Joint Budget Committee

Staff Budget Briefing
FY 2026-27

Department of Health Care Policy and Financing
Office of Community Living and County Administration

Prepared by:
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December 15, 2025

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Additional Resources

To find the online version of the briefing document search the General Assembly's website for budget documents (https://content.leg.colorado.gov/content/budget#budget-documents-section).

Overview of Office of Community Living

The Office of Community Living provides long-term services and supports for people with intellectual and developmental disabilities. The federal government provided waivers so Colorado can earn a federal match on services that go above and beyond standard Medicaid. The waivers require Colorado to demonstrate that the services are cost neutral or provide a savings compared to other services covered by Medicaid, such as nursing home care. Because these services are provided through waivers, rather than standard Medicaid, the State can limit eligibility, services, and expenditures.

The Office oversees Home- and Community-Based Services (HCBS) for individuals with intellectual and developmental disabilities. The division is responsible for the following functions related to the provision of services by community-based providers:

- administration of four Medicaid waivers for individuals with developmental disabilities;
- establishment of service reimbursement rates;
- ensuring compliance with federal Centers for Medicare and Medicaid rules and regulations;
- communication and coordination with case management agencies, providers, and members regarding waiver policies, rate changes, and waiting list information reporting; and
- administration of the Family Support Services Program.

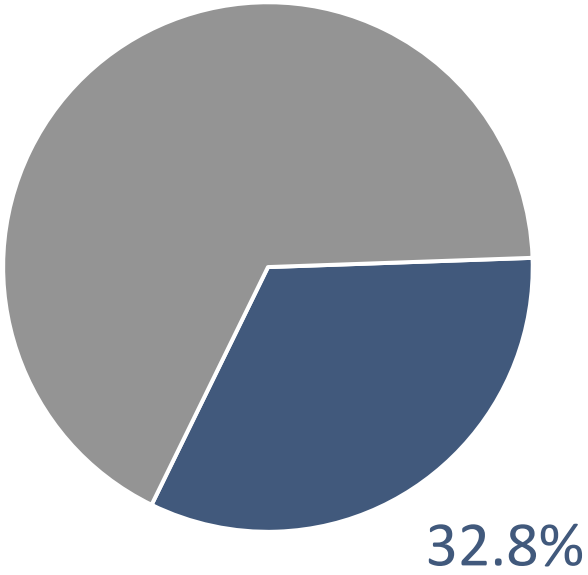
Recent Appropriations

Office of Community Living: Recent Appropriations

Funding Source	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26
General Fund	$391,011,268	$523,368,767	$653,787,290	$700,209,770
Cash Funds	31,100,093	22,213,215	30,271,689	20,944,201
Reappropriated Funds	0	0	0	0
Federal Funds	492,424,174	524,360,011	662,302,684	702,566,480
Total Funds	$914,535,535	$1,069,941,993	$1,346,361,663	$1,423,720,451
Full Time Equivalent Staff	39.5	39.5	39.5	39.5

