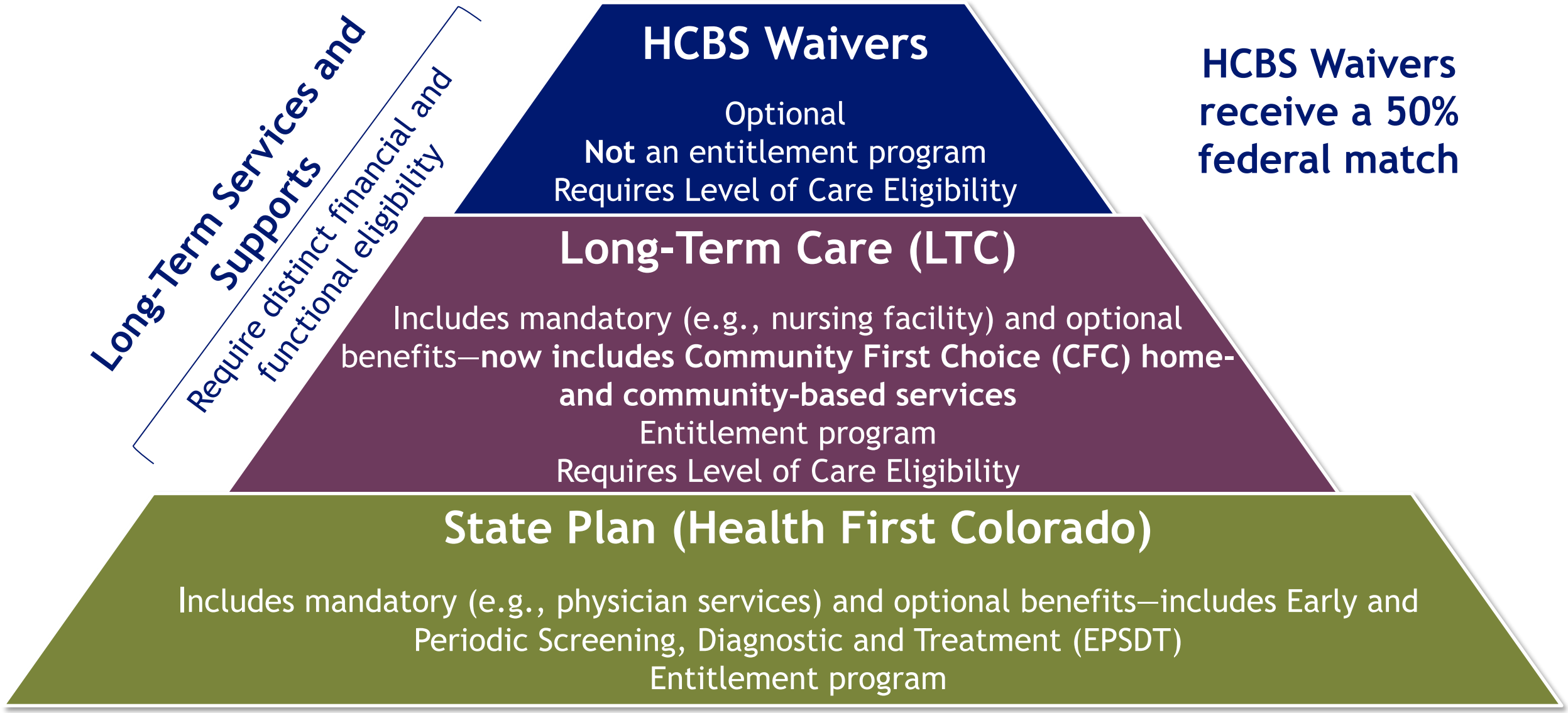
Program of All-Inclusive Care for the Elderly (PACE)



Institutional Settings

Nursing Facilities, Intermediate Care Facilities, and Hospital Back-Up Program (HBU)

Q. 36 Medicaid Benefits Pyramid



HCBS Waivers receive a 50% federal match

Who Receives Long-Term Services & Supports?

People who contribute to Colorado communities at school, work, and beyond

16%

Children & Adolescents

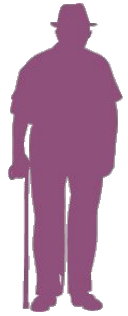
ages 20 & younger & qualifying former foster care youth

41%

Adults

ages 21-64

43%



Older Adults

ages 65 or older

Cross Disability

- **Physical Disabilities** - e.g., Spinal Cord Injury, Parkinson's disease
- **Cognitive Disabilities** - e.g., I/DD, Brain Injury, Dementia
- **Mental Health**
- **86% have a chronic condition** (compared to 32% of all Medicaid members)
  - 38% have 5 or more such conditions
- I/DD can overlap w/other disabilities → various waivers available

FY 2024-25; data represent percentage of people receiving Medicaid LTSS in various age groups.

Q. 37 Long-Term Services & Supports Programs

Home- & Community-Based Services (HCBS) Waivers	62,876
State-Funded Only Programs	6,179
Facility-Based Programs	12,903
Program for All-Inclusive Care for the Elderly	5,872
Long-Term Home Health & Private Duty Nursing	5,464*

Total Served in LTSS

93,294

*Apx 15,260 members receive LTHH/PDN and other LTSS services

SOURCE: FY 2024-25; based on claims in MMIS. Data from FY 2025-26 will reflect CFC.

LTSS Cost Growth

Questions 38-44

Q. 38 Systemic Drivers of LTSS Growth

- People with complex needs are living longer
  - The population of adults with I/DD aged 60 and older is projected to double between 2000 and 2030

- The need for long-term care also rises with age
  - An estimated 70% of individuals over 65 will require some form of LTSS, with even higher rates among older age groups

- There is an overreliance on Medicaid
  - Those needing LTSS are more likely to have incomes below the federal poverty level
  - Nationally, Medicaid accounted for 45.6% ($257 billion) of LTSS expenditures in 2023

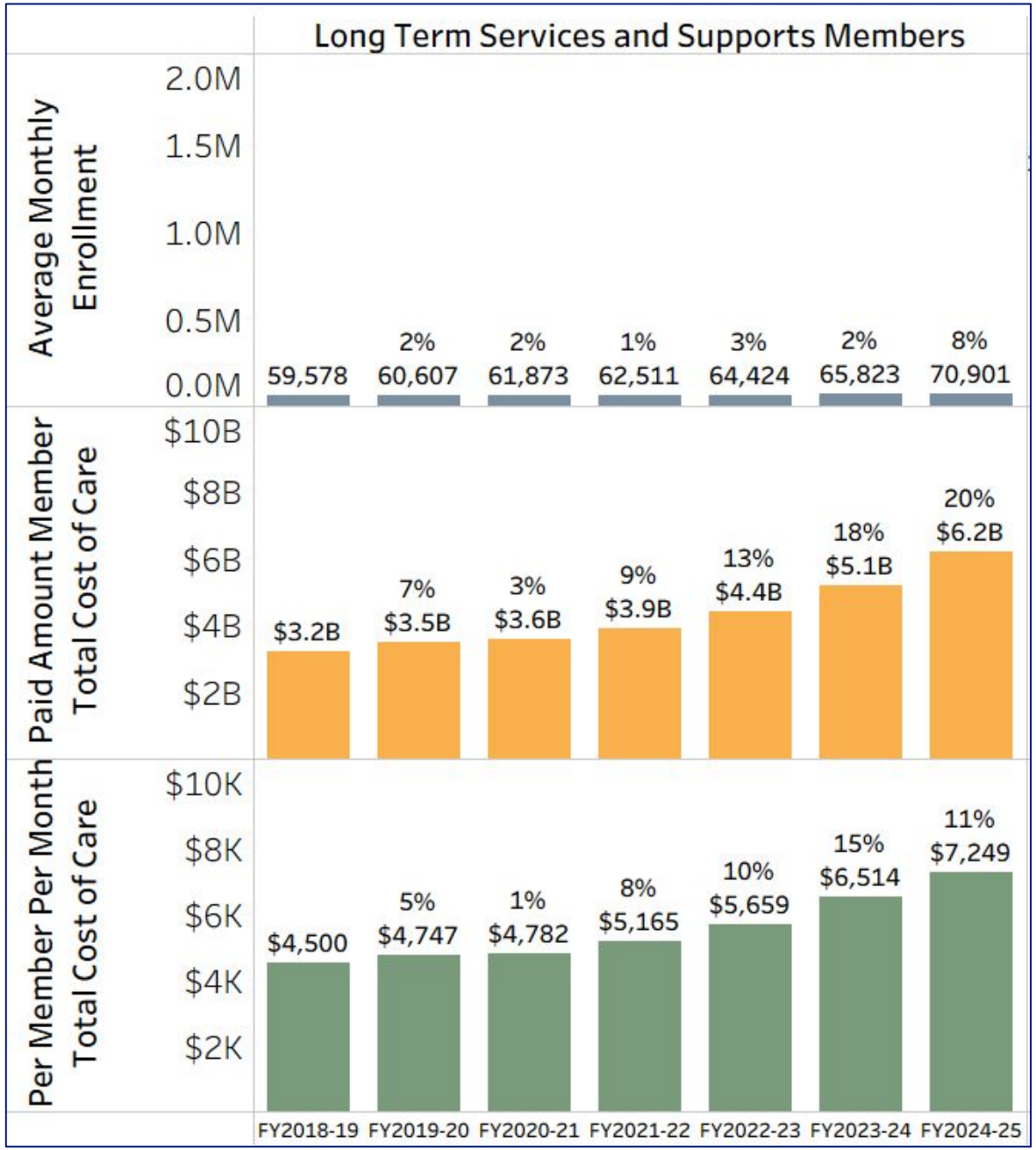
- LTSS services are expensive
  - Nationally, Medicaid enrollees who use LTSS have spending 8 times higher than those without LTSS

LTSS Rising Enrollment & Cost Trend

The cost trend for Long-Term Services and Supports has continued to **grow at a rapid rate: With total cost of care for LTSS members increasing by $1.02B in just one year (FY23/24 to FY24/25)**

Over the past several years, the increase year over year has gotten **as high as 20%**

Though member total cost of care is increasing overall, **the primary driver of that increase is the cost of member's LTSS**



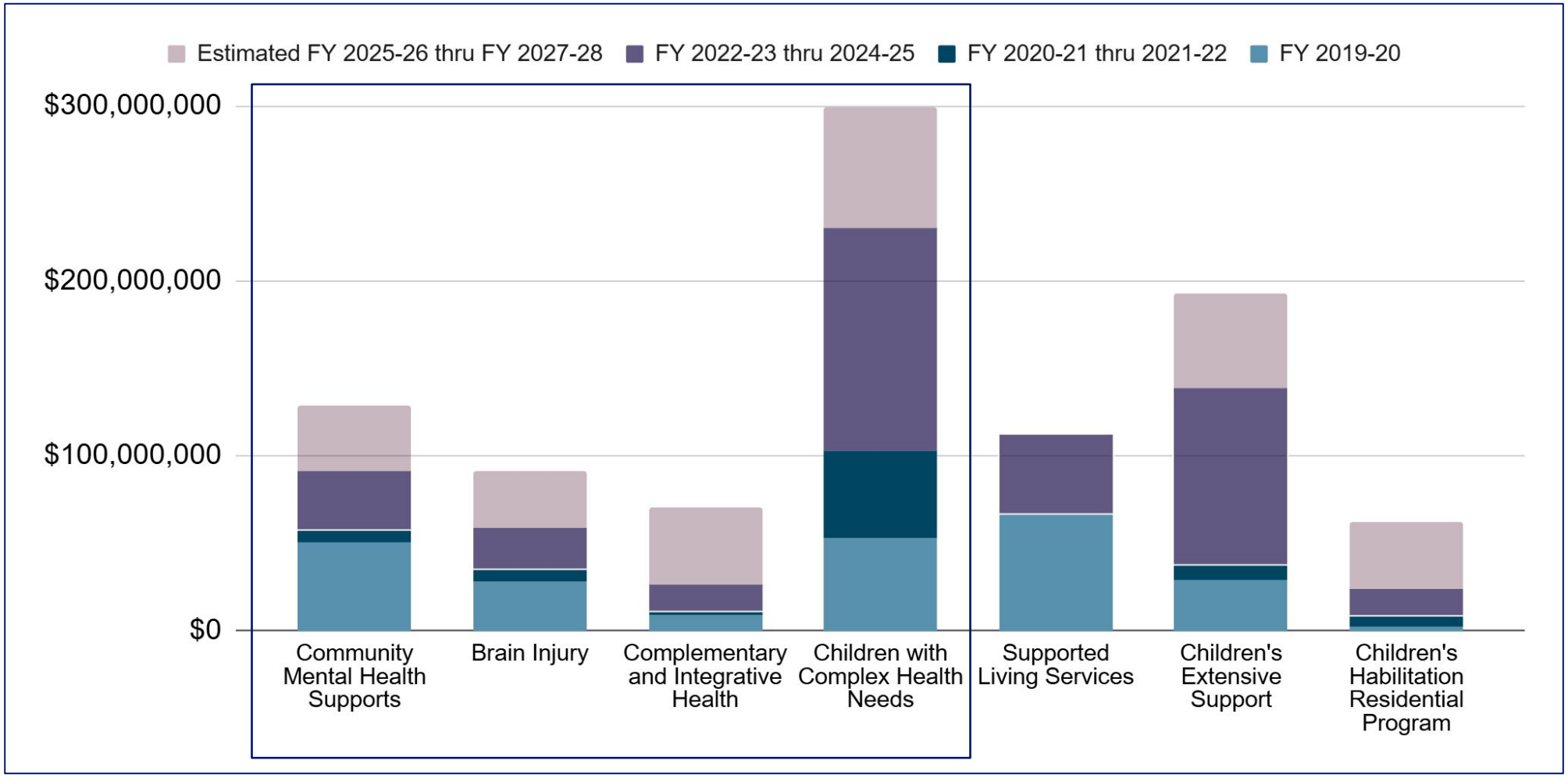
Continued Spending Growth Forecasted

FY 2026-27 LTSS Budget increasing by $217M

Item	Total Funds	General Funds	Cash Funds	Federal Funds
FY 2026-27 Forecasted Year over Year Growth in LTSS	$378.1M	$148.2M	$3.1M	$227.8M
Sustainability Actions Savings	-$161.96M	-$79.6M	-$616K	-$81.7M
FY 2026-27 New Year Over Year Growth	**$217.2M**	$68.6M	$2.4M	$146.1M

Q. 39 Total Waiver Expenditure Growth

FY 2019/20 - FY 2027/28



Total Waiver Expenditure Growth (cont.)

