



Advanced Deliverable: Medicaid Growth Trends

Medicaid Commission, September 17, 2026

Purpose

This packet provides background on Medicaid cost growth. The memo includes a summary of General Fund growth by service category and three fact sheets about benefits with high growth in utilization and spending.

General Fund Growth

The Department's General Fund appropriation grew from \$2.6 billion to \$5.3 billion from FY2021 to FY2026, an increase of \$2.7 billion. Growth was concentrated in Community Based Long Term Care (inclusive of Community First Choice), Acute Care (inclusive of Pharmacy) and Behavioral Health. These three categories account for approximately \$2.3 billion of the \$2.7 billion increase.

Service Category	Growth in Dollars	Total Percent Growth	FY2025-26 Percent Growth
Acute Services	\$849 million	73%	9.6%
Behavioral Health Services	\$202 million	115%	13.6%
Community Based Long Term Care	\$1.26 billion	149%	16.3%

Note: Figures reflect General Fund appropriation only and are not comparable to the program spending figures shown in the fact sheets, which include all fund sources.

Fact Sheets Included

Each fact sheet examines one high-growth service within the categories above. Together they illustrate the range of reasons Medicaid spending grows including price and product mix, capitation rate structure (where applicable), and utilization.

- **Pharmacy** - a component of Acute Services
- **Capitated Behavioral Health** - a component of Behavioral Health Services
- **Community First Choice** - a component of Community Based Long Term Care

For more information contact

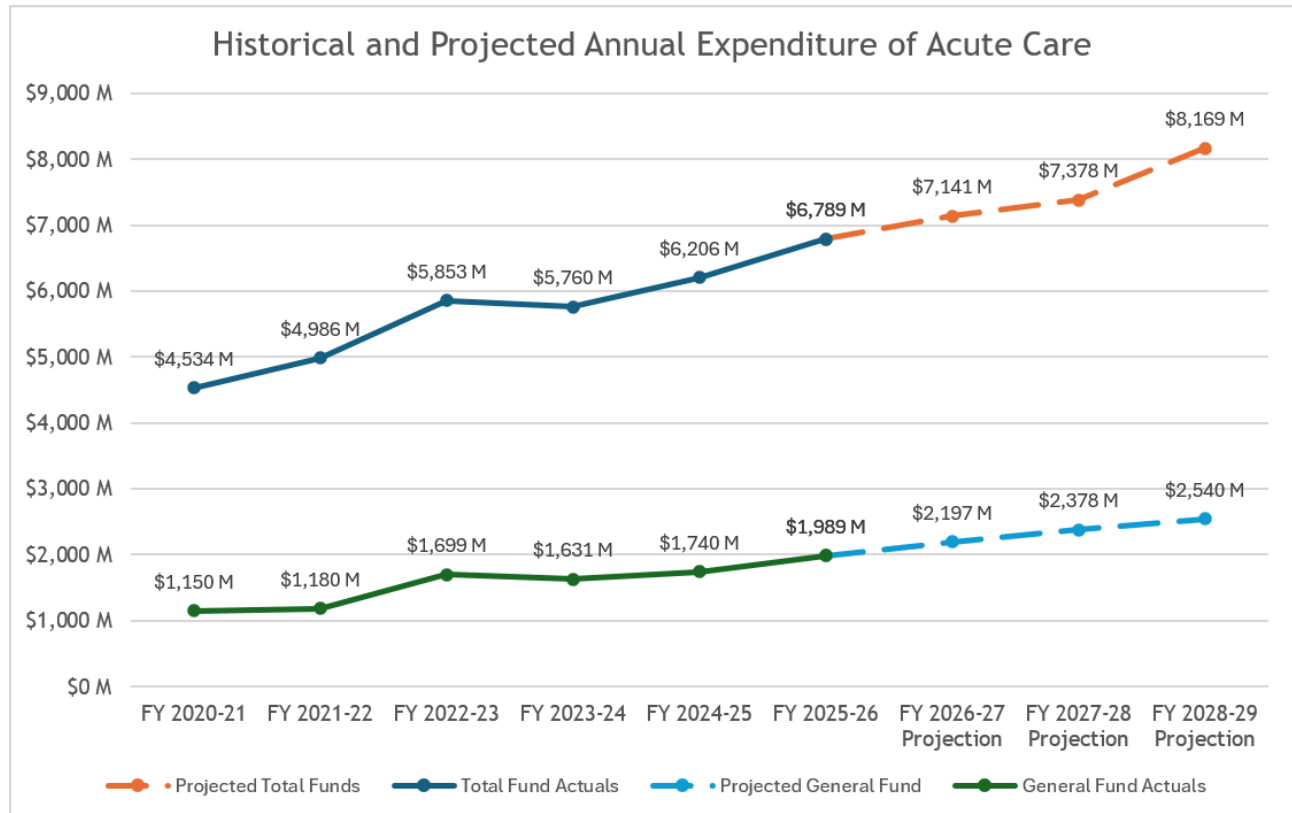
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Acute Care & Pharmacy Benefit Cost Growth

Acute Care contains many benefits and service categories across Medicaid¹. As shown in Figure 1 projected expenditures for Acute Care will exceed \$8.169 billion TF by FY 2028-29 if no action is taken. A significant driver of that growth is the Pharmacy benefit, which is discussed in depth below.