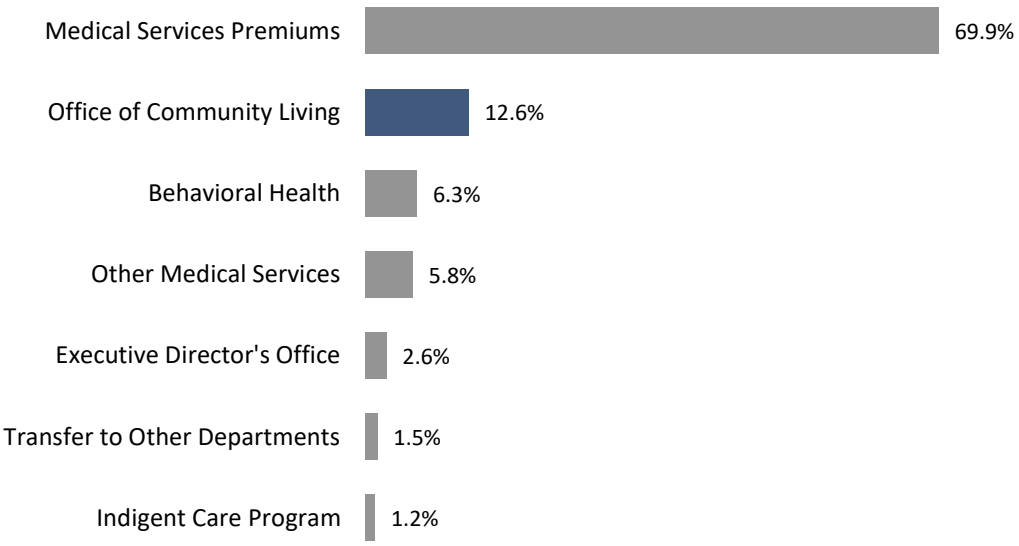
Graphic Overview

Department's Share of Statewide General Fund



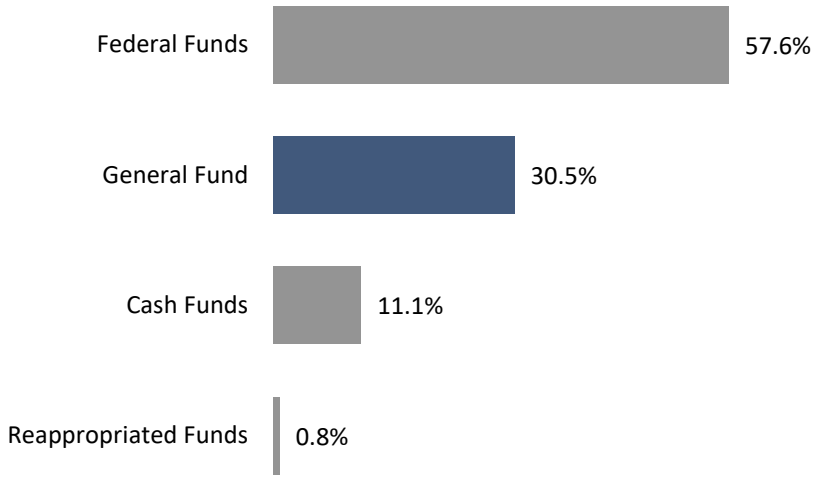
Based on the FY 2025-26 appropriation.

Distribution of General Fund by Division



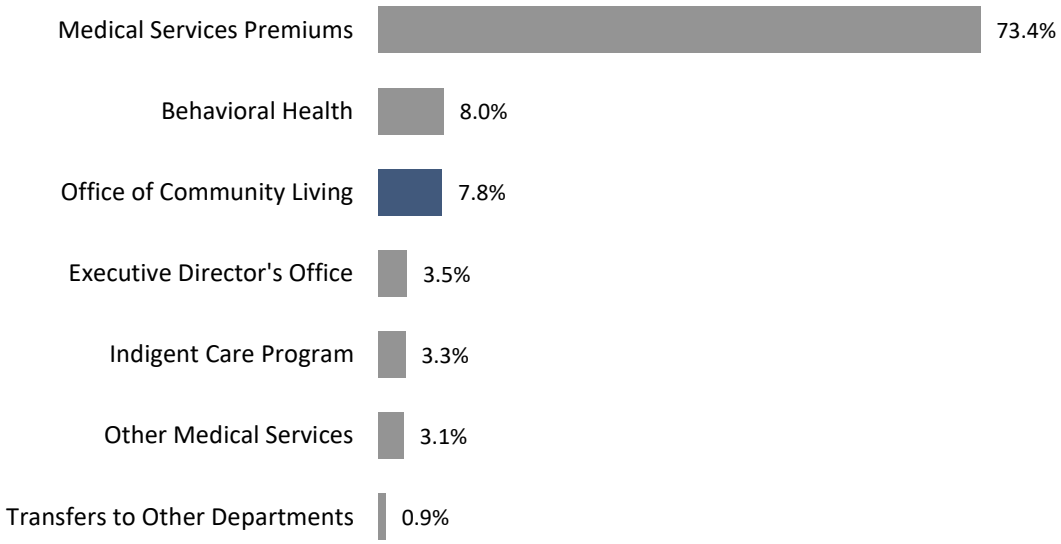
Based on the FY 2025-26 Appropriation

Department Funding Sources



Based on the FY 2025-26 appropriation.

