Medicaid Sustainability

Program Improvement Advisory Committee
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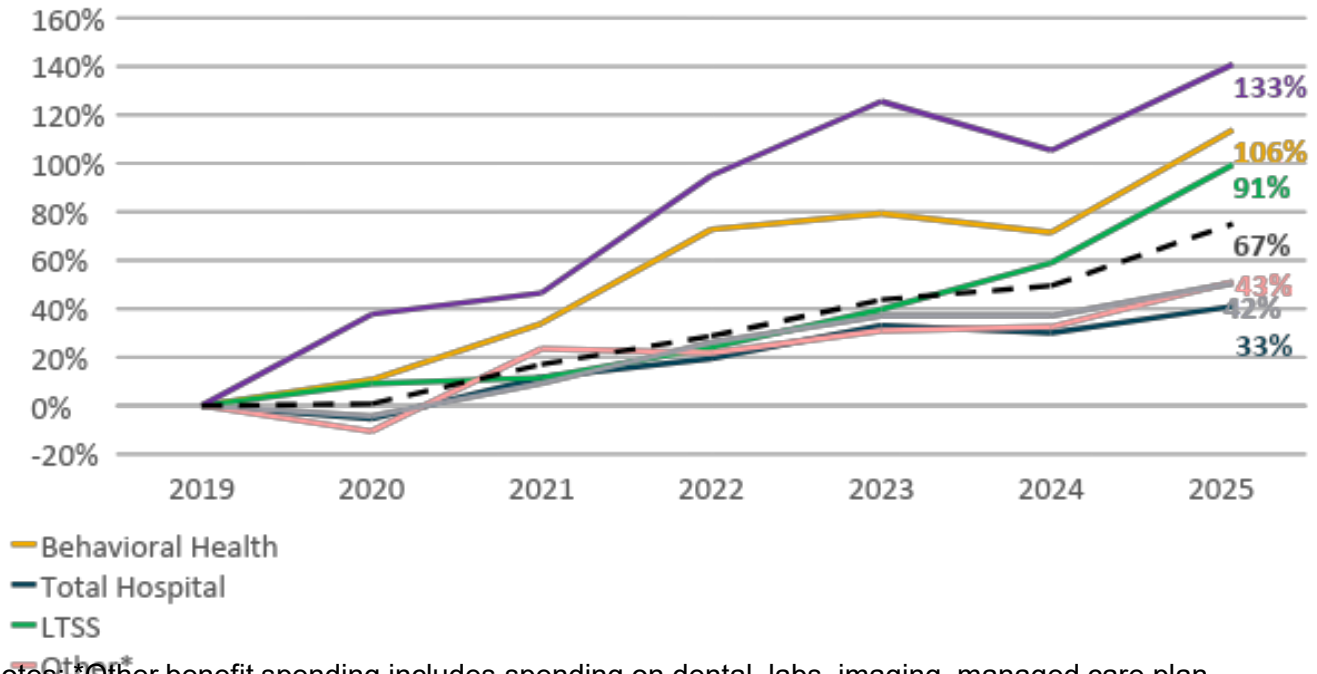
HCPF Medicaid Innovation, Sustainability, and Opportunities (MISO) Project

Manatt Health

Colorado Medicaid Cost Growth Drivers

Growth in 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 and total spending include drug rebates. Hospital supplemental payments include inpatient and outpatient supplemental payments.
Source: Data on PBT spending 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	133%	$682
Non-Emergency Medical Transportation (NEMT)	436%	$289
Pediatric Behavioral Therapy (PBT)	471%	$287
Total	67%	$15,023