Figure 1. Historical and Projected Annual Expenditure of Acute Care



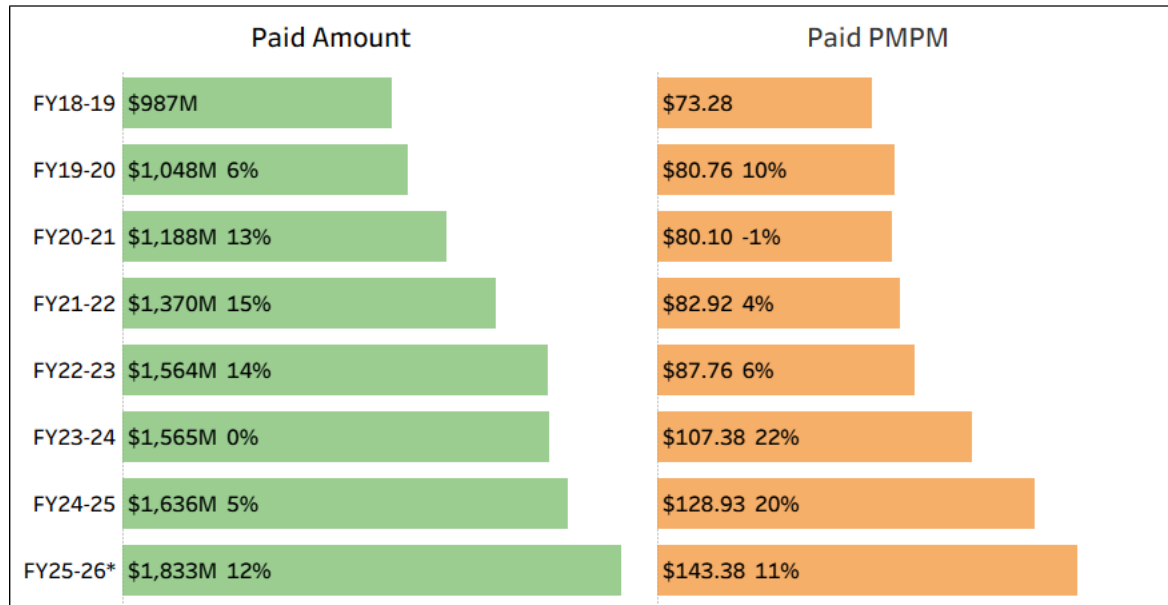
Prescription drugs are one of the fastest-growing areas of Colorado's Medicaid spending. Between FY 2018-19 and FY 2025-26, total pharmacy spending grew from \$987 million to an estimated \$1.83 billion, an increase of 86%. Figure 2 demonstrates the growth in the total amount spent on prescription drugs and the growth in the amount spent per member per month on prescription drugs. It is important to note that Figure 2 does not include rebates paid back to the Department through the federal Medicaid Drug Rebate Program (MDRP). Rebates from manufacturers account for as much as 40% savings. Roughly 685,000 Medicaid members access

¹ Benefits included in Acute Care: EPSDT Screening, Emergency Transportation, Non-Emergency Medical Transportation, Dental Service, Health Maintenance Organization, Inpatient Hospital, Outpatient Hospital, Laboratory and X-Ray, Durable Medical Equipment (DME), Pharmacy, Drug Rebates - Standard, Rural Health Centers, Federally Qualified Health Centers, Co-Insurance (Title XVIII-Medicare), Breast and Cervical Cancer Treatment Program, Other Medical Services, Preventive Services, Acute Home Health.



the pharmacy benefit. The most common prescriptions include albuterol, gabapentin, trazodone and sertraline.

Figure 2. Prescription Drug Costs

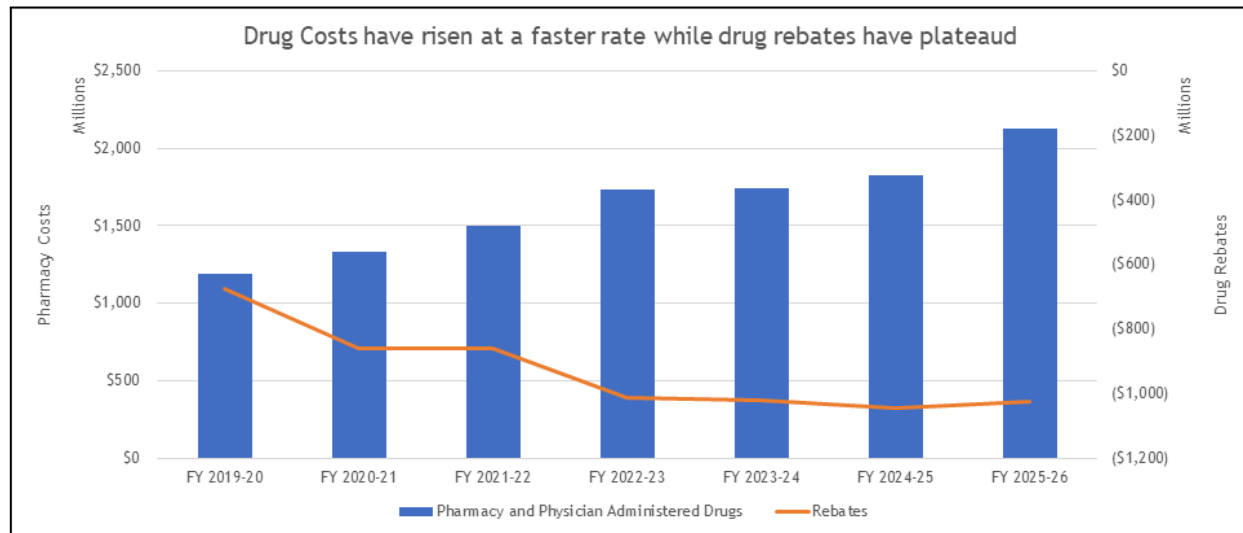


Notes: *FY2025-26 total paid is estimated based on 11 out of 12 months of claims submissions. Paid PMPM is the average cost per fully covered member per month. Percentages listed are the year over year change. Paid amounts are gross of rebate, not net of rebate.

Medicaid Drug Rebate Program

The Medicaid Drug Rebate Program requires drug manufacturers to pay rebates on outpatient prescription drugs in exchange for having their products covered by Medicaid. Under this program, HCPF is required to cover all products for manufacturers that participate in the Medicaid Drug Rebate Program, and for those covered drugs, the Department must cover them for all FDA-approved uses. Historically, rebates under the MDRP have significantly offset the annual cost of prescription drugs used by Medicaid members. However, recent impacts from the implementation of the Inflation Reduction Act (IRA) and the American Rescue Plan Act (ARPA) have reduced the rebates HCPF collects through the program. In Figure 3, the annual growth in costs for prescription drugs is shown against the reduction in rebates.