FY 2019/20 - FY 2027/28

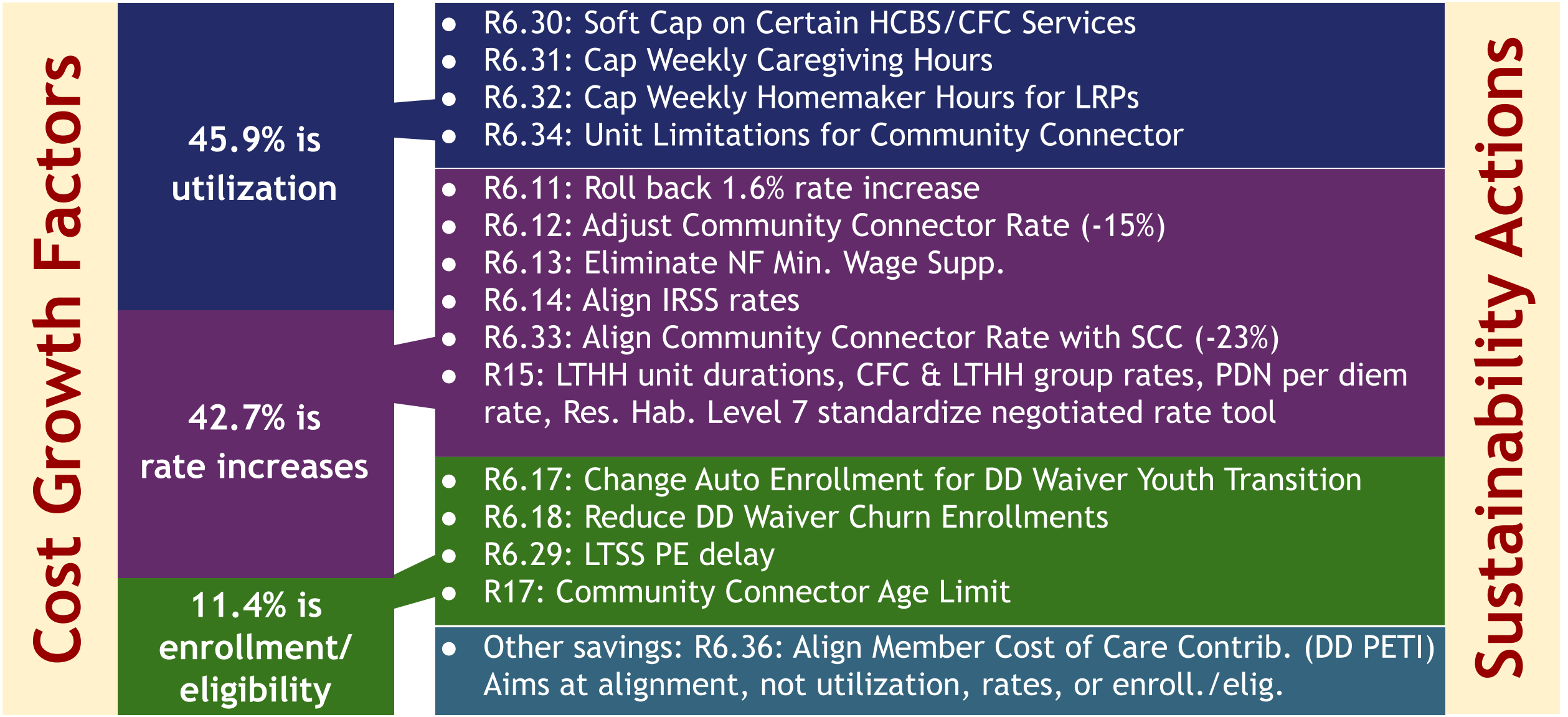
HCBS Waiver Program Growth FY19-25

HCBS Waiver - Children	CLLI	CHCBS	CHRP	CES
Current Enrollment	2,890		588	4,971
Enrollment Growth	-18%	+56%	+1,928%	+130%
Per Member per Month Waiver FY25 Cost & Growth	$3,348 -16%	$74,525 +274%	$87,210 +35%	$40,838 +176%

Merged July 1, 2025

HCBS Waiver - Adults	CIH	DD	BI	EBD	SLS	CMHS
Current Enrollment	481	9,119	907	34,378	5,371	4,171
Enrollment Growth	+203%	+43%	+67%	+28%	+5%	+9%
Per Member per Month Waiver FY25 Cost & Growth	$75,887 +104%	$107,309 +41%	$86,636 +49%	$44,556 +112%	$26,798 +80%	$28,359 +94%

LTSS Sustainability Actions Address Cost Drivers



Not shown: R6.35: Reduce Movement Therapy Rate (withdrawn); R15: PDN acute benefit (budget-neutral).

Q. 40-41 Workforce Investments

42.7% is rate increases

Wage-Based Workforce Investments:

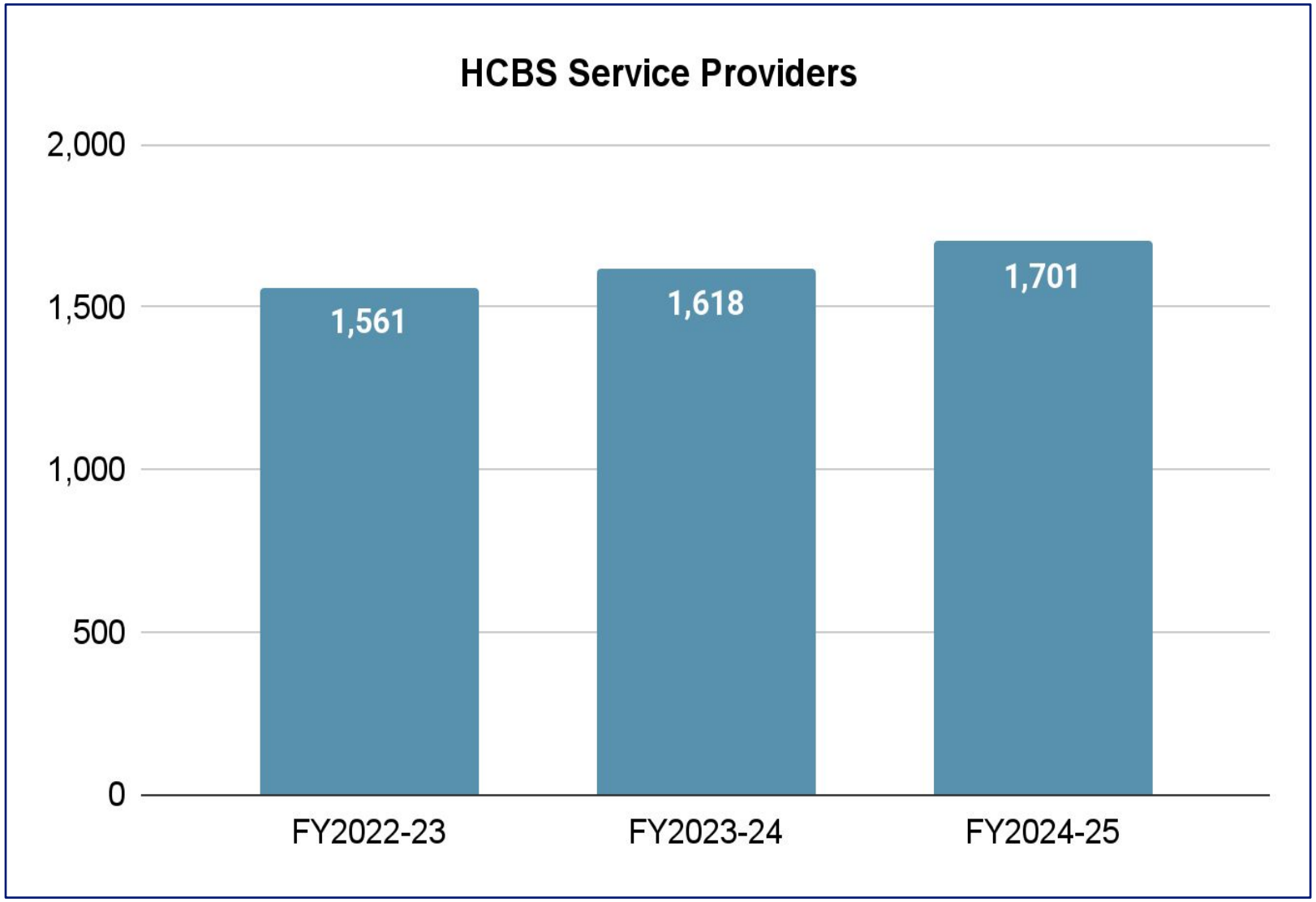
$309 million total funds across 4 fiscal years

- FY 2021-22 S-10 HCBS ARPA Spending Authority - $121 million
- FY 2023-24 R-07 Rate Adjustments - $62 million
- FY 2024-25 R-06 Provider Rate Adjustments - $126 million

Non-Wage Workforce Investments:

- Support for rural providers
- No-cost recruitment and job-matching tools
- Foundational training for new direct care workers
- Free training supports to ease onboarding and reduce provider burden
- Guidance to providers on state resources available to support their employees

Q. 42-44 Provider Capacity



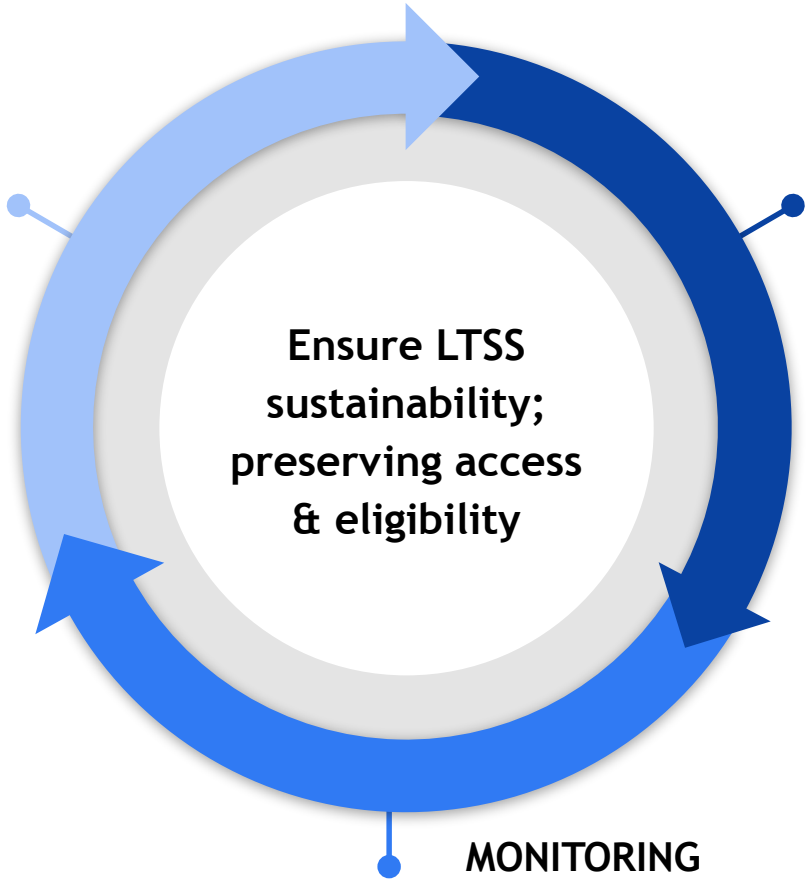
HCBS Provider Specialties

Year	# of Specialties
FY 2022-23	3.57
FY 2023-24	3.62
FY 2024-25	3.67

R-06 | Executive Order and Other Spending Reductions: High-Level

Questions 45-48

Q. 45 LTSS Sustainability Proposals



APPROACH

Targeted guardrails on how services are authorized and delivered—not cuts to benefits

POLICY DESIGN

- Limits (e.g., weekly caps) set well above average use; exceptions processes for higher needs
- Targeted enrollment adjustments based on member's ability to get other/comparable services

MONITORING

Ongoing oversight of nursing facility use, hospitalizations, and transitions to higher care levels

Q. 46-47 Impacts on Member Enrollment and Service Authorization

Adults and Children with High Utilization

Between FY20-25:

- Homemaker expenditures +224%
- IHSS enrollment +154% and utilization per member +43%; leading to +367% paid amount

Goals:

1. Add a check on very high utilizers to ensure level is needed
2. Bring family caregiving program into better alignment with goals

Strategies:

R6.30: Soft Cap on Certain HCBS/CFC Services

Children in CES & CHRP Waivers

Between FY19-25:

- CES waiver enrollment +130% and per member per month cost +176%
- Community Connector (CHRP and CES) paid amount +1,178%
- CES Homemaker paid amount +1,404%

Goals:

1. Address rapid and unsustainable growth in key services (Community Connector and Homemaker)
2. Better align programs with service goals and parental responsibilities

Strategies:

R6.34: Unit Limitations for Community Connector

R17: Community Connector Age Limit (not included in R6)

Adults Waiting for the DD Waiver

Between FY19-25:

- DD waiver enrollment +43%
- Per member per month cost +41%
- Total waiver expenditures +112%

Goals:

1. Slow unsustainable enrollment growth

Strategies:

R6.17: Change Auto Enrollment for DD Waiver Youth Transition

R6.18: Reduce DD Waiver Churn Enrollments

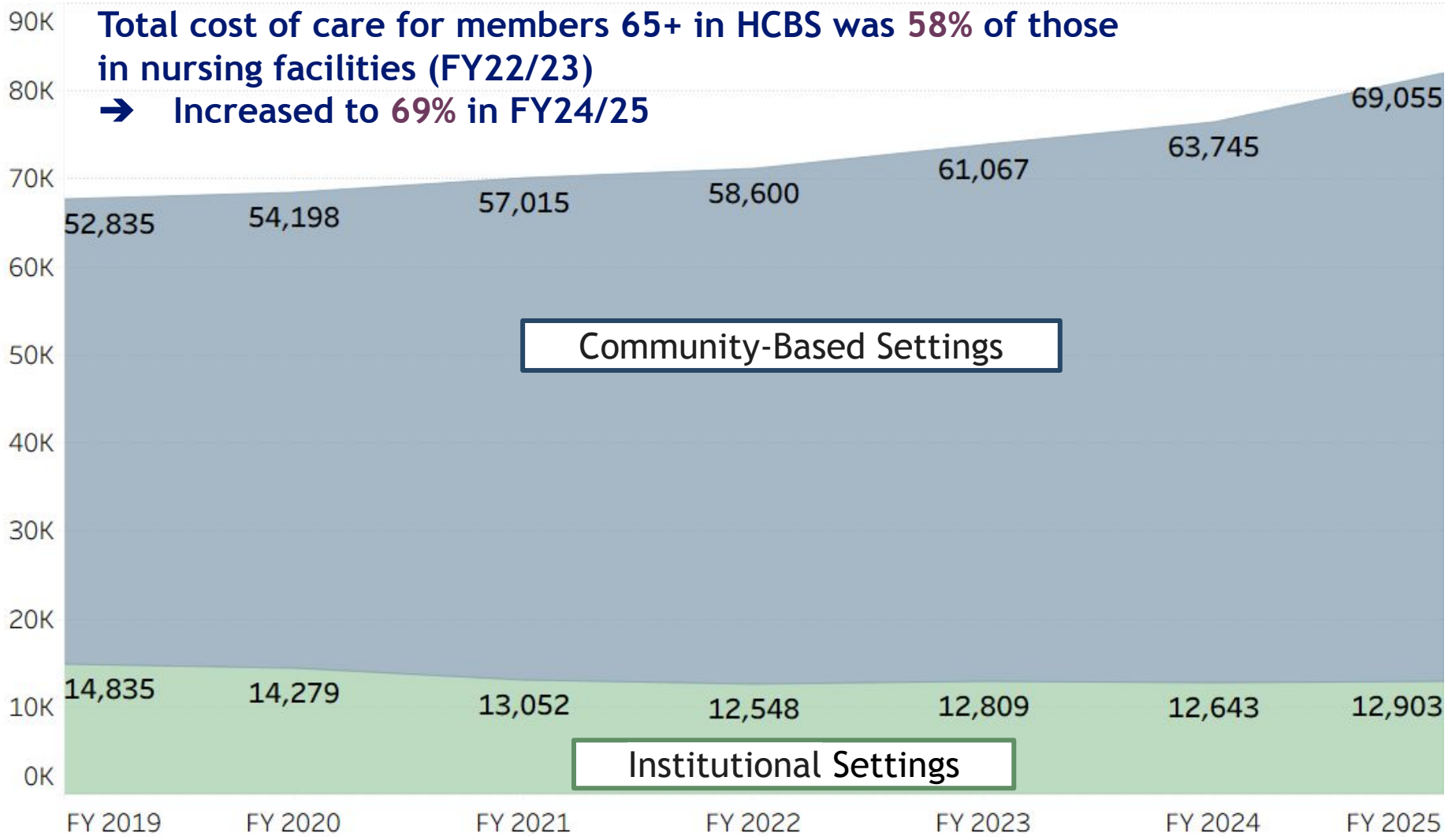
Continue to Protect Members

- Implementing guardrails, not cuts: services remain available while we are limiting extreme outlier use and pairing this with exceptions.
- Emergency pathways and transitions from institutions are preserved to prevent unnecessary institutionalization.
- Alternative options are available (for example, youth can move to SLS or EBD waiver and maintain same paid caregivers via CFC, IHSS, and CDASS).
- Monitoring outcomes closely and can adjust if we see access or safety concerns.