Landscape Analysis Findings: Behavioral Health

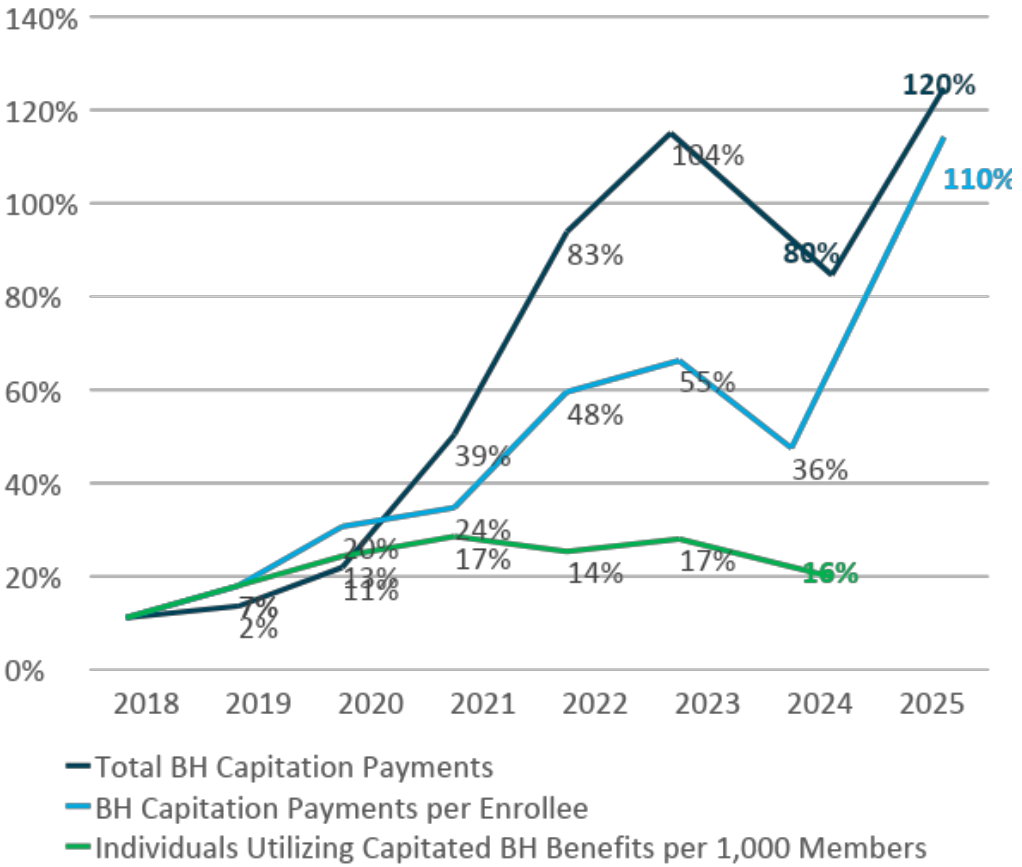
Key Findings

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.

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 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.

NEW!

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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, WM is **not clinically indicated** for all substances for which it is being used (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)

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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)

NEW!

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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)

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Medicaid Sustainability

Updates on Behavioral Health and Managed Care Actions

Background and Purpose

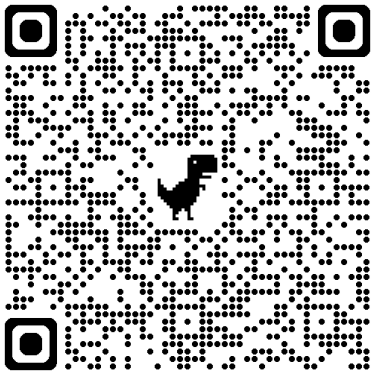
HCPF created the Medicaid Sustainability Memo for the RAEs outlining strategy and actions.

Goal was to share with multiple audiences, communicate expectations and purpose.

Memo included:

- JBC actions, what they mean
- HCPF expectation of RAEs to help control trend
- Areas we are researching for future action

Link to Memo:



Medicaid Sustainability Framework

- Address Drivers of Trend
- Maximize Federal Funding
- Invest in Coloradans
- Make Reasonable Medicaid Cuts or Adjustments
- Reassess New Policies
- Exercise Caution in Crafting Increases

Outlines HCPF's approach to addressing fiscal challenges and mitigate additional cuts.

Meeting Purpose

Progress update on policies, changes, and data expectations.

Sustainability Actions	
Limiting Peer Support Scope	Reduce / Adjust Available B3 Codes, H-Codes
Removing 988 Billing and Associated Funds	Certified Community Behavioral Health Clinics Demonstration
Treatment for Youth Without a Covered Diagnosis	Implementation of ASAM 4th Edition Requirements
Monitoring and Retroactive Review of Outpatient Rates	Stabilize Inpatient Behavioral Health Payment Across Settings
National Correct Coding Initiative (NCCI) Edits Directed Payment Policy Review	Prospective Payment System Guardrails for Comprehensive Providers

Limiting Peer Support Scope

Scoping Services Provided by Peers and Billing Providers

- **Complete:** Effective July 1, 2025, HCPF:
  - Limited the providers that can bill for services delivered by a Peer Support Professional
  - Updated the codes that can be billed for services delivered by a Peer Support Professional.
  - Prioritized SUD and team-based care

Update: Too early to see changes in utilization data for Peer Services due to claims runout.

NCCI Edits and CO MUEs

Apply National Correct Coding Initiative (NCCI) Edits and Colorado Medically Unlikely Edits (MUEs)

- **Complete:**
  - Effective July 1, 2025, RAEs are required to implement all NCCI edits.
  - Effective October 1, 2025, RAEs are required to follow CO MUEs.