Figure 3. Drug Costs and Rebate Trends



Specialty Drugs

Specialty drugs require special handling, complex administration, and/or are limited to distribution drugs. They are rarely prescribed but account for a disproportionate share of spending. Specialty drugs are a major driver of national Medicaid pharmacy spending, accounting for nearly half (48.5%) of fee for service drug spending in 2019 while representing 1.3% of drug utilization.² Nationally, from 2018-2021, the average cost of a brand drug increased by almost 50%. This rise is attributed to the use of new, high-cost specialty drugs.³ Colorado's data mirrors this trend.

² MACPAC Addressing High Cost Specialty Drugs (2021).

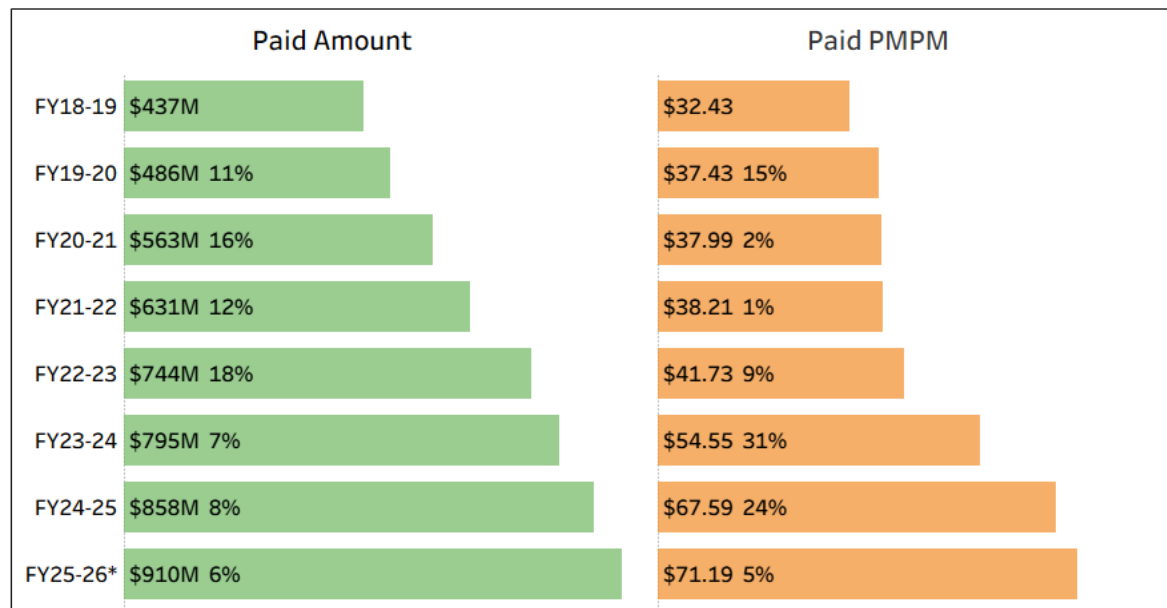
<https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-1-Addressing-High-Cost-Specialty-Drugs.pdf>

³ MACPAC High Cost Drugs and the Medicaid Program (2024).

<https://www.macpac.gov/wp-content/uploads/2024/02/Policy-in-Brief-High-Cost-Drugs-FINAL-2.pdf>



Figure 4. Specialty Pharmacy Expenditures



What HCPF is Doing

HCPF is limited in the action it can take to reduce expenditures on prescription drugs because of federal Medicaid rules and regulations that govern the pharmacy benefit and the Medicaid Drug Rebate Program. Coverage of prescription drugs is technically an optional benefit under Medicaid, however, all 50 states include this coverage and it is considered a standard benefit of both public and private health insurance.

In an effort to ensure high program integrity with the pharmacy benefit, the Department leverages the best practices of our Pharmacy Benefit Management vendor and actively partners with the Medicaid Fraud, Abuse and Neglect Unit at the Attorney General's Office on:

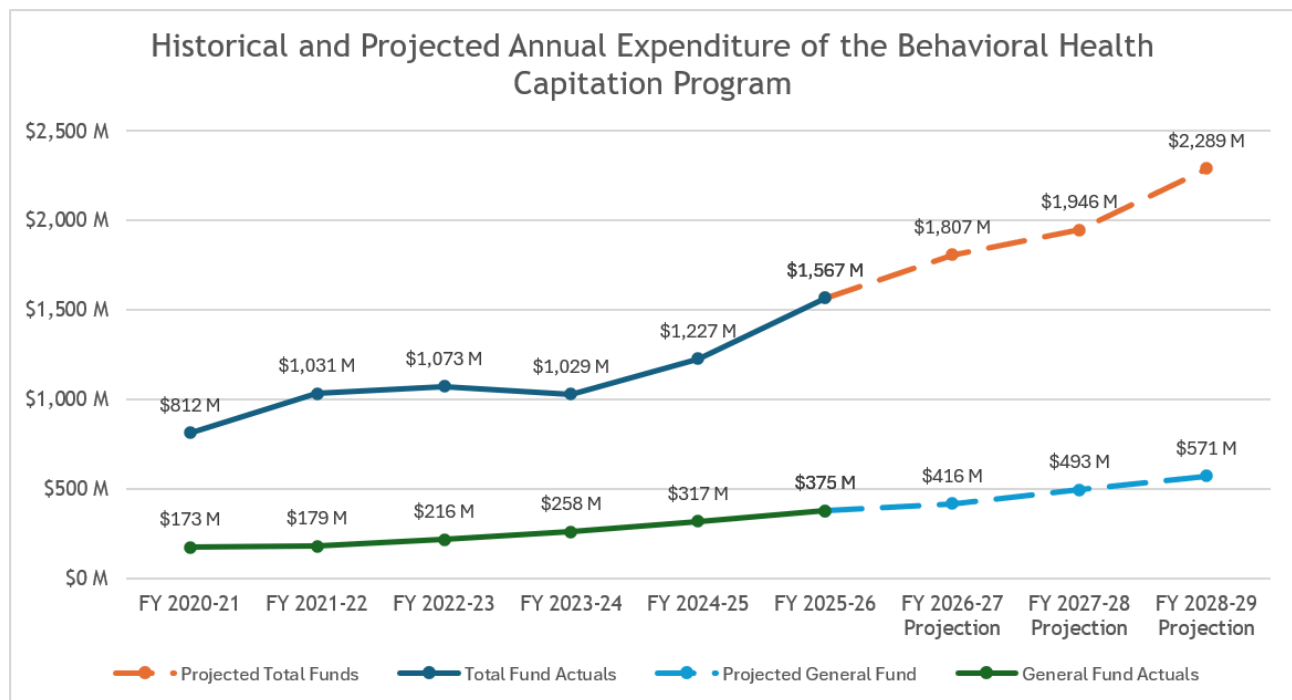
- Pharmacy outlier billing practices.
- Analysis of billing practices of out of state pharmacy providers.
- Analysis of outlier billing related to BOTOX claims for members.
- Application of ALIVIA modeling to pharmacy claims analysis.