Distribution of Total Funds by Division



Based on the FY 2025-26 Appropriation

Cash Funds Detail

Department of Health Care Policy and Financing: Office of Community Living Cash Funds Detail				
Fund Name	FY 2025-26 Approp.	Note	Primary Revenue Sources	Primary Uses in Dept.
Healthcare Affordability and Sustainability Hospital Provider (HAS) Fee Cash Fund (a.k.a., hospital provider fee)	$20,944,200	[1]	Hospital fees	Supplemental payments to increase hospital reimbursements; eligibility expansion populations; General Fund relief; and admin related to the above
Health Care Expansion Fund	1	[2]	Tobacco taxes	Eligibility and benefits expansion
Total	$20,944,201			

[1] Not appropriated by the General Assembly. Amounts shown in Long Bill are for informational purposes only.
[2] Some tobacco taxes are subject to TABOR but the revenue for these purposes is exempt.

Additional detail for select funds

Healthcare Affordability and Sustainability Hospital Provider (HAS) Fee Cash Fund: Hospitals pay fees into the fund that are then matched with federal funds and returned with the federal funds to the hospitals in the form of supplemental payments. The supplemental payments are in proportion to the indigent care provided, so the fees paid by an individual hospital might be more or less than the supplemental payments received. A portion of the revenue is used to pay for health care services for expansion populations (primarily for adults without dependent children and higher income parents). To the extent hospitals serve the expansion populations, the hospitals receive the payments for expansion populations in the form of Medicaid and CHP+ reimbursements for services. The General Assembly designated the HAS Fee as part of an enterprise that is exempt from TABOR. The fees are set annually by the board for the enterprise to maximize supplemental payments while not exceeding federal regulatory limits.

General Factors Driving the Budget

Medicaid Waivers

Medicaid provides health insurance to people with low income and people needing long-term care. Participants generally do not pay annual premiums and copayments at the time of service are either nominal or not required. The federal and state government share responsibility for financing, administering, and policy setting for the program. Medicaid generally operates as an entitlement program, meaning the people deemed eligible have a legal right to the plan benefits. As a result, if the eligible population and/or the eligible services utilized are greater than expected, then the state and federal government must pay the higher cost, regardless of the initial appropriation.

A Medicaid waiver is a provision in Medicaid law which allows the federal government to waive rules that usually apply to the Medicaid program. The intention is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage, or improving care for certain target groups. There are several different types of Medicaid waivers, all of which serve different purposes.

- Section 1115 waivers – Often referred to as research and demonstration waivers, these allow states to temporarily test out new approaches to delivering Medicaid care and financing.
- Section 1915(c) waivers – Home- and Community-Based Services (HCBS) waivers are designed to allow states to provide home- and community-based services to people in need of long-term care. This means they can stay in their own home or a community setting (such as a relative's home or a supported living community) instead of going into a facility.
- Section 1915(b) waivers – "Freedom of choice waivers" allow states to provide care via managed care delivery systems. These organizations contract with state Medicaid agencies, and are paid from the state Medicaid fund for providing health care services to the beneficiaries.

HCBS waivers must demonstrate that providing waiver services will not cost more than providing these services in an institution, sometimes known as budget neutrality.

IDD Waiver Services

Medicaid intellectual and developmental disability (IDD) waiver services are not subject to standard Medicaid State Plan service and duration limits, but rather are provided under a Medicaid waiver program. Colorado has four Medicaid waivers for intellectual and developmental disability services.

- The Adult Comprehensive/Developmental Disabilities waiver (DD waiver) for individuals over the age of 18 who require residential and daily support services to live in the community.
- The Supported Living Services waiver (SLS waiver) for individuals over the age of 18 who do not require residential services but require daily support services to live in the community.
- The Children's Extensive Services waiver (CES waiver or children's waiver) for youth aged 5 to 18 who do not require residential services but do require daily support services to be able to live in their family home.
- The Children's Habilitation Residential Services waiver (CHRP waiver) for children with intellectual and developmental disabilities and complex behavioral support needs requiring HCBS services. This program is residential, unlike the CES waiver above.

Four factors determine the overall cost of waiver services, including:

- number of individuals eligible for services;
- number of enrollments funded for the DD waiver;
- number of providers willing and able to provide services; and
- rates of reimbursement for each type of services.