PPS Guardrails

Prospective Payment System Guardrails for Comprehensive Providers

- **Complete:** Contract with vendor, engage stakeholders
- **In progress:** Data analysis, revision, monitoring strategy, decertification process, stratification of rate
- Implement CSNP and CCBHC PPS. **7/1/2026**

Update: Renamed PPS Accountability Guidelines; using CCBHC grant funds; on track to implement

Monitoring and Retroactive Review of OP Rates

Establish RAE utilization management strategy to address OP psychotherapy service outliers

- **Complete:**
  - Review of current service rates by RAE. 3/31/2025
- **In progress:**
  - RAEs determining appropriate regional UM approach within permissible options- not limited to PARs

Update: JBC denied request to restore PARs as option for RAEs; Rep Brown may run a bill to restore PARs

Stabilize IP BH Payment Across Settings

Explore DRG as a way to stabilize payment for inpatient BH across settings

- **Complete:**
  - ➢ Research and create recommendations. 10/1/2025.
- Implement recommendations. **7/1/2026**

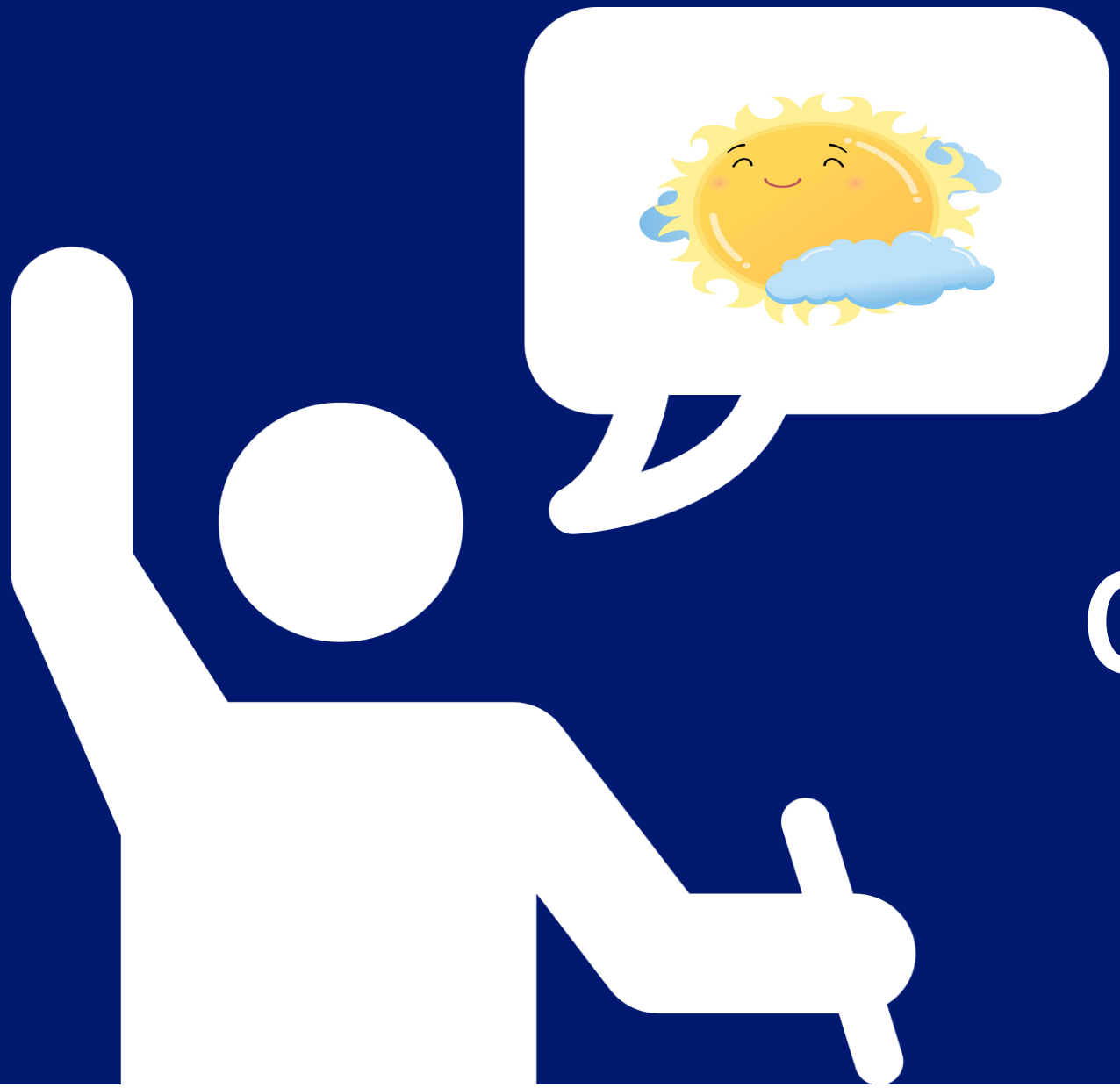
Update: Executing contract w/ KPMG analysis due end of April

Reduce / Adjust Available B3 Codes, H-Codes

Explore opportunities to either reduce or adjust the current available B3 codes and H-Codes.

- **Complete:** Research existing utilization of codes
- **In progress:** Create recommendations for modification
- Implement recommendations. **7/1/2026**

Update: Will need RAE support to draft recs by region and implementation of approved recs



Questions?

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