Behavioral Health Cost Growth

Medicaid spending on behavioral health services has grown over recent years as a result of new benefits, intentional expansion of contracted behavioral health providers, and the number of services per Medicaid member. Behavioral health services include mental health and substance use disorder services such as individual, family and group psychotherapy; crisis and intensive outpatient services; residential and inpatient care; medication assisted treatment; and support services such as case management, outreach, life skills, education, and housing supports. Figure 1 shows the historical and forecasted growth of the Behavioral Health Capitation program through FY 2028-2029, with a projected spend of \$2.289 billion TF by 2029, if no action is taken.

Figure 1. Historical and Projected Annual Expenditure of the Behavioral Health Capitation Program



The majority of behavioral health services are provided through the Accountable Care Collaborative. The Department contracts with four Regional Accountable Entities that contract with a statewide network of behavioral health providers that provide mental health and substance use disorder services for members. HCPF pays Regional Accountable Entities (RAEs) a capitated rate for each enrolled member to manage the Medicaid behavioral health benefit. The rates paid to the RAEs for the covered behavioral health services are based on historic utilization patterns, estimated rates, and unique regional variations that affect pricing. RAEs accept financial risk under this arrangement and pay all claims submitted by behavioral health providers.

Figure 2 shows two trends over the same period. Medicaid enrollment rose sharply during the continuous coverage period created during the national Public Health Emergency and has since



fallen back and flattened. At the same time, the average per member per month weighted rate paid to the RAEs to cover the cost of services has risen to \$112.00 in FY 2025-26 and is projected to reach \$171.48 by FY 2028-29. Spending increases in this benefit is largely attributed to rising costs to cover behavioral health services, and increased utilization per person, rather than the total Medicaid population count. In FY2024-25, 241,345 Medicaid members accessed capitation behavioral health services. Figure 3 shows that the total number of Medicaid members receiving services increased in both volume and percent of total members, from 14% to 20%, which explains some growth but is not as significant a factor in total costs.

Figure 2. Average Caseload and Average Weighted Rate by Fiscal Year

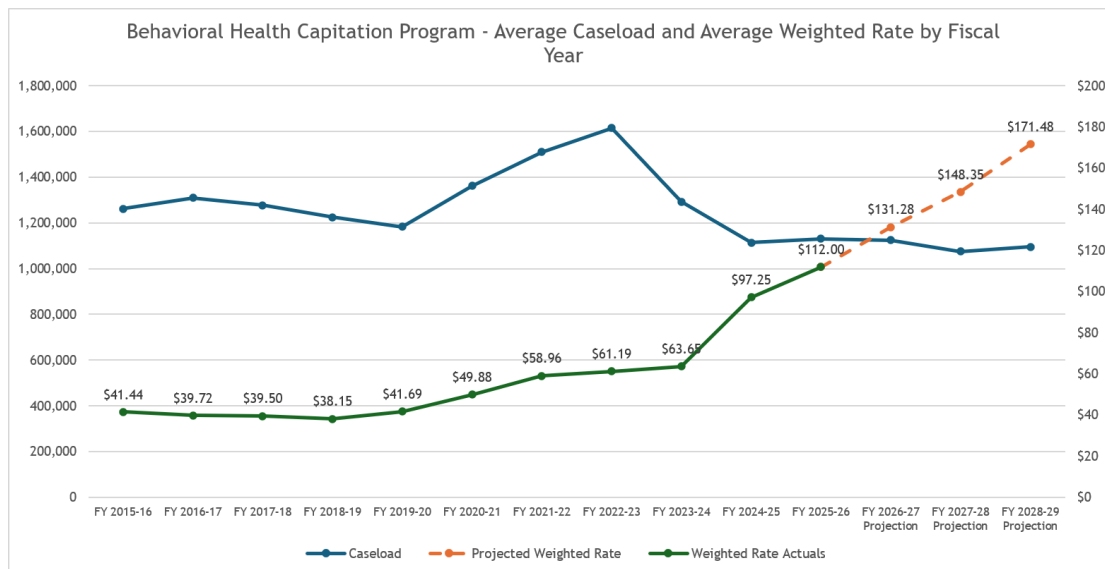
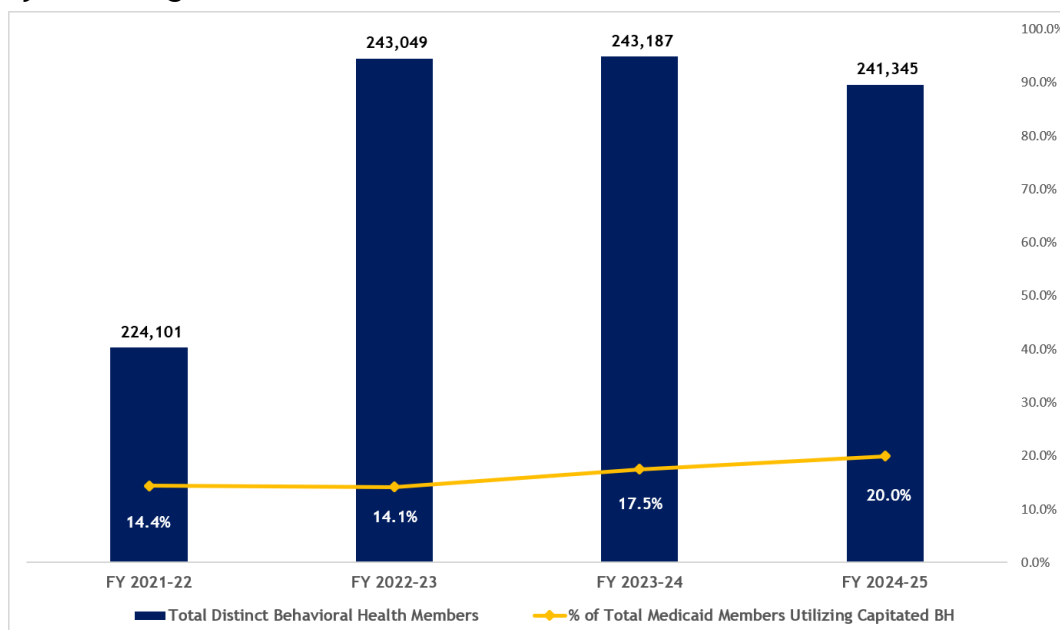