As part of the waivers, Colorado is allowed to limit the number of waiver program participants. Annually, the General Assembly has appropriated sufficient funding to ensure no waiting list for the SLS, CES, and CHRP waivers.

Unlike the SLS, CES, and CHRP waivers, the DD waiver continues to have a waiting list for enrollments. As of September 2025, 2,749 individuals were identified as needing DD services as soon as available. Of this amount, 88 were newly placed on the waitlist. While the majority of these individuals receive services through other programs, including the SLS waiver, some may not be receiving the level of services required to meet their needs. The Department requests that new DD waiver enrollments are funded annually for youth transitioning to adult services, individuals requiring services resulting from emergency situations, and individuals transitioning from institutions.

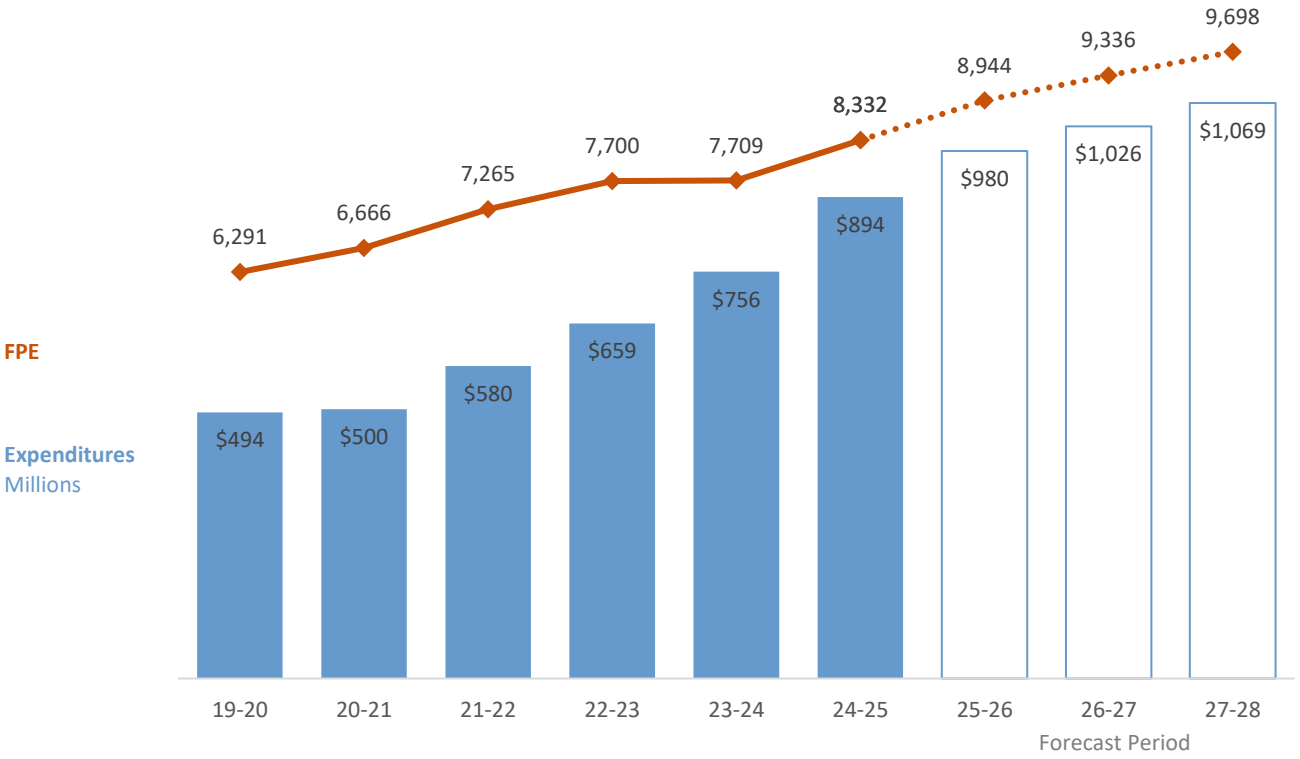
An individuals placement on the waiting list is determined by their order of selection date. The order of selection date is the date on which the case management agency first determines that the person has a developmental disability. For individuals identified as having a developmental disability before their 14th birthday, the order of selection date is their 14th birthday. An individual's position on the waiting list is not based on the date they were added to the list; rather, it is always determined in relation to other enrolled individuals' order of selection dates.