Q. 48 Community-Based Program Growth

Total cost of care for members 65+ in HCBS was 58% of those in nursing facilities (FY22/23)

➔ **Increased to 69% in FY24/25**



Members in Community-Based Settings
+ 31% growth

Members in Institutional Settings
- 13% decline

R-06: Rates Related Changes

Questions 49-52

Q. 49 What is Community Connector & Who Provides it?

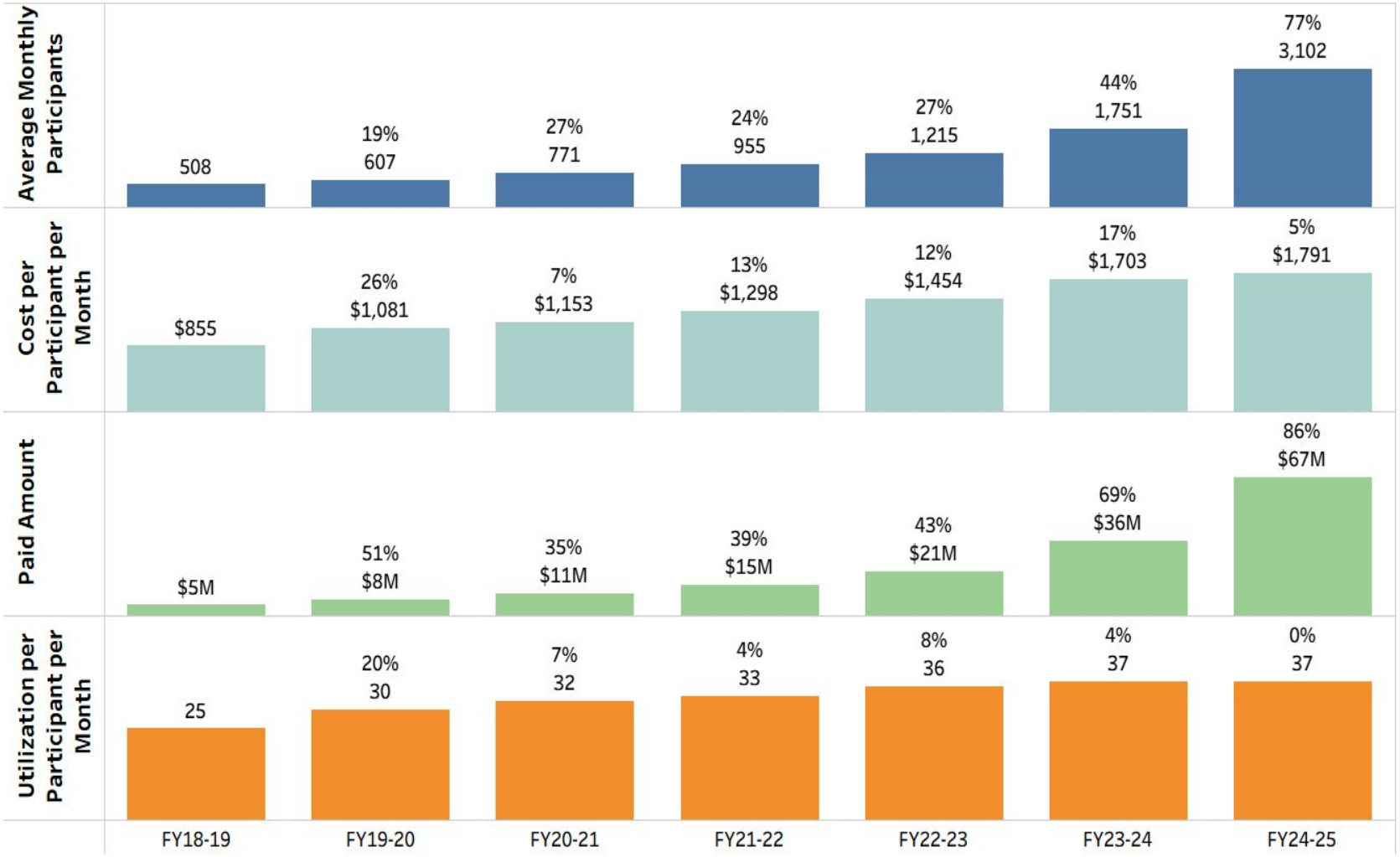
Community Connector

1:1 support to help a child or youth build the skills and relationships needed to participate in typical community life, using real community settings as the learning environment and tying the work to measurable goals in the support plan.

Provider Quals

Must be 18+, complete State-required training, follow the service plan, document services, and have the skills to support people with developmental disabilities. Parents serving as providers must focus on skill building, not routine parental care.

Community Connector Service



Cumulative Growth	Sustainability Actions
510%	**R17**: Community Connector Age Limit
109% 1,178%	**R6.11**: Roll back 1.6% rate increase **.75% ATB Rate Reduction** **R6.12**: Adjust Community Connector Rate (-15%) **R6.33**: Align Community Connector Rate with SCC (-23%)
51%	**R6.34**: Unit Limitations for Community Connector

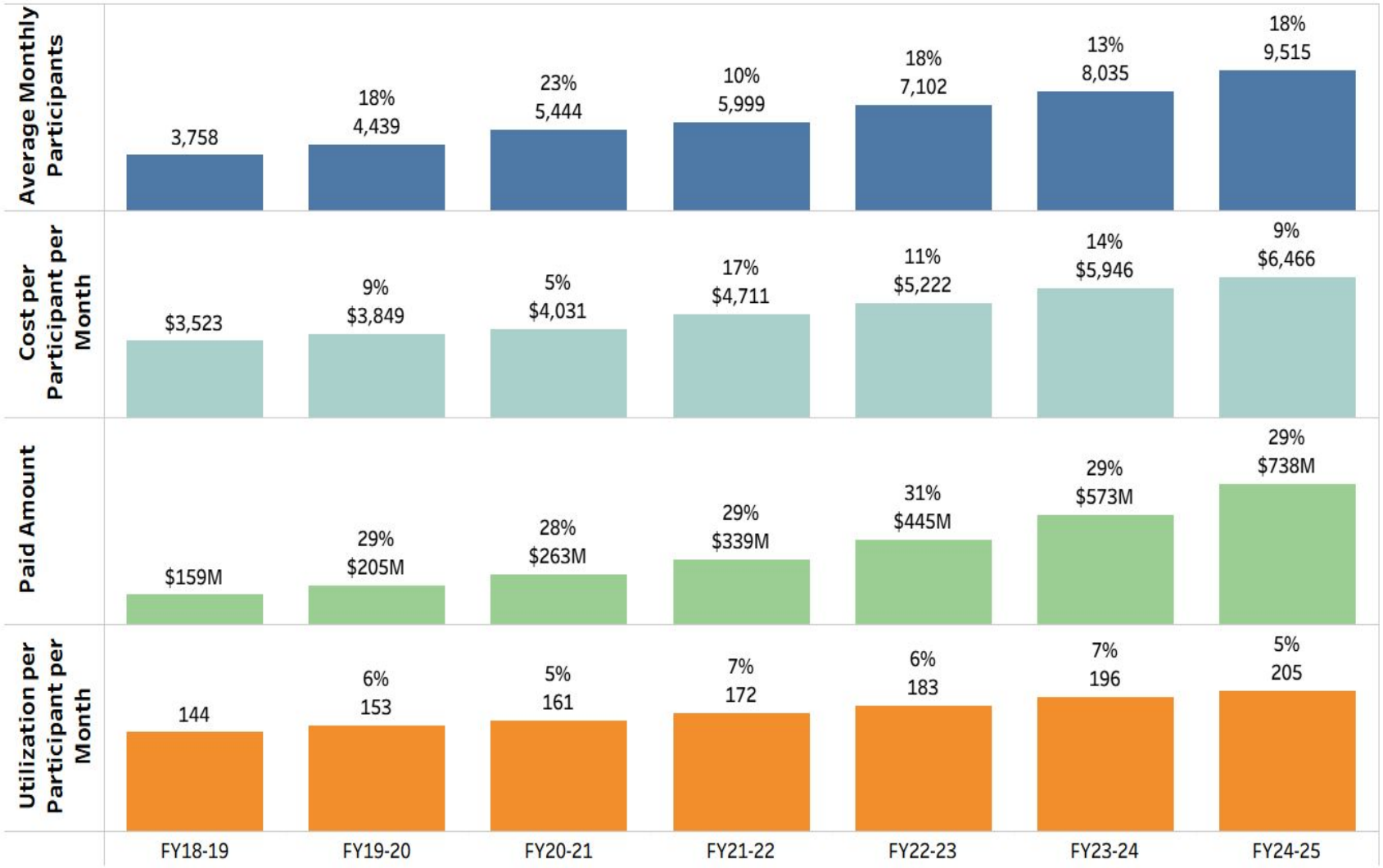
R-06: Utilization Related Changes

Questions 53-54

Q. 53 Unit & Caregiver Limits

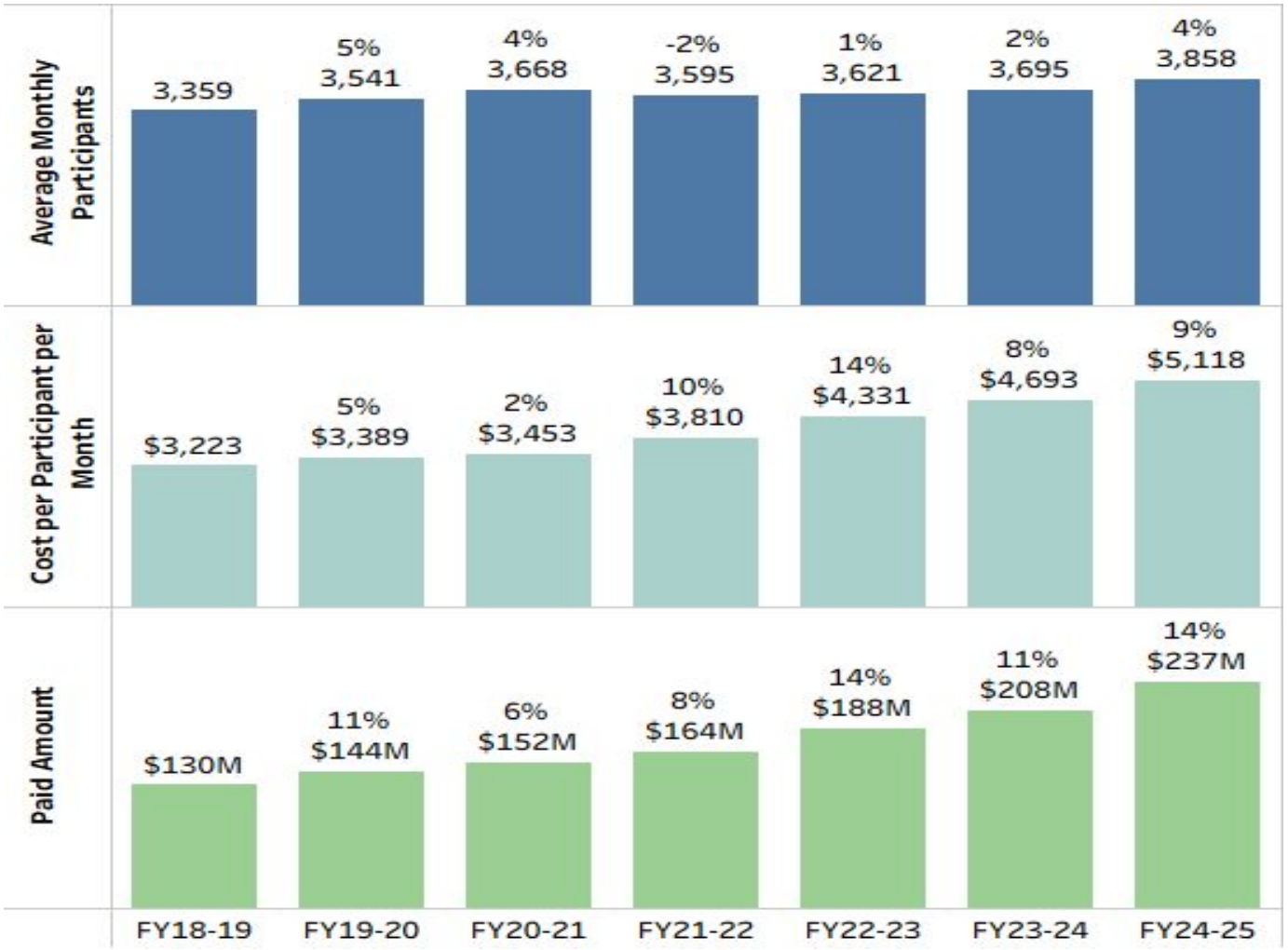
HCBS Soft Caps	Weekly Limits for Caregivers	LRP Homemaker
New annual soft cap (with exceptions) for select services • Health Maintenance Activities (HMA): 19,000 units (about 13 hours per day) • Personal Care: 10,000 units (about 6.8 hours per day) • Homemaker: 4,500 units (about 3 hours per day) Delivered through: • CFC (both non-participant directed and participant directed programs- Consumer-Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)) • Non-participant directed services within the waivers (until 7/2026)	**New weekly limit of 56 hours per caregiving, per member** Services included in the 56 hour limit: • Long-Term Home Health-CNA and RN • Personal Care, Homemaker, and Health Maintenance Activities (HMA) Delivered through: • CFC (both non participant and participant directed programs- CDASS and IHSS) • Non-participant directed within the waivers (until 7/2026) • State Plan LTHH which can be provided by parents when they meet all certification and/or licensure requirements	**New weekly limit of 5 hours per member of homemaking from legally responsible persons** Services include Homemaking delivered through: • CFC (participant directed programs - CDASS and IHSS) • Non-participant directed within the waivers (until 7/2026)

In-Home Support Services



Cumulative Growth	Sustainability Actions
154%	CFC, age appropriate guidelines & task standards, & protective oversight
84%	**R6.11**: Roll back 1.6% rate increase **.75% ATB Rate Reduction** **R15**: CFC & LTHH group rates
367%	**R6.30**: HCBS/CFC Soft Cap on Certain Services **R6.31**: Cap Weekly Caregiving Hours **R6.32**: Cap Weekly Homemaker Hours for LRPs
43%	

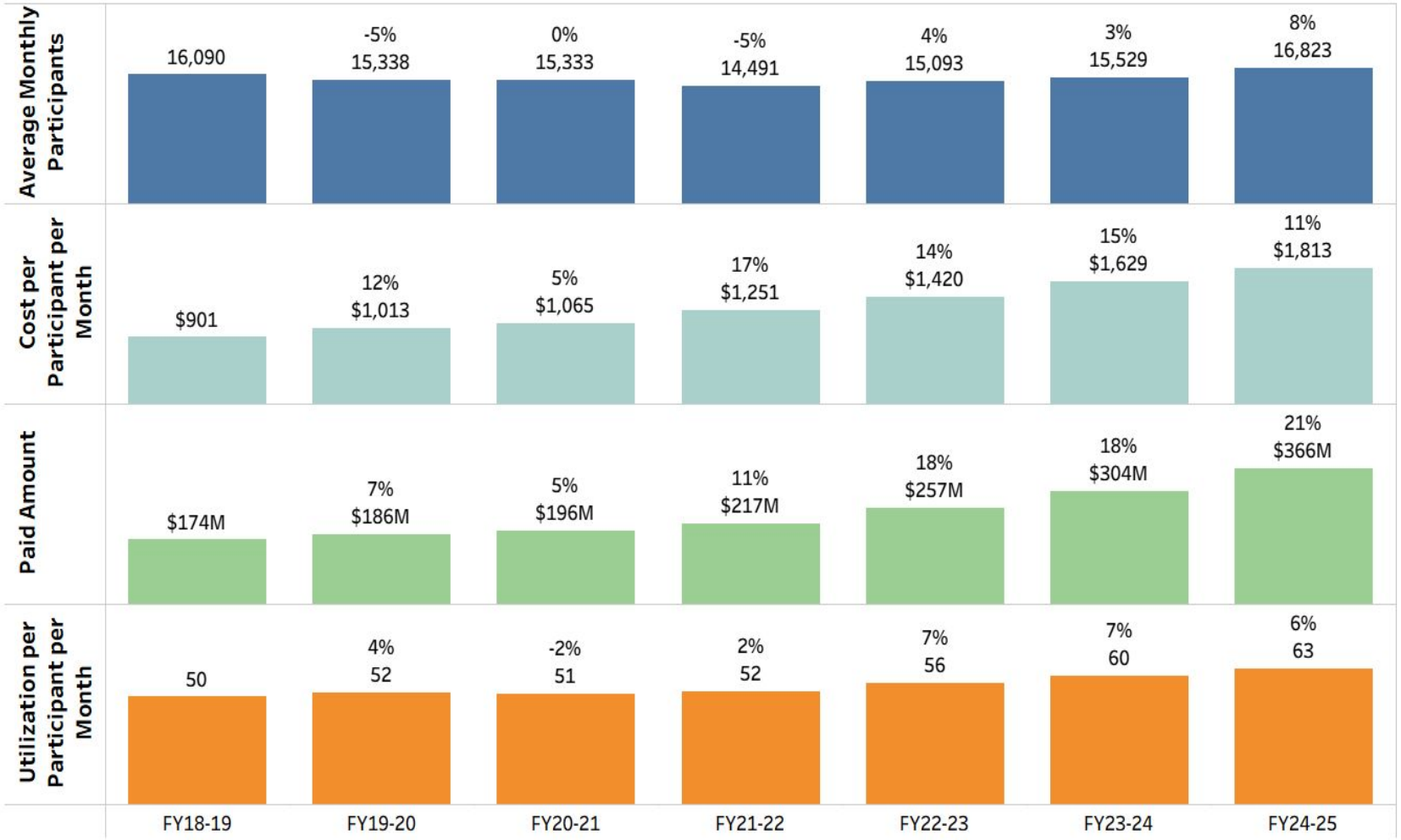
Consumer-Directed Attendant Support Services



Cumulative Growth	Sustainability Actions
15%	CFC, age appropriate guidelines & task standards, & protective oversight
59%	**R6.11**: Roll back 1.6% rate increase **.75% ATB Rate Reduction**
82%	**R15**: CFC & LTHH group rates

Personal Care & Homemaker

Non-Consumer Directed



Cumulative Growth	Sustainability Actions
-4%	CFC, age appropriate guidelines & task standards, & protective oversight
101%	**R6.11**: Roll back 1.6% rate increase **.75% ATB Rate Reduction**
104%	**R15**: CFC & LTHH group rates **R6.30**: Soft Cap on Certain Services **R6.31**: Cap Weekly Caregiving Hours
34%	**R6.32**: Cap Weekly Homemaker Hours for LRPs

Q. 54 Homemaker Costs & Policy Impact

Fiscal Year	Total Homemaker Expenditures	Year over Year Percent Change
FY 2018-19	$45,765,407.18	19.00%
FY 2019-20	$53,790,859.59	17.54%
FY 2020-21	$62,911,598.98	16.96%
FY 2021-22	$71,544,224.11	13.72%
FY 2022-23	$89,114,542.94	24.56%
FY 2023-24	$117,054,785.29	31.35%
FY 2024-25	$174,099,143.89	48.73%

Base wage increases began in 2021 and have impacted homemaker costs in following years

PHE flexibility allowed for legally responsible persons (LRP) to provide Homemaker services.