Figure 3. Colorado Medicaid Members Accessing Behavioral Health Services, by Individual and by Percentage of all Medicaid Members





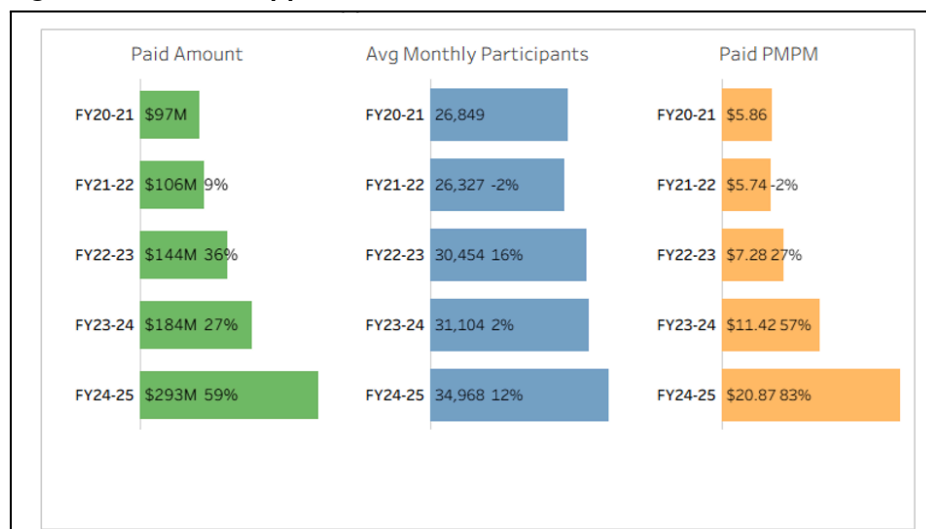
Much of the rate growth reflects deliberate policy choices. Colorado made significant efforts to expand behavioral health access and services over the past 5-7 years, including expanding the workforce, adding new providers, and developing new models of care, including:

- Increase of providers accepting Medicaid from ~6,000 to over 14,000 from 2018-2025
- Expanded coverage through a 1115 Demonstration Waiver including
 - Residential and inpatient services Substance Use Disorder (SUD) beginning 2022 and Partial Hospitalization in 2024;
 - Expanded inpatient mental health for adults in October 2025;
 - Housing navigation and support services in July 2025; and
 - Coverage for some services in jails and prisons 90 days prior to reentry in 2026.
- Expanded coverage for peer and recovery support services and qualified Behavioral Health assistants in 2021, 2022, and 2025
- Removal of prior authorization for outpatient psychotherapy services via [SB22-156](#) in 2022
- New safety net provider standards and public provider expansion in partnership with the Behavioral Health Administration from 2021-2023
- Development of services for youth with complex needs and high-acuity youth through the Colorado System of Care from 2024-present
- Creating a new cost-based payment (the Prospective Payment System or PPS) for safety net providers

Service Areas with Concentrated Growth

Member utilization of peer and support services, SUD residential care and outpatient psychotherapy has grown significantly in the last few years. Figures 4, 5 and 6 show the paid amount for these services, the average monthly participants and the amount paid per member per month for each year. The percentages on each bar represent the percent increase year over year.