The Department's annual budget request is based on forecasts of the cost per full program equivalent (FPE) in each of the waivers. FPE is calculated as the average number of clients with a paid claim in a given month or year. Adjustments to targeted appropriations reflect the current average cost per FPE, are based upon current spending trends, and are intended to maximize the number of individuals that can be served in each program. Because the DD and CHRP waivers provide residential services in addition to daily support services, the average cost of the individuals receiving services through these waivers are significantly higher than those for individuals receiving services through other waivers.The FY 2024-25 full program equivalent for the DD waiver was 8,332, up 8.2 percent from the previous fiscal year.

Waiver Programs

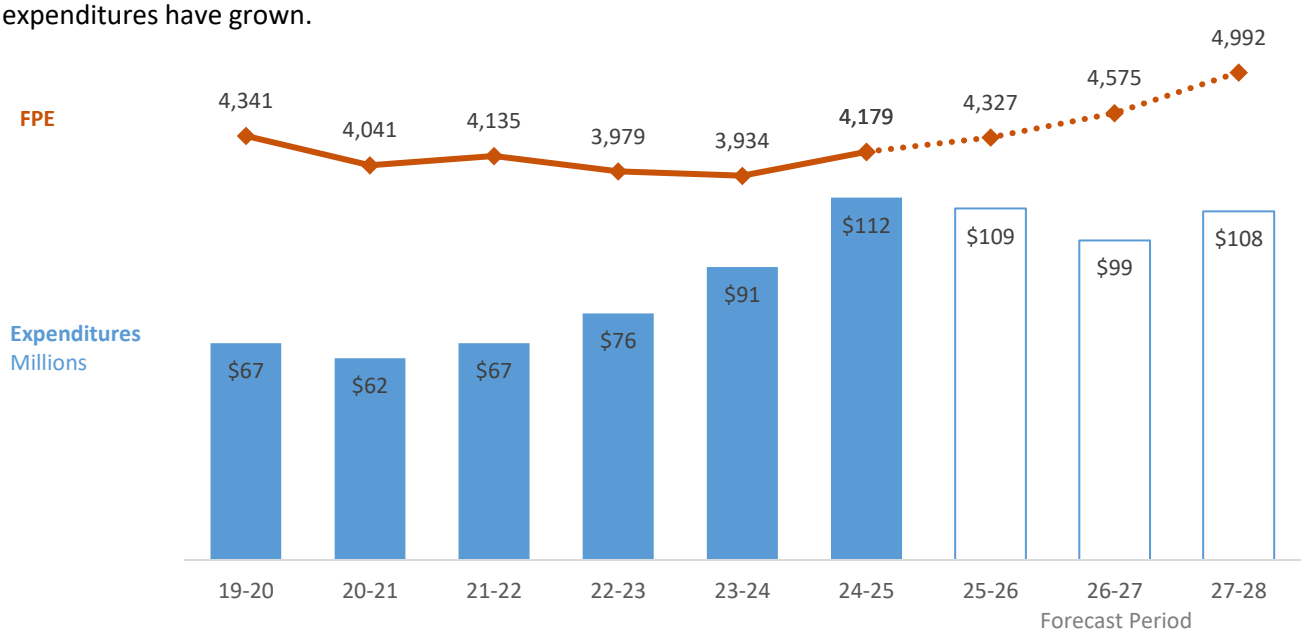
The Adult Comprehensive waiver provides access to 24-hour/seven-day-a-week supervision through residential habilitation and daily habilitation services and supports. Caseload and expenditures for the DD waiver have consistently grown over the last six fiscal years, and the Department projects continued growth in the next three fiscal years.

Comprehensive (DD) waiver caseload and expenditures continue to grow.