Continued allowance of LRPs to provide homemaker services, and continued increases to CES waiver enrollment for access to homemaker for young children.

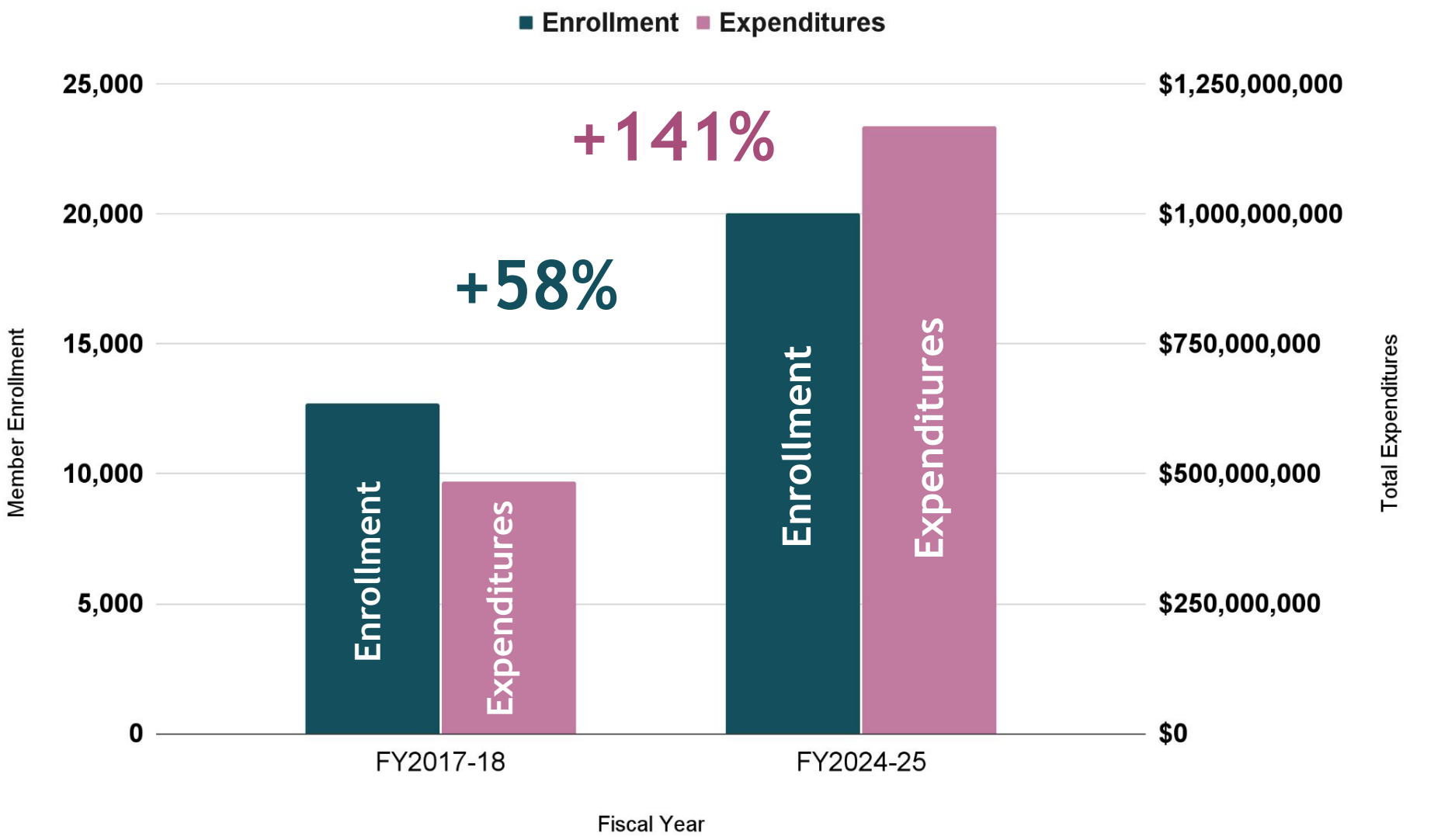
R-06: Enrollment Related Changes

Question 55-80

Intellectual and Developmental Disabilities Waivers

Questions 55-57

Q. 55 IDD Waivers Growth



FY 2024-25
21,949
Members with I/DD Served Across all Waivers

Q. 56 & 57 Negotiated Rates

HCPF approves all Negotiated Rates

Just over **3.5% of DD waiver members** have a negotiated rate (307 members)

Negotiations are time consuming and subjective

Rely on tools created in 2007 and on average require approximately 55 hours per month across 5 FTE to review each request

Negotiated rates are increasing

Between FY 2018 and FY 2024, the avg. daily negotiated rate for DD waiver increased ~66%, from ~$374 per day to ~$623 per day

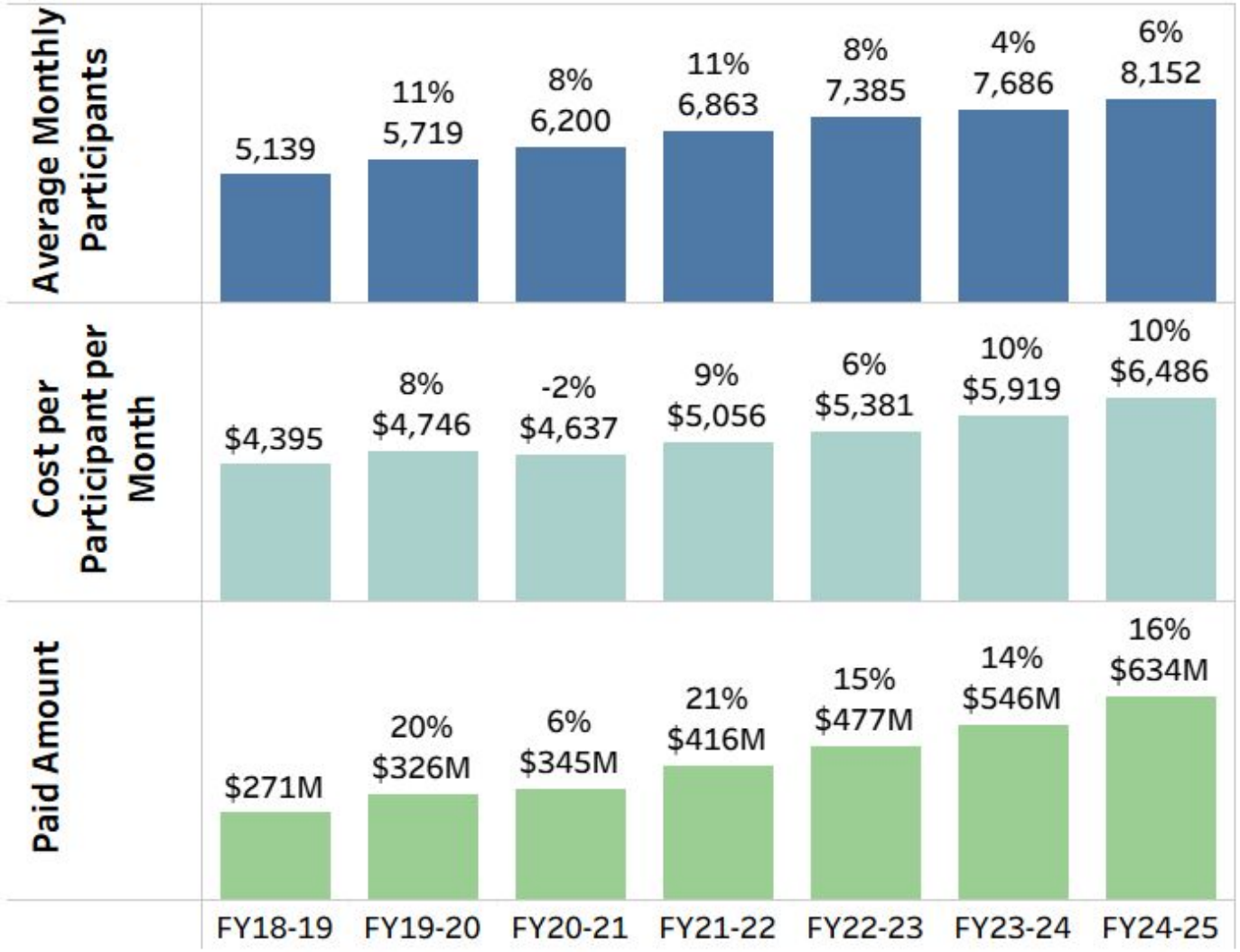
R-15 request to improve process

Develop a more standardized, objective way to negotiate rates, which would only apply to future negotiated rates

Adult Comprehensive (DD) Waiver Services and Other Residential Options in Medicaid

Questions 58-61

Q. 60 & 61 Individual Residential Services & Supports

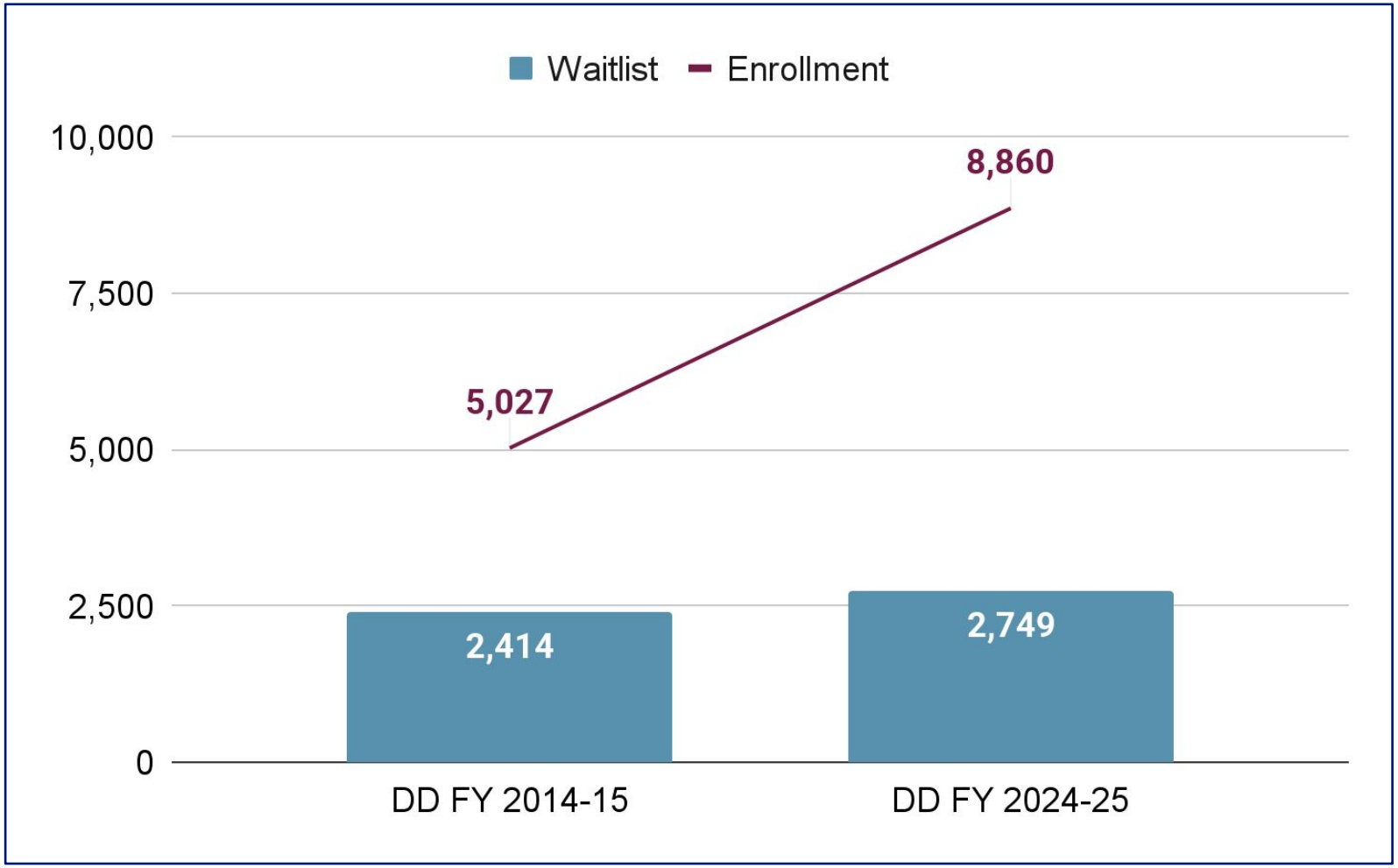


Cumulative Growth	Sustainability Actions
59%	**R6.17**: Change Auto Enrollment for DD Waiver Youth Transition **R6.18**: Reduce DD Waiver Churn Enrollments
48% 134%	**R6.11**: Roll back 1.6% rate increase **.75% ATB Rate Reduction** **R6.14**: Align IRSS rates **R6.36**: PETI **R15**: Res. Hab. Level 7 standardize negotiated rate tool

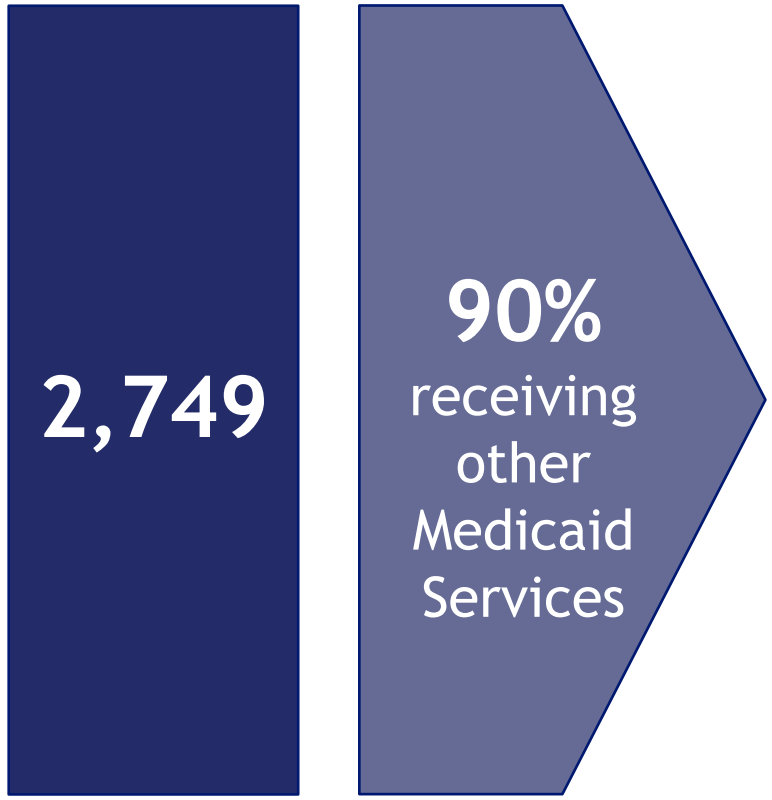
DD Waitlist Overview

Questions 62-70

Q. 63 & 64 Developmental Disabilities Waiver: Waiting List Progress



Q. 65 & 66 Meeting The Needs of Members



"As Soon As Available" DD Waiting List

Declinations are not Uncommon

Primary Declination Reason: Individuals reporting they are happy with their current services

Q. 67 Justification for Policy Change

DD Waiver	Growth	FY 2018-19	FY 2024-25
Enrollment Growth	+43%	6,376	9,119
Per Member Per Month Cost Growth	+41%	$6,325	$8,943
Expenditure Growth	+112%*	$422,166,719	$894,095,505

*Without action, the DD waiver expenditures are forecasted to grow another 20% between 2024-25 and FY2027-28; expenditures will be above $1B by FY2026-27

Q. 68-70 DD Waitlist Impacts

Factors for Waitlist Increase

Fewer enrollments available: 50% less “As Soon as Available” enrollment spaces

Increasing members joining the waitlist: CES & CHRP youth who otherwise would have enrolled

Factors for Waitlist Decrease

Members receive enhanced support during transitions: Stronger options counseling

Right services, right time: Members are better served on other waivers (including SLS and CFC); decline enrollment when offered or do not join the waitlist at all

IDD Youth Transitions & Post-Eligibility Treatment of Income

Questions 71-80

Q. 71 Continuity of Care

Member Transition Support: Each member transitioning out of CES or CHRP will receive enhanced transition support, with a focus on ensuring youth receive the right services at the right time.