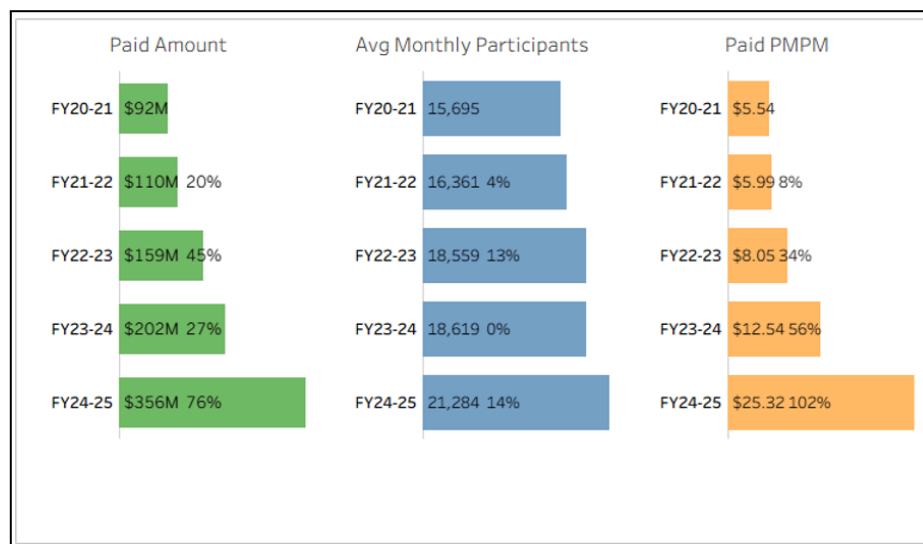
Figure 4. Peer & Supportive Services





The Department’s internal analysis over the past two years shows growth in peer support services exceeding expectations in both pace and scale. Supportive services are non-clinical services, often provided by peers, case managers, or other unlicensed professionals. Examples include skills training, peer recovery supports, outreach, wraparound care, activity therapy and stress management. Utilization of outpatient supportive services has grown faster than the benefit overall, from 9.25 hours per person getting support services per year in FY 2022-23 to 24.75 hours in FY 2025-26. Services billed under Self-Help Peer Services (H0038), Behavioral Health Outreach (H0023), and Skills Training and Development (H2014) grew 286% between FY2022 and FY2024, and H0038 alone rose from \$8.8 million in FY2022 to \$51.8 million in FY 2025. Part of this reflects the intended results of workforce expansion, new providers, new models of care, and federal ARPA investment in peer support training. Recent analysis into the unprecedented growth however, indicate these services are being delivered without appropriate oversight from a clinical team, concentrated among newer providers whose programs rely heavily on unlicensed staff, which raises quality-of-care concerns alongside the question of sustainability.

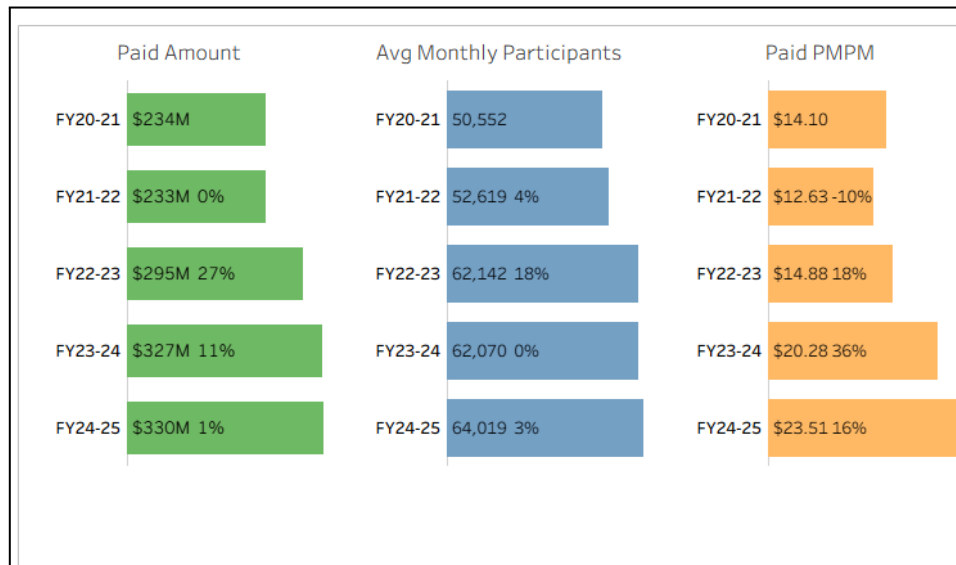
Figure 5. Residential Services - Substance Use Disorder



SUD residential and inpatient services became a covered benefit in 2021 under the federal 1115 Demonstration Waiver, so some growth in this area reflects a new benefit reaching members who previously had no coverage for it. The scale and pace warrant continued attention. The amounts paid for these services grew from \$92 million in FY2020-21 to \$356 million in FY 2024-25, including a 76% increase in the most recent year alone. That growth is not primarily a volume effect: average monthly participants grew 14% in FY2024-25 while cost per member per month more than doubled, rising 102%.



Figure 6. Individual and Group Psychotherapy



Note: Utilization data is pulled from behavioral health encounter data submitted by the RAEs detailing out the services utilized under the capitated behavioral health benefit and the percent growth year over year. HCPF will have reliable FY2025/26 data to share later in the fall.

Outpatient psychotherapy is the most commonly billed behavioral health service. The State removed prior authorization for these services under SB22-156 in 2022, which limits the Department’s ability to manage utilization through prior authorization for services. The Department continues to monitor this service area given its size and the absence of prior authorization as a management tool.

What HCPF is Doing

Following this period of rapid growth and change, HCPF has evaluated the impact of these increased costs to establish a Medicaid Sustainability strategy to preserve necessary services for vulnerable members in fiscally responsible ways. HCPF has leaned heavily on data and stakeholder input to identify opportunities with particular attention to the three service areas above given their outsized impact on total cost trends.

HCPF continues to implement and explore methods to address behavioral health utilization and spending trends including:

- Network management activities by RAEs including review of outlier billing and prioritizing providers that can demonstrate outcomes
- Monitoring and retroactive review of outpatient therapy
- Implementing National Correct Coding Initiative (NCCI) edits and Medically Unlikely Edits (MUEs) to ensure accurate billing and coding
- Guardrails on the Prospective Payment System (PPS) for Comprehensive Providers
 - Removing non-required services like SUD residential and 24/7 crisis stabilization units from cost-based billing in the PPS