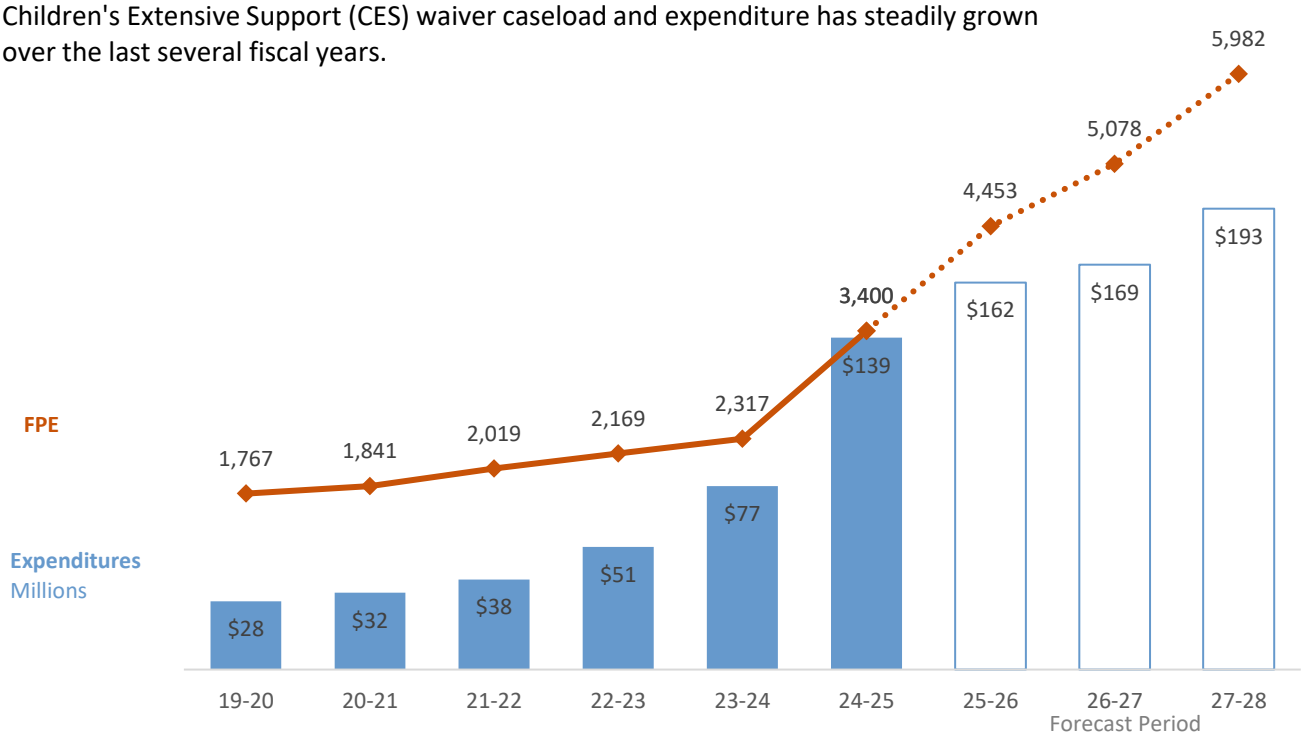
The Supported Living Services waiver provides necessary services and supports for adults with intellectual or developmental disabilities so they can remain in their homes and communities with minimal impact to the individual's community and social supports. The caseload for SLS waivers has moderately declined over the last six fiscal years, while expenditures have increase substantially in the last three fiscal years. The Department projects caseload to remain relatively flat in the next three fiscal years, with expenditures remaining relatively stable.

Supported Living Services (SLS) caseload has declined in the last several fiscal years, but expenditures have grown.