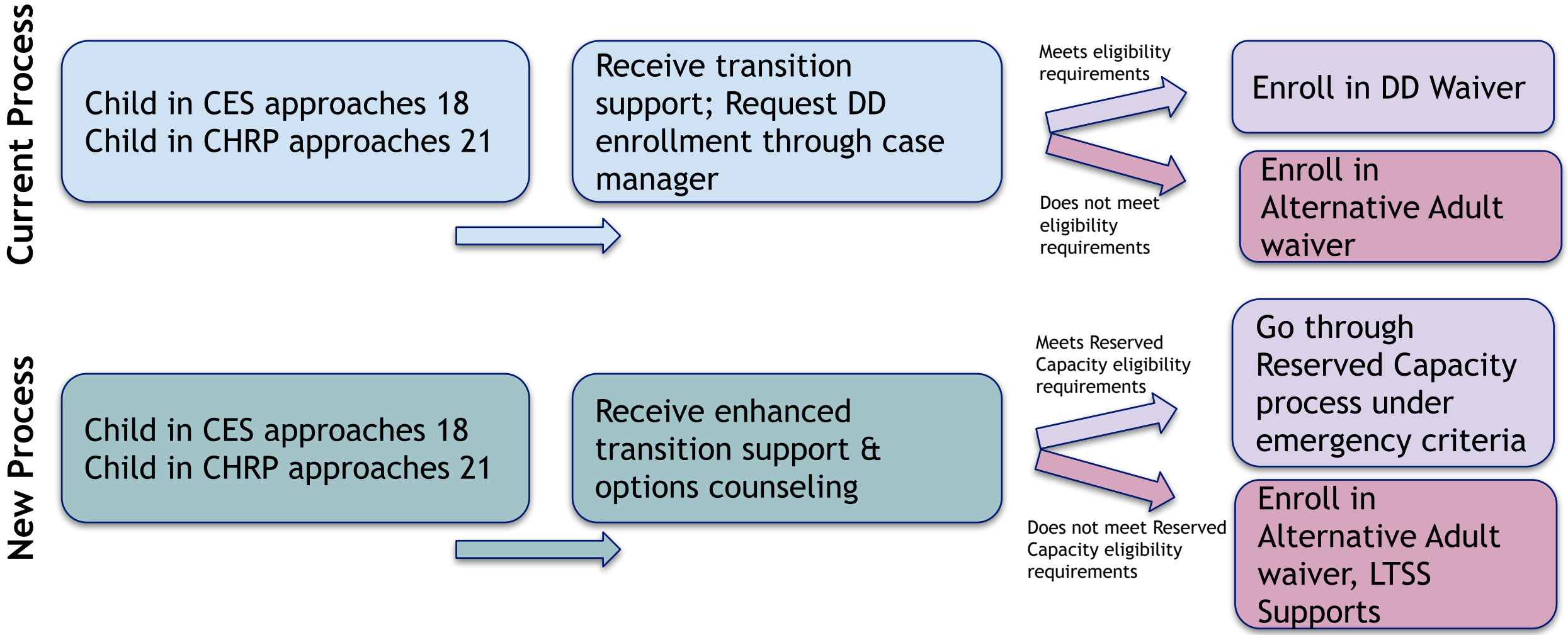
Continuation of Care at Home: Most members can continue to be supported at home, by their family, whether they enroll in the DD waiver or another waiver program.

- Since July 1, 2025, youth aging out of children's waivers have new, streamlined pathways to maintain caregiver continuity through Community First Choice (CFC) and the accompanying participant-directed options such as In-Home Support Services (IHSS) and Consumer-Directed Attendant Support Services (CDASS).

Residential Care: For the relatively small number of children in out-of-home placements through child welfare, they typically remain with the same residential provider agency—and often the same direct support staff—with only back-end billing and waiver authority changing.

- Currently, 88 members or 13% of members enrolled on the CHRP waiver are in child welfare.

Q. 72-76 Youth Transitions Process



Q. 77-80 Post-Eligibility Treatment of Income (PETI)

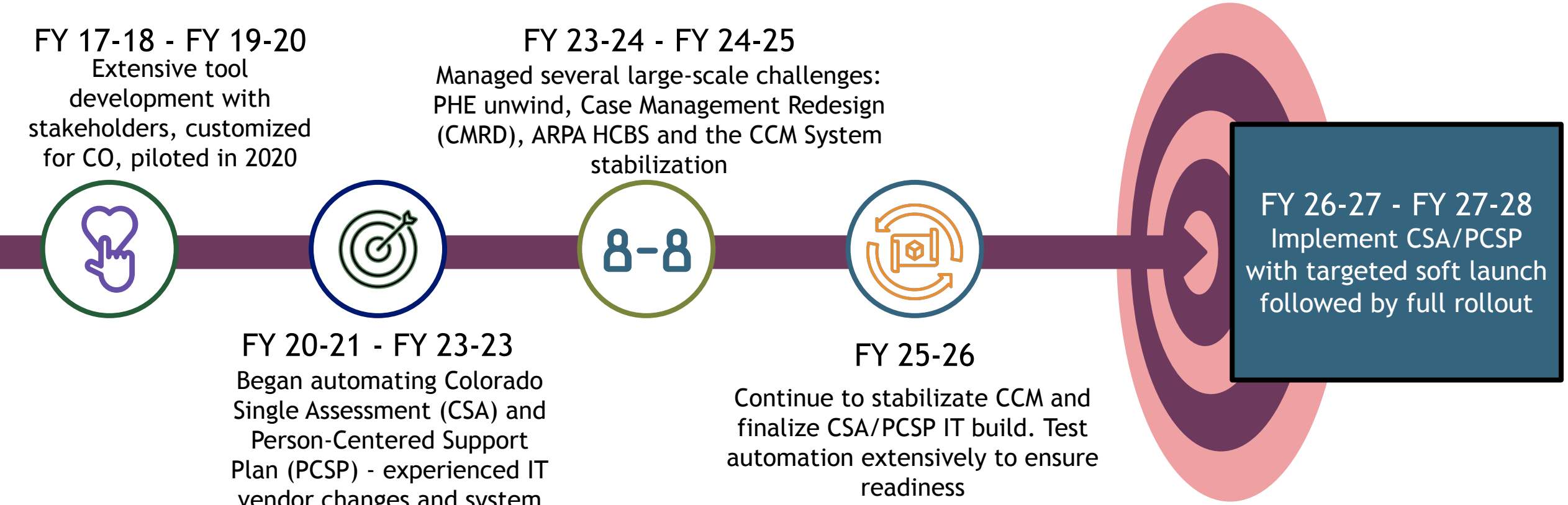
Residential Setting	Room & Board Paid by Member	Personal Needs Allowance (PNA) Protected	Income Contributes to Services Cost
Nursing Facility, Alternative Care Facility, Supported Living Program	✔	✔	✔
Residential Habilitation (DD Waiver) Current	✔	✔	X
Residential Habilitation (DD Waiver) Proposed	✔	✔	✔
Example: $1,500 Income	$797	$421.46	$281.54

- Today, Medicaid pays the full residential habilitation rate for the DD waiver.
- Under this proposal, PETI will apply to DD waiver residential services — the same policy already used in other residential settings.
- Only income above room and board and the personal needs allowance would contribute toward service costs.
- Savings of approx. $6.3 mil GF in FY 2026-27 and $13.1 mil GF in FY 2027-28
- Members enrolled in the Working Adults with Disabilities (WAwD) program will be exempt from the PETI process.

Other Requests | R-8, R-12, R-15

Questions 81-89

Q. 81-82 R-8 Colorado Single Assessment & Person-Centered Support Plan



Q. 83-86 Nurse Assessor Program & Prior Authorization Request (PAR) Savings

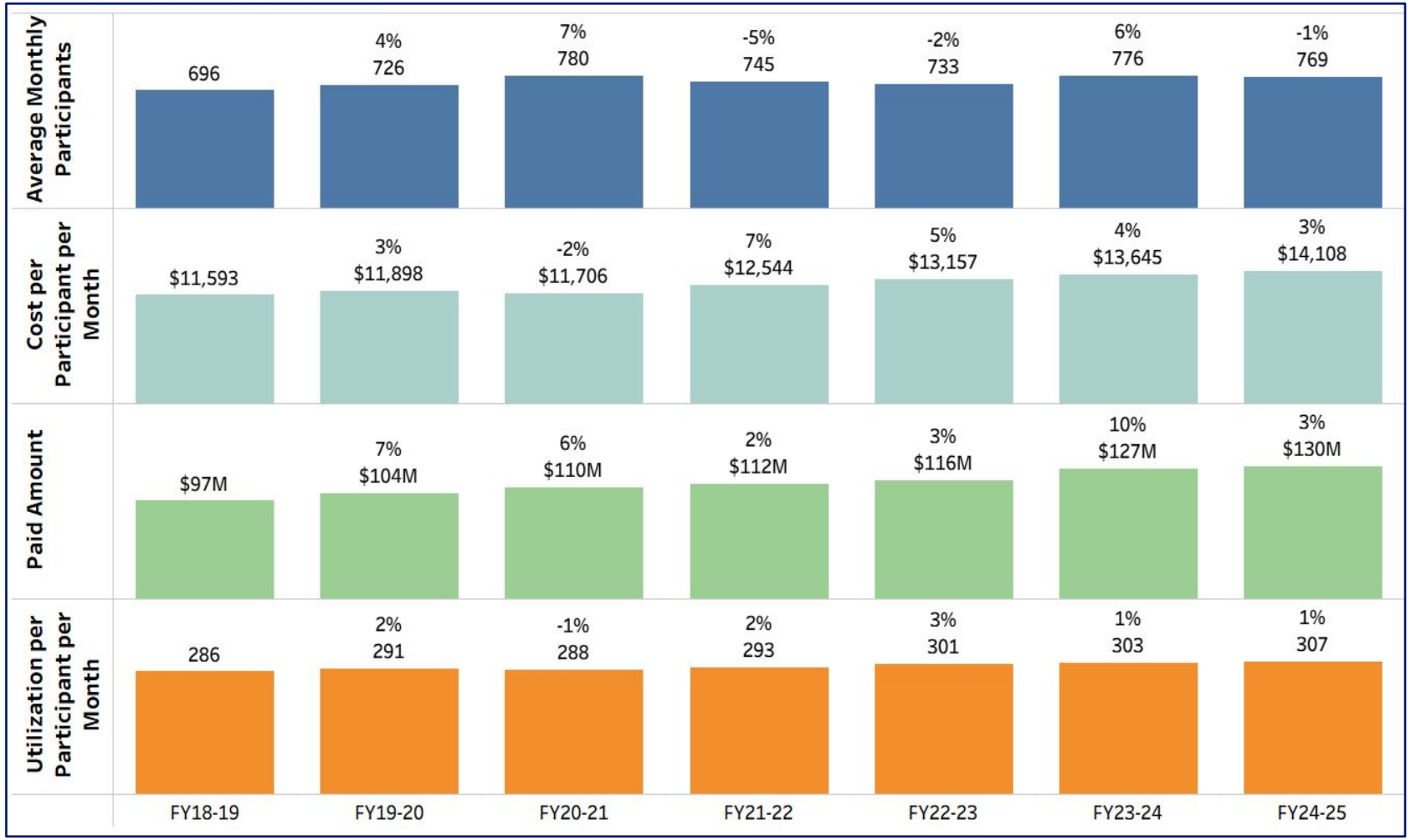
Nurse Assessor Program

- **Not a cost-reduction initiative**; no projected savings were assumed.
- **Update:** HCPF has decided to **end** this due to challenges preserving access and administrative burdens.

Resuming Prior Authorization (PAR) process for Long-Term Home Health (LTHH)

- **R-12 Still Needed**: Supports staffing for appeals, benefit oversight, and provider support, and ensures proper implementation of medical necessity reviews.
  - Appeals staff: term-limited as increase in appeals is expected to be temporary.
  - Permanent staff: needed to manage the benefit ongoing.
- **Source of Savings:**
  - **Resuming PARs for LTHH**—after pause during the pandemic—ensures services meet medical necessity, reducing costs relative to what they would otherwise be (by $14.3M TF in FY2025-26 and $48.1M TF in FY2026-27).
  - Those savings **do not push members into nursing facilities or other institutions**. The savings come from lower expenditures for home-based services through ensuring medical necessity.

Q. 87 Private Duty Nursing Service



Cumulative Growth	Sustainability Actions
11%	No actions targeted at enrollment for PDN
22% 34%	**R6.11:** Roll back 1.6% rate increase **.75% ATB Rate Reduction** **R15:** PDN Per Diem
7%	No actions targeted at utilization for PDN

Q. 88 No Rate Cuts to Nursing Services

Apart from the 1.6% & .75% across-the-board rate decreases to providers, HCPF is **not** proposing any rate decrease to nursing services.

- Shorter units: LTHH PT/OT/ST will bill in 30-min. increments, and LTHH CNA in 15-min. increments
- Closer to the time providers actually spend

- New per diem PDN unit which includes a mix of CNA and RN level of care tasks
- New PDN Acute Benefit
- Better reflects actual care needs and tasks done

- New group unit: for a worker serving multiple members at the same time under certain CFC and LTHH-CNA services
- Reduces duplicative billing for shared tasks

These changes preserve access to current service authorization(s), increase staffing flexibilities, and enhance accuracy of billing for services provided.

Q. 89 PDN Per Diem

24-Hour Nursing Needs

There is a shortage of RNs throughout the state. Members with 24/7 nursing needs may also have CNA-type tasks mixed in

+

CNA-Type Tasks

A rate that includes CNA-type tasks reflects real-world care intensity for members with 24/7 care needs

→

PDN Per Diem Rate

A rate that includes the real world combination of care needs, allows for more flexible staffing, freeing up nurses across the state.

- The per diem applies only when PDN is provided on a 24-hour basis
- This will both maintain member hours and allow greater staffing flexibility
- The per diem aligns payment with actual care intensity
- There will be robust stakeholder engagement to develop this request further

HR 1: Rural Health Transformation Program & Rural Providers Questions 90-97

Question 90: Rural Health Transformation Program

HR 1's RHTP provides **$50 billion in federal grants**, to be allocated to approved states over 5 federal fiscal years, with **$10 billion of funding available each year**, beginning in FFY 2026 and ending in FFY 2030.

- **$5 billion (50%) will be distributed equally** among approved states, and
- **$5 billion (50%) will be allocated by CMS based competitive factors such as:** rural population, proportion of rural health facilities to total health facilities, rural hospital sustainability, and other factors.

CMS announced on December 29, 2025 that Colorado was awarded $200 million annually through the RHTP, representing $1 billion over the 5 year period.

Question 91: Next Steps: Governance & Timelines

- HCPF released a draft governance structure for the RHTP on Dec 19, with feedback due Jan. 7, 2026.
- Included Advisory & Executive Committees, ensuring eligible providers (rural hospitals, RHCs, FQHCs, CMHCs, Emergency Medical Services) or their associations could engage.
- Jan. 2026, funds distributed to approved states. States must enter into a cooperative agreement with CMS (details unknown) and negotiate funding distribution by area and implementation timeline.
- Any decisions of funding distribution and timing cannot be made until Colorado meets with CMS and the cooperative agreement is final.

For more information visit our website.

CMS Guidelines for Application Structure

CMS's Strategic Goals for RHTP

- Make Rural America Healthy Again
- Sustainable Access
- Workforce Development
- Innovative Care
- Tech Innovation

Permissible Use restrictions

- Strict prohibitions
- Tightly defined entities
- Limitations

These entities are eligible for funding:

- **Hospitals**: CAHs, Sole Community Hospitals, and other defined rural types.
- **Tribes and Facilities.**
- **Community Health Centers**: FQHCs, FQHC look-alikes, designated rural-health clinics, and other CHCs receiving Section 330 grants.
- **Behavioral Health Providers**: CMHCs, CCBHC, and opioid treatment programs.
- **Emergency Medical Services.**

Questions 92-95: Colorado's Permissible Uses - Reflect Stakeholder Priorities

- Chronic disease management and prevention
- Technology-driven solutions
- Assisting rural communities to right size their health care delivery systems
- Developing innovative models of care including value-based and alternative payment
- Initiating, fostering, and strengthening local and regional strategic partnerships
- Workforce recruitment and retention
- A full list of the 11 permissible uses can be found in the Webinar's Appendix.