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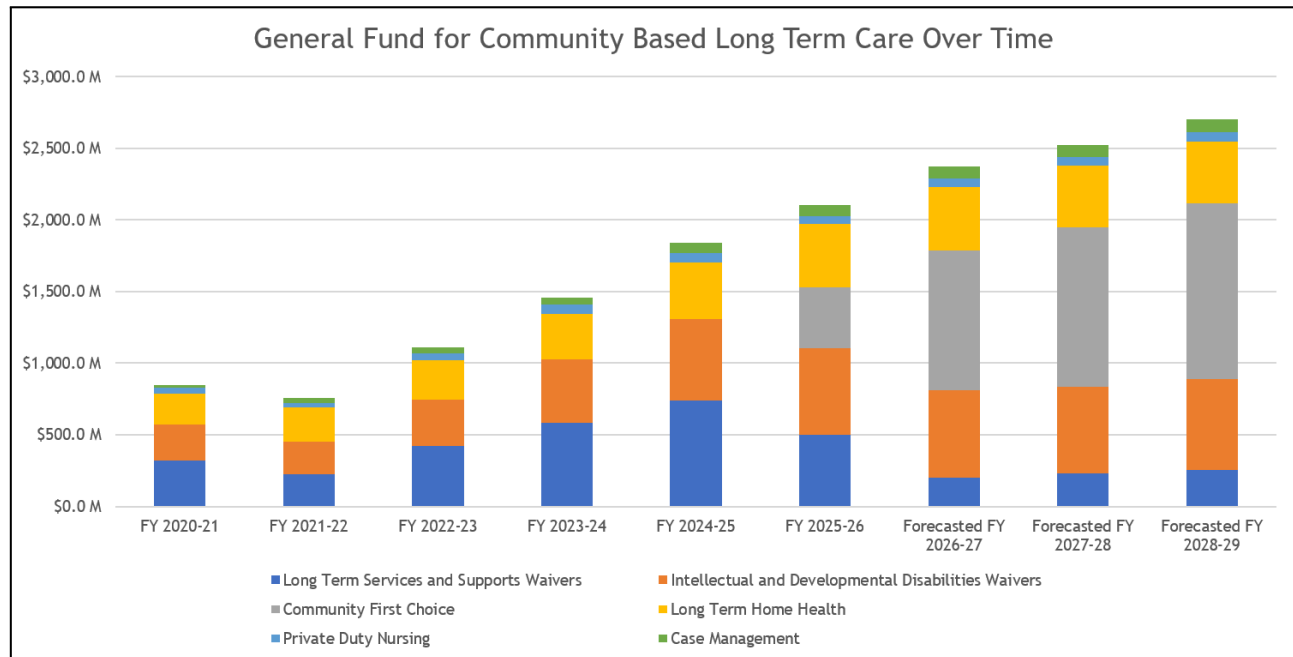
- Connect PPS payment to outcomes
 - Limit senior salaries to 150% of federal salary cap
- Limiting allowable place of services and provider type that can provide support services, increasing clinical oversight requirements for unlicensed services
- Strengthen and focus Program Integrity efforts through ongoing collaboration with the RAEs



Community Based Long Term Care & Community First Choice Cost Growth

Community-based long-term services and supports spending has increased significantly in recent years, with projected expenditures estimated to reach over \$2.5 billion GF by FY 2028-29 (Figure 1).

Figure 1. General Fund For Community Based Long Term Care Over Time



The primary contributor to recent growth is Community First Choice (CFC), an optional Medicaid State Plan benefit that allows states to provide certain home and community-based services to eligible members. CFC provides a 6 percentage point enhanced federal match for eligible services, reducing the state General Fund share of each dollar spent. Specifically, we see growth concentrated in two benefits: personal care and homemaker services. Utilization of these two services have grown more than projected, and the additional spending has exceeded the savings generated by the enhanced federal match.

Figure 2 below lists the eligible CFC services and delivery options for reference. CFC also created more consistent rules for services that previously operated under different HCBS waiver requirements and expanded access to some services and caregiver arrangements.



Figure 2. CFC Services and Delivery

Community First Choice Services:	Service Delivery Options:
• Health Maintenance Activities (HMA) • Home Delivered Meals • Homemaker (HMKR) • Medication Reminder • Personal Care (PC) • Personal Emergency Response Systems • Remote Supports • Transition Setup	• Self-directed (HMA, HMKR, PC) ◦ In-Home Support Services (IHSS) ◦ Consumer Directed Attendant Support Services (CDASS) • Care via an agency (HMKR, PC)

CFC became effective in Colorado on July 1, 2025 and was implemented gradually over FY2025-26. CFC did not create new service categories, but it changed how certain services are accessed and who may provide them. Services that previously operated under different HCBS waiver requirements were moved into CFC and made available under a more consistent set of rules.

Growth in Two Service Areas: Homemaker and Personal Care

When CFC was implemented, HCPF projected approximately \$45 million in General Fund savings. The forecast reflected the enhanced federal match available for CFC services, as well as assumptions about how members would use services after implementation.

Actual experience has differed from those assumptions. As a result, the additional federal funding available through CFC has not been sufficient to offset the increased spending.

The sections below describe where that growth is occurring and the factors HCPF believes are contributing to it.

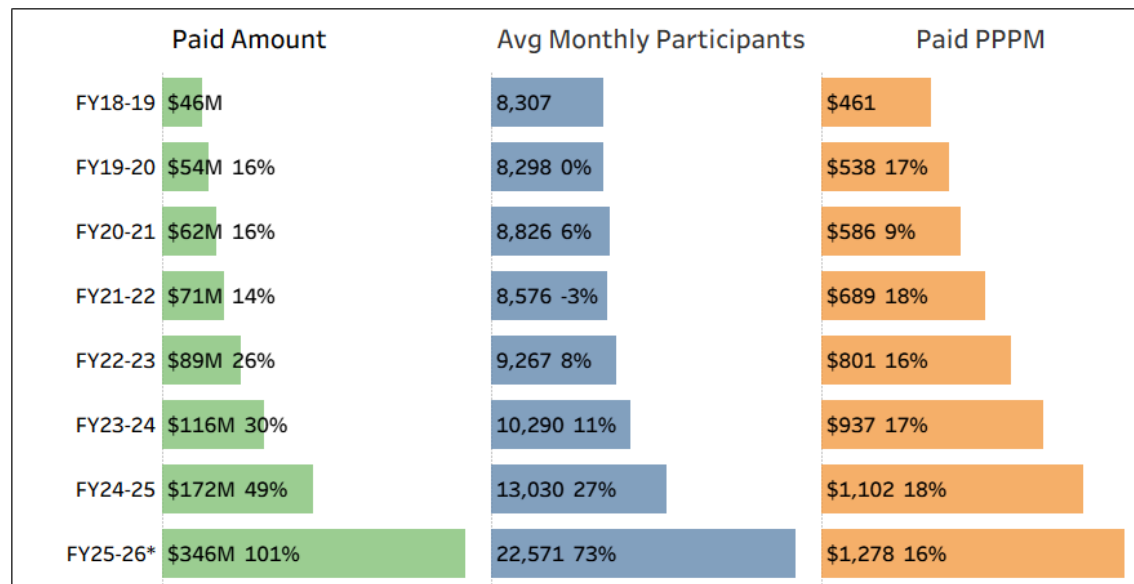
Homemaker Services

Figure 3 shows the growth in the number of members receiving Homemaker services and the growth in overall spending on the services. The growth is concentrated among adults who previously had access to Homemaker through an HCBS waiver but were not using the service. HCPF's analysis indicates that much of the increase is associated with agency-delivered care, including care provided by family caregivers. This represents a significant change from historical utilization patterns and was not fully anticipated in the original CFC forecast.