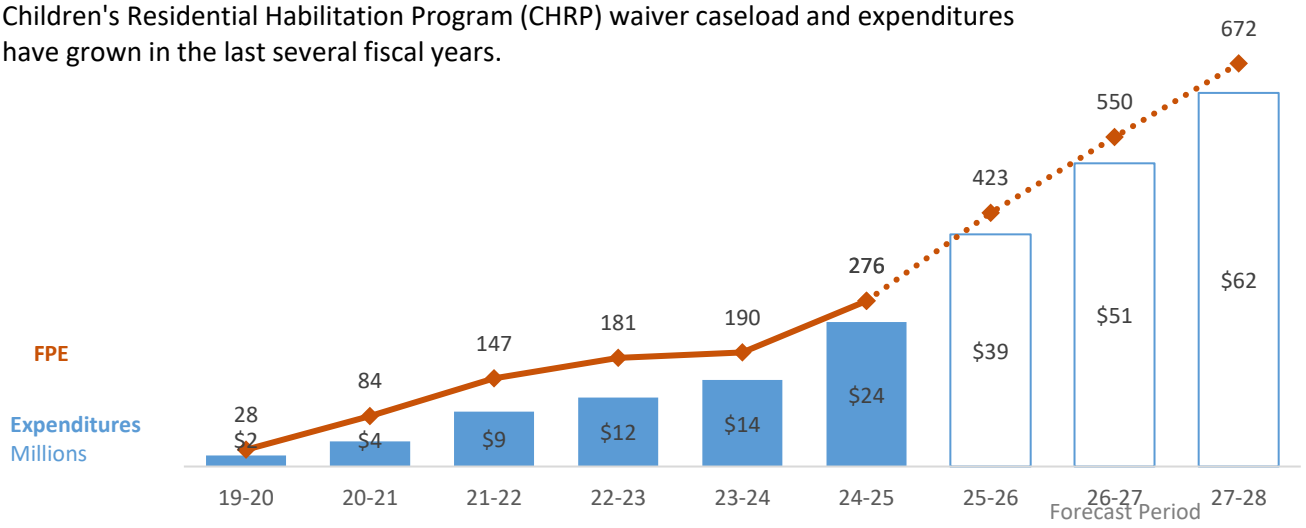
The Children's Extensive Support waiver provides services and supports to children and families that will help children establish a long-term foundation for community inclusion as they grow into adulthood. Caseload and expenditures for the CES waiver have grown over the last six fiscal years. The Department significant growth in caseload in the next three fiscal years, as they have recorded a nearly 60.0 percent increase in enrollments since January 2024. New enrollees onto this waiver tend to be younger than previously experienced, with the highest proportion of new enrollees in the 0-6 age range. Additionally, homemaker and community connector services are the highest used services by new enrollees.

Children's Extensive Support (CES) waiver caseload and expenditure has steadily grown over the last several fiscal years.



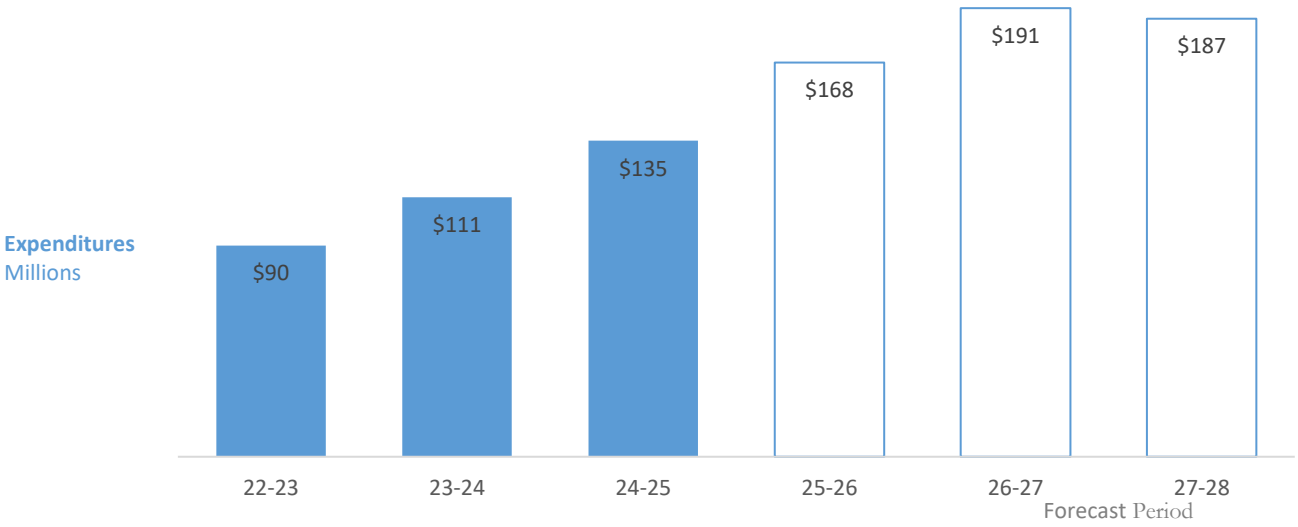
The Children's Habilitation Residential Program waiver provides residential services for children and youth in foster care or at risk of child welfare involvement who have a developmental disability and very high needs that put them at risk for institutional care. Caseload and expenditures for the CHRP waiver have grown substantially over the last six fiscal years. The Department projects significant continued growth in the next three fiscal years.