Stakeholder Engagement

Rural Health Care providers actively participated in discussions that shaped our application. **>50 rural health care providers were consulted in its development.**

HCPF and CRHC held formal stakeholder sessions in **September and October** to outline CMS's strategic goals, permissible uses, options, and restrictions. We spoke with over **200 stakeholder attendees at each of three separate sessions.**

Rural Provider Payment Methodologies Questions 96-97

HR. 1 Medicaid Impacts

Overview

H.R.1 Medicaid Coverage Threats

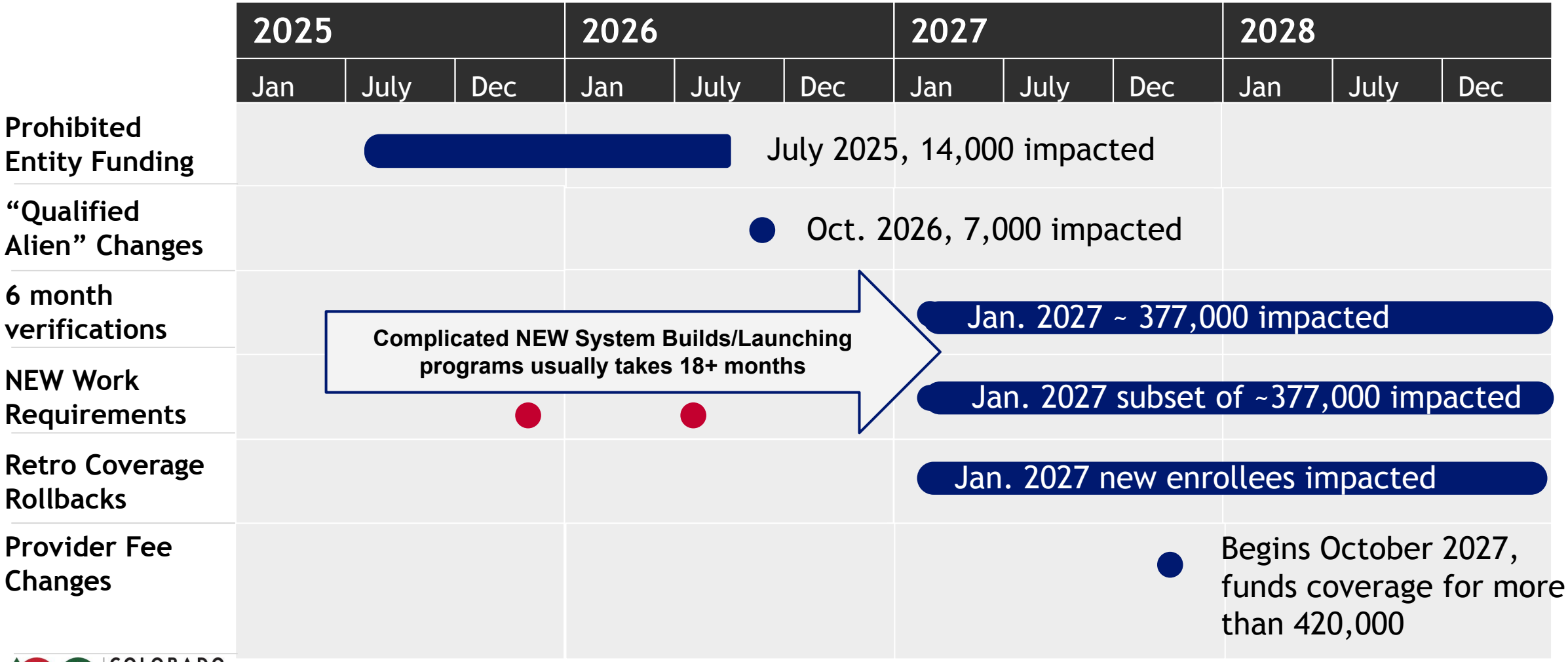
Medicaid Expansion population ~ 377,000 Medicaid members:

- **Federal CHASE Funding Reductions** impact this population and hospitals - also funds Buy-In programs & CHP+ **impacting more than 420K members**
- **Eligibility redeterminations increased** from every 12 months to every 6, starting Jan. 1, 2027
- **Work requirements** for most "able-bodied adults" ages 19-64, starting Jan. 1, 2027 - some exemptions allowed
  - Working, Going to school, or Volunteering at least 80 hrs/mo to qualify
- **Coloradans may lose coverage because** they don't meet the new requirements or because of administrative complications

North Star: Mitigate coverage losses and its catastrophic consequences to Coloradans, providers, economy

H.R. 1 Medicaid Coverage, Eligibility & Financing
(not comprehensive of all changes)

- CMS Guidance - preliminary guidance in December 2025, final rules in June 2026



HR 1: Financing Impacts - Provider Fee, State Directed Payments Questions 98-101

Question: 98 Robust HCPF Plan to help navigate H.R. 1

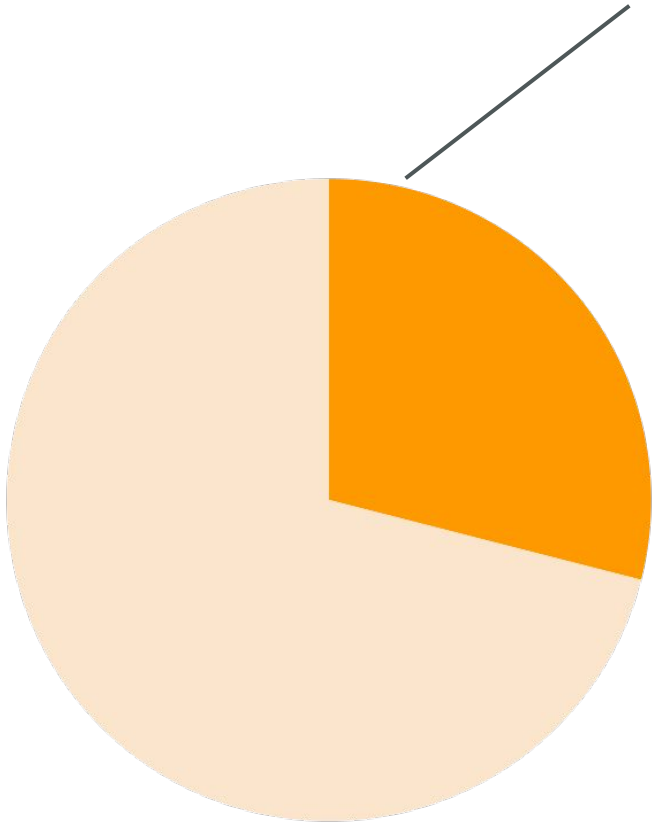
- Discipline to Medicaid Sustainability Framework: Grounded in facts/insights and alignment around shared goals
- Understanding H.R.1 impacts and aligned goals:
  - Eligibility ecosystem and state/county modernizations
  - Fraud, Waste, Abuse enhancements
  - North Star: Shared efforts to help Coloradans comply and stay covered
- Seeking other federal funding
- Leverage ACC Phase III and Innovations (eConsults, Prescriber Tools, Value Based Payments, etc.) to control trends and improve quality
- Prioritize engagement, transparency, partnership, leadership
- **Leverage third-party insights, state comparisons, learnings**

Cost Sharing & Buy In Programs Questions 102-105

Question 102: Cost Sharing

Limitations:

- Premiums may be charged only for 150% Federal Poverty Level (FPL) & premiums plus copays cannot exceed 5% of the family's income
- Of ~**1.2M members, only 3.33% (38,606) earned above 150% FPL**
- **($23,475 for 1 or $39,975 for 3)**



341k (29%)
have no reported household income

- Will be exempt from cost sharing
- Most at-risk of losing coverage from work requirements if not exempted

Question 103: Historical Cost Sharing

Medicaid Cost Sharing	
Amount	Nominal $1-$3 (repealed) $8 non emergent ER
Annual Max.	5% of income
Exclusions	<150% FPL, certain populations

Copays eliminated per SB23-222

CHP+ MCO	CHP+ Co-Pay Structure
Colorado Access	4 income levels range $1-$50
Denver Health	Does not collect
Kaiser Permanente	Does not collect
Rocky Mountain Health Plans	3 levels range $0-$20
DentaQuest	3 levels range $0-$15

CHP+ Enrollment Fees $25-$105/year, income dependent

Enrollment fees eliminated per HB22-1289

Questions 104-105: Buy-Ins

Working Adults with Disabilities

Federal Poverty Level (FPL)	Monthly Income for an Individual	Monthly Premium
0-40%	$0- $522*	$0
41-133%	$523 - $1,735*	$25
134-200%	$1,736 - $2,609*	$90
201-300%	$2,610 - $3,913*	$130
301-450%	$3,914 - $5,869*	$200

Children with Disabilities

Federal Poverty Level (FPL)	Monthly Income for Family of 4	Monthly Premium
0% - 133%	$0 - $3,564	$0
134% - 185%	$3,565 - $4,957	$70
186% - 250%	$4,958 - $6,698	$90
251% - 300%	$6,699 - $8,038	$120

HR 1: Work Requirements Questions 106-116

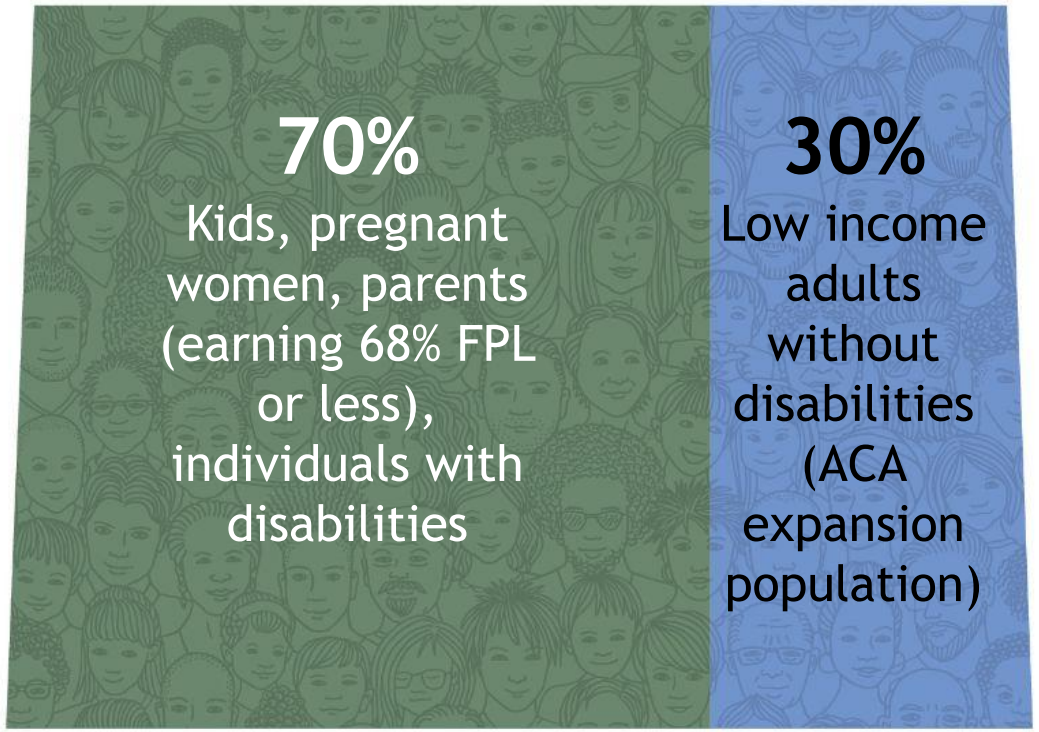
Expansion Population Impacts

6 Month Renewals & Work Requirements starting Jan. 2027

1,230,633

Total Colorado Medicaid enrollment

Does NOT have to meet the work requirement or do twice a year renewals



MAY have to meet Work Requirement

MUST do every 6 month renewals

Data Notes: Data is based on annualized monthly caseload from FY 24-25 as of June 30, 2025. More detailed information including former foster care, dual eligible, Buy-Ins, OAP and other program breakouts are available at Colorado.gov/hcpf in our caseload reports.

Work Requirements

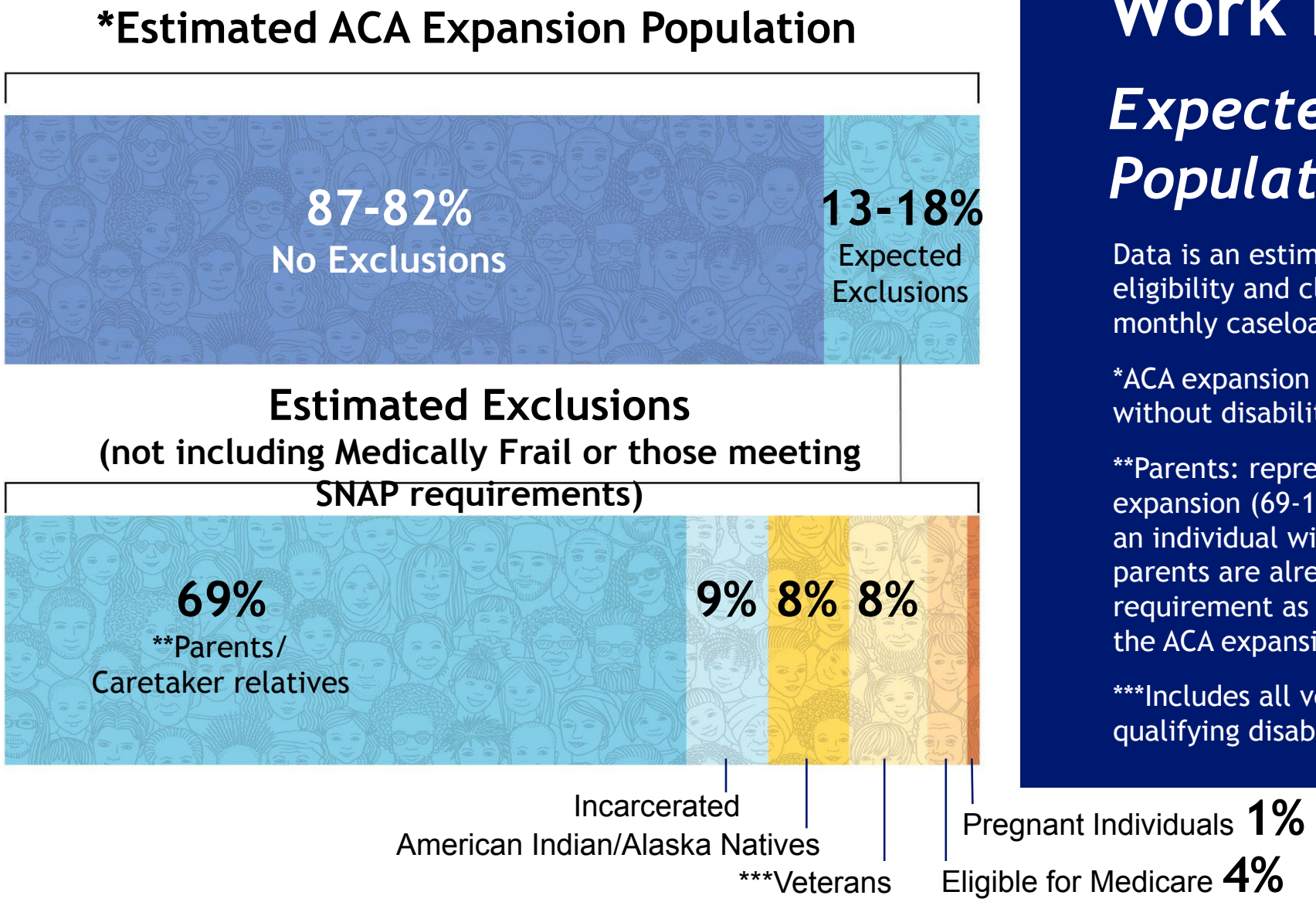
Expected ACA Expansion Population Exclusions

Data is an estimate only based on information in eligibility and claims systems, annualized average monthly caseload from FY 24-25 as of June 30, 2025.

*ACA expansion population includes low income adults without disabilities.

**Parents: represents parents who are part of the ACA expansion (69-133% FPL) who share a Case Number with an individual with disabilities or child under 14. Most parents are already excluded from the work requirement as they are earning 68% FPL or less (not in the ACA expansion population).

***Includes all veterans not just veterans with a qualifying disability so this figure is overestimated.



Questions 106-114: Medicaid Work Requirements: Minimum Viable Product (MVP)

- **Preliminary, basic guidance from CMS issued in late November and December - States will have less flexibility than what we expected under the law**
  - Limited ability to leverage self-reporting or “self-attestation”
  - Feds will NOT let states define Medically Frail
  - Strong emphasis on everything being auditable

- **Colorado should not expect any CMS waivers to delay implementation.**

- CMS is encouraging a **Minimum Viable Products (MVP) at launch.**
  - Must be operational by all States by January 1, 2027
  - Colorado is designing its MVP model now.