HCPF believes the expanded opportunity for family caregivers to provide paid care has contributed to increased participation. HCPF is continuing to monitor how paid family caregiving, provider practices, and CFC service rules are affecting utilization.



Figure 3. Homemaker Services



Notes: *FY2025-26 total paid is estimated based on 11 out of 12 months of claims submissions. Paid PPPM is the average cost per participant per month. Percentages listed are the year over year change.

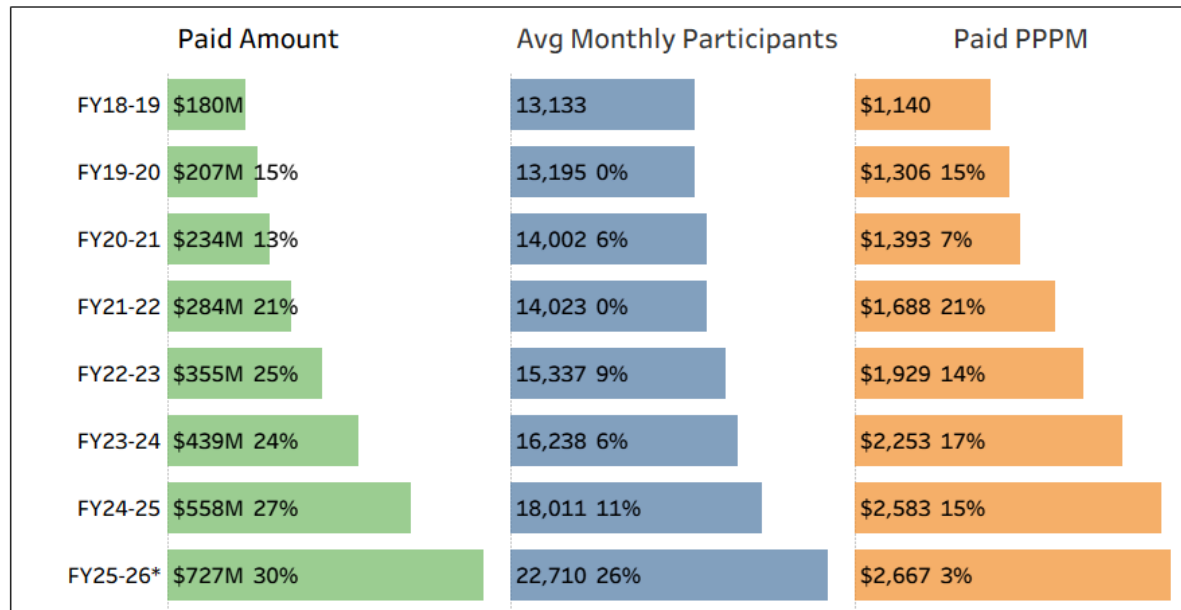
Personal Care Services

The growth in Personal Care is concentrated among children, whose access to the service was more limited before CFC. CFC expanded access to Personal Care and expanded who could provide the service, including allowing parents who meet provider requirements to provide paid care to their children. These policy changes increased access as intended, but participation and spending have grown substantially faster than anticipated.

HCPF's analysis indicates that recent growth is concentrated in agency-delivered care rather than self-directed care. This is a notable change from historical utilization patterns and is an important area of continued analysis as HCPF evaluates the factors contributing to increased spending. Figure 4 shows this in more detail.



Figure 4. Personal Care Services



Notes: *FY2025-26 total paid is estimated based on 11 out of 12 months of claims submissions. Paid PPM is the average cost per participant per month. Percentages listed are the year over year change.

What HCPF is Doing

HCPF has already implemented and is implementing several changes to respond to the growth in utilization. These include limits on Homemaker services, limits on the number of Homemaker hours that may be provided by a legally responsible person (LRP), service authorization standards and age-appropriate guidelines, and a soft cap for Personal Care. HCPF is also implementing a 56-hour weekly limit on paid family caregiving across applicable services and delivery models.

HCPF is analyzing where additional policy changes are needed to address these key cost drivers within the CFC program. Additional changes will need to move forward quickly to slow expenditure growth and ensure that the program can operate within available resources over the long term. HCPF has stakeholder engagement planned for early October 2026 to discuss proposed policy changes with members, families, providers, and other stakeholders.

HCPF is also strengthening provider accountability in response to concerns that certain marketing and recruitment practices may be contributing to increased utilization. HCPF has recently adopted regulations establishing clearer standards for provider direct outreach, marketing, and coaching of LTSS members. HCPF will monitor implementation and determine whether additional provider accountability measures are needed, in collaboration with federal partners.

Additionally, HCPF is taking action to strengthen payment controls. The Department is working to modify the Electronic Visit Verification (EVV) pre-payment claim edit so that claims are paid only when required EVV records support the duration of care billed. This control addresses whether

billed services were delivered as claimed and is separate from HCPF's work to ensure that service authorizations are appropriate and consistent with member needs.

HCPF has also identified structural limitations in the original forecasting approach. The initial forecast did not sufficiently align policy and fiscal assumptions or account for how changing federal requirements could affect program implementation and spending. It also did not fully anticipate how providers would respond to new opportunities under CFC, including increased agency participation in paid family caregiving, or the speed and scale of changes in participation and utilization following implementation.

HCPF has since strengthened its forecasting process to better align policy and fiscal assumptions, incorporate changing federal requirements, and consider how provider behavior may affect utilization and spending. HCPF has also improved monitoring of emerging participation, utilization, and expenditure trends so that material differences between projected and actual experience can be identified earlier and policy, operational, and budget assumptions can be adjusted more quickly.