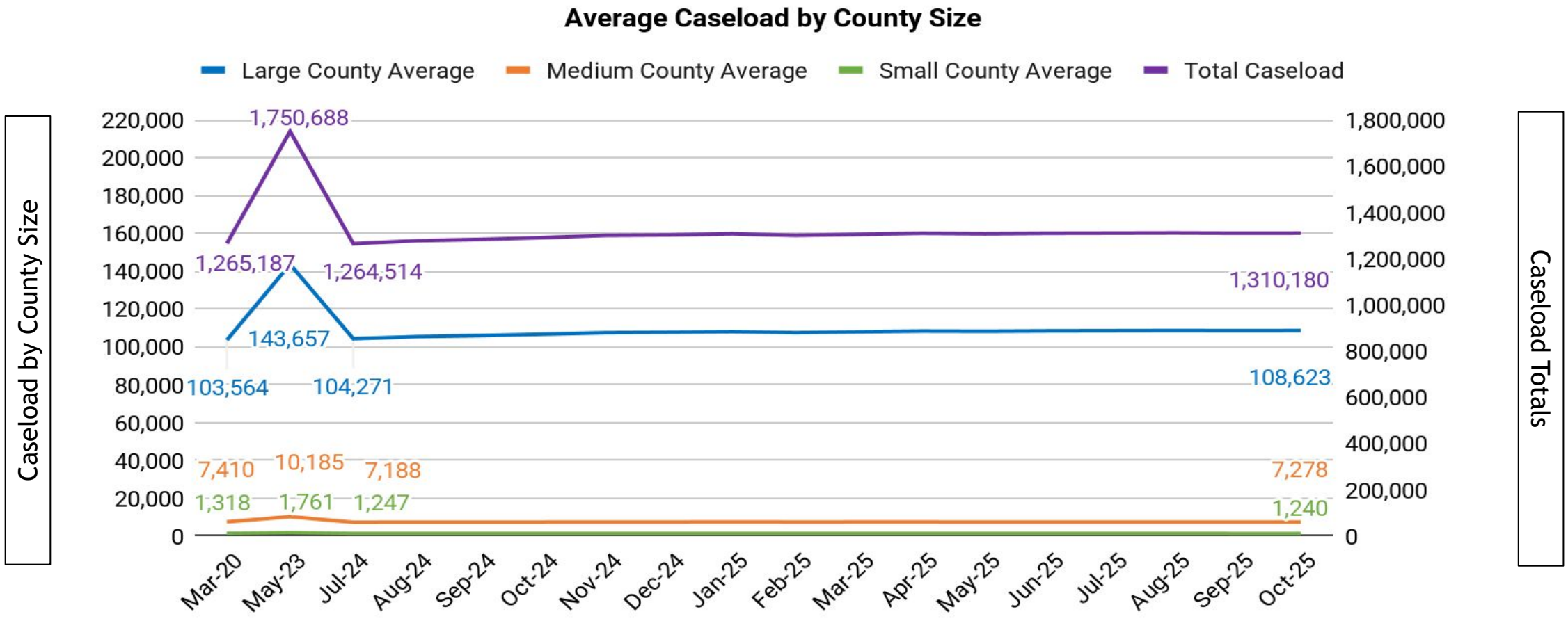
Question 115-116: Minimum Viable Product (MVP) Engagement Timeline

OCT 2025	NOV/DEC 2025	JAN-MARCH 2026	MARCH 2026
High Level Concept of MVP Presenting MVP concepts to key partners, gathering FAQs & starting work on improvements beyond MVP.	**CMS Issues Initial Guidance Allowing for More Detailed Conversations on Workings of MVP** Focus on more detailed workings of MVP, coordination with counties & key partners.	**Member Outreach Noticing Development** Working with stakeholders on initial noticing about work requirements and related correspondence needed for reporting. Planning member journey & outreach strategy pending additional funding.	**Iterating on MVP: Longer Term Improvements to the system** Working with stakeholders on improving the MVP using interfaces and system improvements to reduce member & county burden. Conversations facilitated by contracted vendor pending additional funding.

Ongoing collaboration with SNAP/TANF & other programs with work requirements.

R7: Driving County Efficiencies, Shared Services Questions 117-123

County Caseload



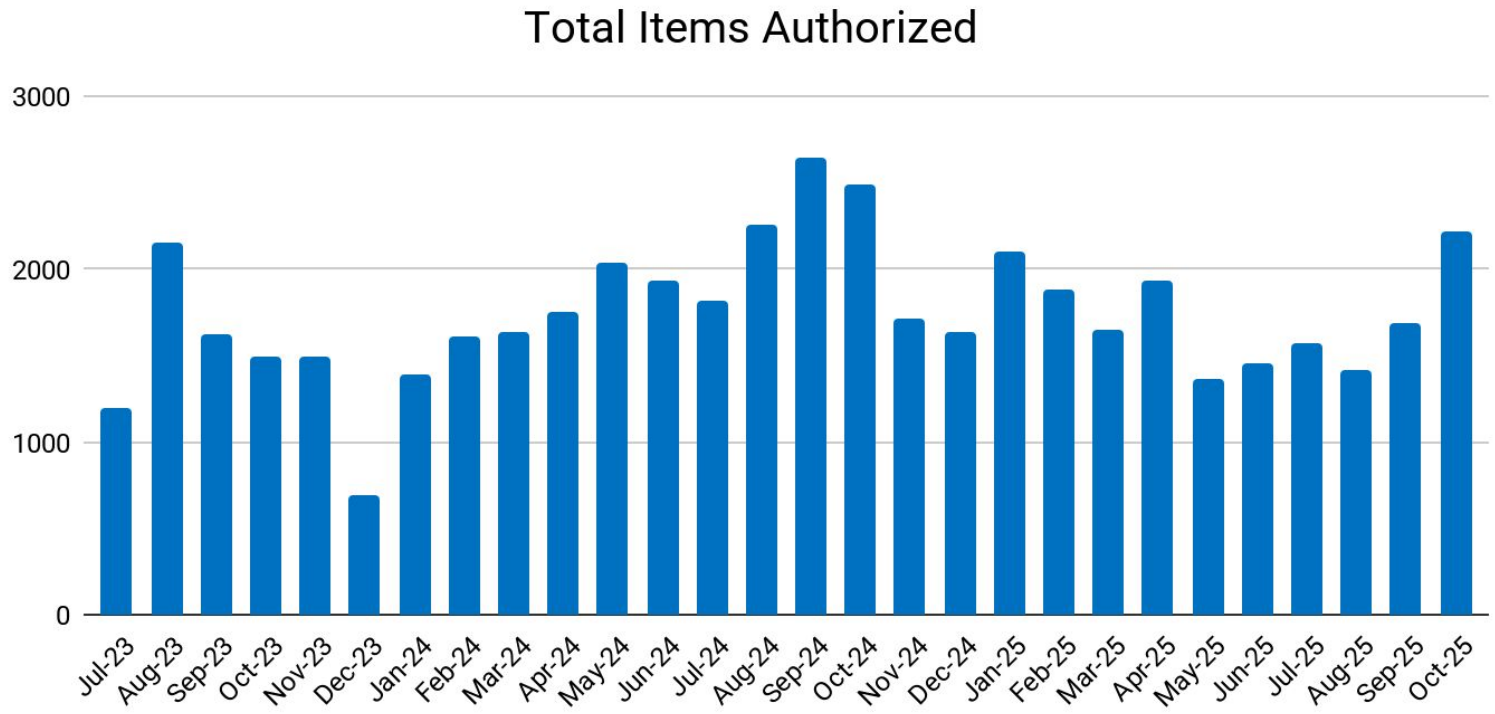
This slide shows the average caseload by county size as well as the total caseload. It shows March 2020, May 2023, and the current fiscal year.

Overflow Processing Center

October 2025

Counties working with OPC

1. Adams - 37 months
2. Arapahoe - off and on for 34 months
3. Archuleta - 9 months
4. Clear Creek - 36 months
5. Costilla - 2 months
6. Denver - 4 months
7. El Paso - off and on for 33 months
8. Garfield - 34 months
9. Gunnison/ Hinsdale - 8 months
10. Lake - 24 months
11. Moffat - 34 months
12. Pitkin - 0 months
13. Saguache - 32 months
14. Washington - 8 months



HCPF directs what work is sent to the OPC and which counties may use the OPC, to best leverage the resource to support Renewals and backlog reduction plans.

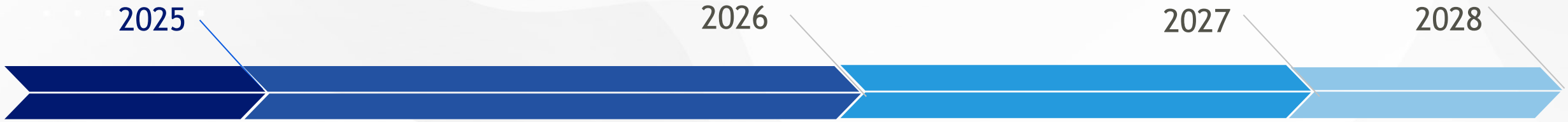
Questions 117-120
R-07: Driving Efficiencies in Benefit Services Delivery - Shared Services

- Centralizes, in one county, various administrative functions
- Allows counties to focus on the core duty of determining eligibility.
- Provides financial and workload relief while modernizing current administration processes increasing efficiency and sustainability.
- 4 shared services in proposal:
  - **Tier 1 Statewide Call Center** for CBMS programs
  - **Central Document Scanning** where documents not physically dropped off at county would be scanned, indexed and work assigned to the appropriate county.
  - Two additional shared services are in development (HCPF only at this time) **Member Case Integrity & Quality Assurance**.
- **Roll out will be phased over tim**e to align with foundational technology implementation

Link to Shared Services Overview Document (PDF)

Question 121-123: How Shared Services & Districts Work Together

(Updated with County Feedback as of 12/18/2025)



Tech		**Jan-April 2026:** Contracting and design	**May 2026 - June 2027:** • Design and implementation of document management and workflow management, PEAK replacement, and Phase 1 CBMS replacement	**July - Dec. 2027:** • Rollout and implementation of document management, workflow management, and scheduler with phased district launch	
Shared Services		**Jan-June 2026** • Shared Services Workgroups • Shared Services Procurement, Contracting, and Set Up			**July 2028:** • Shared Services fully operational
Districts	**Dec. 2025:** • Advisory Group • Fiscal Workgroup • Budget Amendment revisions	**Jan. 2026:** • Budget Amendment **Jan. - May 2026:** • Policy decisions (training, staffing, fiscal, legal, etc.) via Leg Session • Workgroups established • Develop Performance Based Contracts	**July 2026 - June 2027:** • Draft and negotiate Hub Agreements • Change- management, stakeholder engagement, operational readiness, eligibility business processes	**July - Dec. 2027:** • Phased district launch; roll out July (2), Sept.(5), Dec. (4).	**July 2028:** • Districts fully operational

R6: Sustainability & Behavioral Health
Questions 124-149

Cristen Bates, Behavioral Health Initiatives
and Coverage Office Director

HealthFirst Colorado, Colorado's Medicaid program, covers mental health and substance use care for all 1.4M Medicaid members.

- Largest payer in the state
- ACC 3.0 Regional Accountable Entities (RAEs) manage integrated network of physical and BH providers
- RAEs contract with 14,000+
- Served 303,000 in FY24-25
- Full continuum of inpatient, high intensity outpatient, community-based and recovery support services.
- Incentives and value based payment programs to drive quality and outcomes
- RAEs work with BHASOs to support Coloradan coming onto or coming off of Medicaid/CHP+
- BHASOs contract with ~430 BH safety net providers
- Service payments are designed to cover Uninsured Coloradans.
- Safety net outpatient mental health, SUD and recovery services, room & board
- Capacity based payments support stable network, help cover expansions

Question 124: Seeing the Impacts of 5+ Years of Focus and Investments in Behavioral Health

Provider Network

- 132% increase in RAE contracted providers; over 14,000 in 2025
- Expanded Comprehensive Provider Network with BHA and independent provider network

Access to Care

- 19% in SFY2021; grew to about 24% in SFY2024, serving over 300,000 Coloradans
- 41% increase in access to services overall from SFY2018

Increased Investment

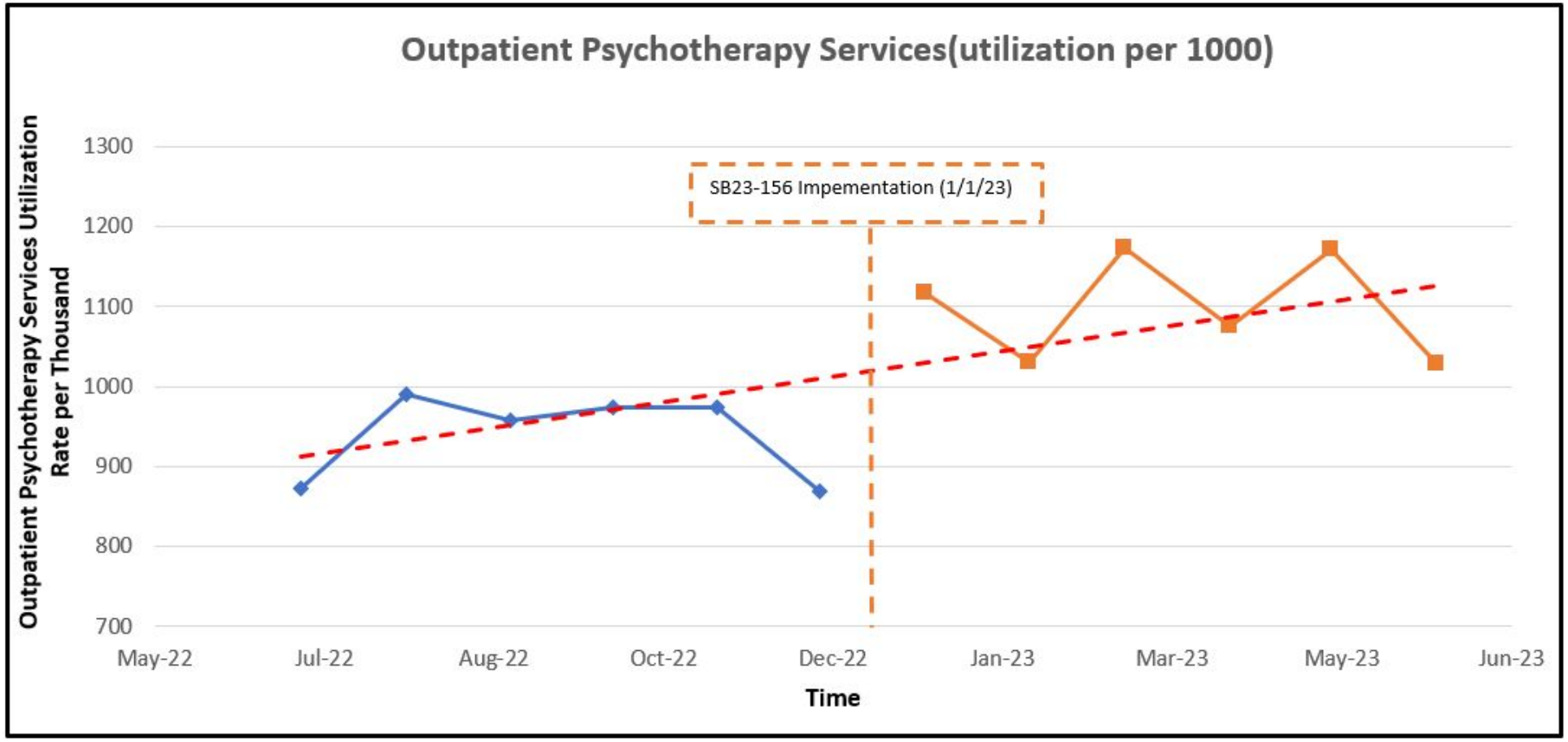
- From $600M in 2019 to $1.2B in 2025
- Sustainability plan to retain progress, but flatten trends

Expanded Benefits

- Full SUD care continuum, enhanced crisis services and secure transport, supportive services, system of care, inpatient mental health expansion, health related social needs

R6: Outpatient Psychotherapy Prior Authorization Requests (PARs) Question 125-128

Outpatient Therapy Trends



Aggregate utilization increased 17% after SB23-156 went into effect. Data represents all outpatient psychotherapy services.

Outpatient Therapy Trends

Reviewing data provided by the RAEs for paid claims for only 60-min psychotherapy services **from SFY 21/22 through FY 23/24**, the number of Medicaid members receiving…

- **26-35** sessions/year increased by 61%. (from 4237 to 6836 members)
- **36-45** sessions/year increased by 68%. (from 2121 to 3569 members)
- **46-55** sessions/year increased by 60%. (from 764 to 1221 members)
- **56 or more** sessions/year increased by 98%. (from 447 to 886 members)
  - $32M of the $36M in increases was this population of those getting more than one therapy session per week.
- **10% of the 125,120 members that received 60 min psychotherapy service that year** received from biweekly (26) to weekly (52+) therapy sessions for a year

Questions 125-128: BH Outpatient PARs policy

- In alignment with Governor's EO, and § 25.5-4-105 which states that **nothing in Article 5, where the PAR prohibition statute resides, shall prevent the state department from complying to maintain a program within the limits of available appropriations.**
- RAEs are required to have UM procedures to audit for fraud, waste, and abuse.
- Most effective to focus on areas where trend is high, automated

R6: Prospective Payment System Question 129-131

Prospective Payment System (PPS) Oversight

PPS started July 2024, need to monitor closely for impact on budget, access, services

PPS rate based on cost report covering actual cost of care:

- Personnel costs: Salaries, training, employee benefits of direct program staff and indirect administrative staff.
- Client-related costs: Medical supplies; payments to other service providers; transportation, uncompensated care
- Occupancy costs: Rent, utilities
- Operating costs: Technology, data, licenses, insurance

Requires guardrails, limits on:

- Currently: salary for execs, lobbying, fundraising, legal fees, unfulfilled contracts, alcohol
- What is a “reasonable cost”? Need standards to be transparent.

PPS pays based on providers meeting safety net standards like: serving priority populations and no eject / no reject

R6: Behavioral Health Incentives Question 132

BHIP Performance by RAE, FY 2023-24 - Unprecedented Patient Outcomes and Quality

RAE	Engagement in Outpatient SUD treatment	Follow-up within 7 days of discharge for a MH condition	Follow-up within 7 days of ED visit for SUD	BH assessment for children in foster care
1 (RMHP)	28%	32.6%	28.9%	17.2%
2 (NHP)	31.4%	25.5%	25.4%	15.7%
3 (COA)	29%	36.3%	30.7%	17.3%
4 (HCI)	13.4%	30.1%	26.3%	34.2%
5 (COA)	31.2%	32.8%	28.3%	39.2%
6 (CCHA)	24.4%	34.9%	26.3%	16.2%
7 (CCHA)	21.1%	28%	25.5%	18.3%

Program is “subject to available funding”, 66-90% goes to providers

R6: SBIRT
Question 133

High Acuity Children and Youth Question 134-146

Implementation Update
Questions 134-136

- RAEs have contracted with providers in every region (Paragon, Diversus Health, Savio House, Turning Point, Mile High Behavioral Health)

- HCPF started to officially serve members under the Colorado System of Care in November 2025.
- There are a total of 17 individual practitioners who have completed at least one HFW training (introduction to wraparound, engagement in wraparound, intermediate wraparound or supervision in wraparound).
- Colorado State University designated as the Workforce Capacity Center
- University of Colorado with the Kempe Center's Rocky Mountain MST Network

Questions 137-138: Fully Contracted with Workforce Capacity Center with CSU

- CSU has contracted with national certifying organizations to bring evidenced based and evidence informed practices to Colorado
- There are 2 WCC Co-Directors and 3 staff
- Engaged an external vendor for IT data and tracking system
- Developed the landscape analysis plan and data collection
- Consulting work with University of Illinois, Case Western University and the National Wraparound Implementation Center (NWIC)

COLORADO STATE UNIVERSITY

Questions 139-140: Budgeting for CO-SOC

Identification Tool

Screen to determine who needs an Enhanced Standardized Assessment

Enhanced Standardized Assessment

Standardized assessment (w/ CANS) to uniformly determine a child's needs and service type.

Enhanced Intensive Care Coordination

High Fidelity Wraparound using the NWIC Model

In-Home Crisis Stabilization Services

Leverage existing mobile crisis and Crisis Resolution Teams

Intensive Home Based Treatment

Use existing models in Multisystemic Therapy (MST) and Functional Family Therapy (FFT)

Support Services

Long-term in-home supports such as respite and therapeutic mentoring

Behavioral Services

Behaviorist e-consult via doc-to-doc consultation from a behavior specialist to treating provider.

Questions 141-145: A System of Care addresses known gaps with proven solutions

- **Why CO-SOC Matters**
  - Some youth no longer meet medical necessity for residential treatment, but families may not feel prepared for them to return home
  - CO-SOC and HFW support youth and families through active discharge planning
  - Discharge planning ensures caregivers and outpatient supports are in place before a youth returns home
- **Impact**
  - Reduces length of stay in residential treatment
  - Improves bed turnover
- **SFY 24/25 Snapshot**
  - 319 youth received PRTF services
  - 268 youth received QRTP services
  - 82 youth were served out of state

Question 146: Medical necessity compliance with federal and state policy

Defined in 10 CCR 2505-10 8.076.1.8. as a program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
b. Is provided in accordance with generally accepted professional standards for health care in the United States;
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
e. Is delivered in the most appropriate setting(s) required by the client's condition;
f. Is not experimental or investigational; and
g. Is not more costly than other equally effective treatment options.

SUD Waiver & Patient Outcomes Question 147-149

Questions 147-148: Colorado's 1115 Waiver: SUD Demonstration & Amendments

Substance Use Disorder (SUD)

Expanding the Substance Use Disorder Continuum of Care provided the state with authority to cover high-quality, clinically appropriate treatment to members with substance use disorders

Implemented January 2021

Health Related Social Needs

Coverage for individuals with chronic conditions who qualify for a housing voucher. Includes housing supports and nutrition support.

Implemented July 2025

Serious Mental Illness and Serious Emotional Disturbance (SMI & SED) Inpatient Care

HCPF can pay for up to 60 days while maintaining an average length of stay of 30 days for members staying in an Institute of Mental Disease (IMD) regardless of the number of days in each episode of care.

Implemented October 2025

Criminal Justice Reentry Services

Coverage includes case management services and medication-assisted treatment (MAT) for SUD 90 days prior to release, plus 30-day supply of medications upon release from jails and prisons

In Progress

*Current waiver has been extended for 90 days

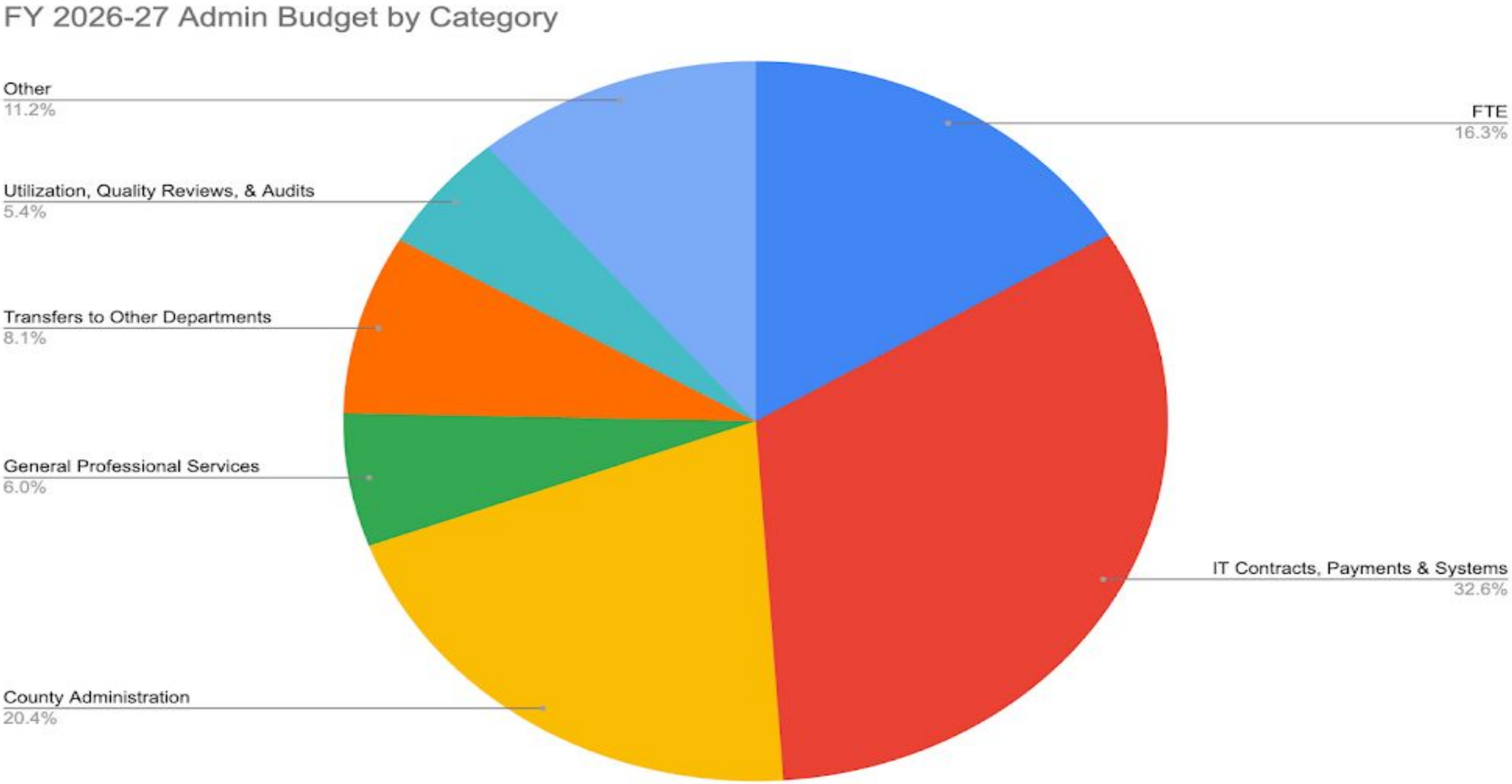
Question 149: Evaluating SUD Outcomes

- Successful use of community-based alternative services
  - 23% increase in use of High Intensity Outpatient
  - 24% decrease in use of residential and hospital SUD
- Withdrawal Management service utilization remains an area of opportunity
  - Growing readmission rates
  - High % don’t transition to other treatment levels of care.

Other Budget Requests & Miscellaneous Questions
Questions 150-153

Medicaid Sustainability: R6 & Related Questions 154-165

HCPF Administration



HCPF Measure	FY 2018/19	FY 2024/25
Member Call Center, Speed of Answer	> 45 minutes	< 2 minutes
Network of Providers	60,000	>105,000
Network BH Providers	~ 6,000	14,800
# of Claims Paid	28.7 million	38.6 million
Eligibility CBMS Automation MAGI/LTSS	35%/20%	76%/41%
Eligibility Approval Rate	55-57%	> 80%
# of Audits on the Dept	Averaging ~ 20	Averaging ~ 30
Fed Requirements: MMIS Systems	Integrated	Modularized
Increasing Future Admin: H.R.1 WR, every 6 months, PERM audit risk, FWA +		

Question 154: Forecasting Accuracy: 11 of 15 years within ~1%

Fiscal Year	Feb. Forecast/ Final GF Spending Authority	Actuals	Over/ Under	Percent Difference
FY 2010-11	$1,025,873,500	$1,035,679,314	$9,805,814	1.0%
FY 2011-12	$1,432,811,369	$1,432,800,513	-$10,856	0.0%
FY 2012-12	$1,579,969,730	$1,575,505,049	-$4,464,681	-0.3%
FY 2013-14	$1,778,137,687	$1,806,485,460	$28,347,773	1.6%
FY 2014-15	$2,223,978,501	$2,210,621,389	-$13,357,112	-0.6%
FY 2015-16	$2,366,158,672	$2,363,959,242	-$2,199,430	-0.1%
FY 2016-17	$2,495,439,413	$2,407,549,881	-$87,889,532	-3.5%
FY 2017-18	$2,665,335,366	$2,679,582,064	$14,246,698	0.5%
FY 2018-19	$2,802,124,489	$2,824,817,876	$22,693,387	0.8%
FY 2019-20	$2,811,474,569	$2,822,471,742	$10,997,173	0.4%
FY 2020-21	$2,652,388,789	$2,556,644,150	-$95,744,639	-3.6%
FY 2021-22	$2,875,906,363	$2,865,707,774	-$10,198,589	-0.4%
FY 2022-23	$3,459,674,591	$3,452,277,272	-$7,397,319	-0.2%
FY 2023-24	$4,238,111,722	$4,361,954,190	$123,842,468	2.9%
FY 2024-25	$4,944,580,913	$5,000,504,115	$55,923,202	1.1%

Question 155: Benefit Expansions

50+ bills expanded eligibility, broadened covered benefits and reduced barriers to care

Eligibility Expansions

- Medicaid buy-in options for individuals with disabilities
- Family planning for individuals over-income for Medicaid
- Coverage of health services for incarcerated individuals prior to release
- Reproductive health coverage for immigrants
- Extended postpartum coverage (12 months)
- Cover All Coloradans initiative
- CHP+ expansion to 260% FPL

Behavioral Health Transformation

- Creating a statewide behavioral health system \ Behavioral Health Administration
- Expanded crisis services
- Peer supports
- Mobile crisis response
- Substance use disorder treatment
- Certified Community Behavioral Health Clinics

Maternal and Reproductive Health

- Doula services
- Choline supplements
- Family planning expansion
- Supports for high-risk pregnancies

Reduced Barriers to Care

- Removal of prior authorization for psychotherapy and equipment repairs
- Elimination of pharmacy and outpatient copays
- Step therapy exceptions
- Coverage of clinical trial costs

Fiscal Yr	Year End GF (in millions)	*% Growth*	*GF Actuals Growth*
FY 2014-15	$2,210.6	22%	$404.10
FY 2015-16	$2,364.0	7%	$153.40
FY 2016-17	$2,407.5	2%	$43.50
FY 2017-18	$2,679.6	11%	$272.10
FY 2018-19	$2,824.8	5%	$145.20
FY 2019-20	$2,822.5	0%	($2.30)
FY 2020-21	$2,556.6	-9%	($265.90)
FY 2021-22	$2,865.7	12%	$309.10
FY 2022-23	$3,452.3	20%	$586.60
FY 2023-24	$4,362.0	26%	$909.70
FY 2024-25	$5,082.5	16%	$720.50

Question:156

Unsustainable Medicaid trends due to increases in medical inflation, increases in our benefits, expansion of our coverage programs, outlier trends in certain areas, and outlier increases to our provider reimbursement rates.

Medicaid General Fund cost trends averaged 6% annually (0-11% range) from FY 2015-16 to FY 2018-19, and averaged +19% (12%-26% range) from FY 2021-22 to FY 2024-25.

Question 157: Approach to better controlling Medicaid costs and driving towards a growth target

- Discipline to Medicaid Sustainability Framework
  - Grounded in facts/insights and alignment around shared goals
  - State budget challenges, Medicaid trend drivers, solutions
- Understanding H.R.1 impacts and aligned goals: North Star - prevent inappropriate loss of coverage and no draconian cuts to Medicaid
  - System builds and investments and eligibility processor investments
- Leverage ACC Phase III and Innovations (eConsults, Prescriber Tools, Value Based Payments, etc.) to control trends and improve quality
- Leverage third-party insights, state comparisons, learnings
- Prioritize engagement, transparency, partnership, leadership

Questions 158-165:HCPF Budget Reductions Context - Key Points

Why Action Is Required

- Medicaid growth **faster than General Fund revenue**
  - 10-year avg growth: **Medicaid 8.8% vs. GF 5.5%**
- Without action, Medicaid will increasingly crowd out other state priorities.

Where the Money Goes

- **96% pays providers** for member services
- **~4% supports admin**
- Admin alone **cannot close the budget gap**

Growing Federal Requirements

- H.R.1 significantly increase workload:
  - Work requirements
  - Eligibility redeterminations every six months
  - Increased audits and reporting
  - Major IT system changes
- Federal government funds **90%** of system build costs; **state 10% match** is required to access those dollars.

Limits on Administrative Cuts

- Most supports **federally required systems and functions**:
  - Eligibility and claims systems
  - Program integrity and audits
  - Federal and state reporting
  - Provider and member access systems
- These costs receive **enhanced federal match (75%-90%)**, yielding **limited General Fund savings**
- Cutting too deeply risks **CMS non-compliance, penalties, or loss of federal funds**.
- Some admin functions **reduce overall state costs** (e.g., utilization management, fraud prevention)

Actions Taken by the Department

- Cost reductions from **vendors**, largest admin cost driver
- Continuing to identify operational efficiencies
- Implementing reductions under **Governor's EOs**
- Will implement **legislative direction** provided through the Long Bill or other legislation.

Thank You