Children's Residential Habilitation Program (CHRP) waiver caseload and expenditures have grown in the last several fiscal years.



Targeted Case Management (TCM) provides assessment of an individual's long-term care needs, the development and implementation of personalized care plans, coordination and monitoring of the delivery of services, and evaluation of the effectiveness of services.

Targeted Case Management expenditures have increased in the last three years due to caselaod growth and the transition to conflict-free case management.



Summary of Request

Department of Health Care Policy and Financing

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 2025-26 Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Total	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
FY 2026-27 Requested Appropriation						
FY 2025-26 Appropriation	$18,217,290,946	$5,554,316,022	$2,030,279,577	$144,020,883	$10,488,674,464	843.2
Medical forecast [1]	2,841,332,450	630,860,236	477,749,914	0	1,732,722,300	0.0
Eligibility & benefit changes [1]	-203,585,062	-82,866,991	-5,345,281	0	-115,372,790	7.0
Provider rates [1]	-341,182,268	-126,227,926	-17,665,178	0	-197,289,164	1.0
Administration [1]	8,655,095	-7,133,048	2,291,649	2,455,447	11,041,047	11.3
Prior year actions [1]	37,382,050	15,219,353	-4,075,326	-1,652,006	27,890,029	-2.6
Employee compensation common policies	8,693,320	2,544,524	1,436,917	0	4,711,879	0.0
Operating common policies	4,277,298	1,280,829	473,422	-13,427	2,536,474	0.0
Impacts driven by other agencies	1,890,335	852,076	93,091	0	945,168	1.8
Total	$20,574,754,164	$5,988,845,075	$2,485,238,785	$144,810,897	$11,955,859,407	861.7
Increase/-Decrease	$2,357,463,218	$434,529,053	$454,959,208	$790,014	$1,467,184,943	18.5
Percentage Change	12.9%	7.8%	22.4%	0.5%	14.0%	2.2%

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

Medical forecast

The Department requests an increase for projected expenditures for Home- and Community-Based Services waivers for individuals with development disabilities under current law and policy. The cost is $136.9 million total funds in FY 2026-27, including $72.9 million General Fund.

Medical forecast

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R1 Medical Services Premiums	$2,282,305,964	$431,286,496	$443,437,319	$0	$1,407,582,149	0.0	EK
R2 Behavioral health	343,831,232	68,242,986	30,852,643	0	244,735,603	0.0	EP
R5 Office of Community Living [1]	136,855,181	72,893,346	-1,713,868	0	65,675,703	0.0	TD
R4 Other programs & services	56,180,311	56,180,311	0	0	0	0.0	EK
R3 Child Health Plan Plus	22,659,762	2,757,097	5,173,820	0	14,728,845	0.0	EK
R6.05 Immigrant family planning	-500,000	-500,000	0	0	0	0.0	EK
Total	$2,841,332,450	$630,860,236	$477,749,914	$0	$1,732,722,300	0.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

The forecasts do not account for the impacts from the Governor's August 28, 2025 Executive Order, or it's October 31st update. Nor do the forecasts account for the impacts of federal H.R. 1. Impacts from the Executive

Order are included in R6. The forecast is based on enrollment and expenditure data through June 2025. The Committee will receive an updated based on enrollment and expenditure data through December 2025 in February 2026 for consideration during figure setting.

Eligibility & benefits changes

The Department requests 18 eligibility and benefit changes across 3 prioritized requests. Nine changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Eligibility and benefit changes

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R18 3D mammograms	$635,758	$128,456	$37,885	$469,417	0.0	EK
R6.09 Outpatient psychotherapy prior auth	-31,330,942	-12,241,619	-959,135	-18,130,188	0.0	EP
R6.04 Continuous coverage	-27,209,010	-11,226,343	-716,877	-15,265,790	0.0	EK
R6.10 Pediatric behavioral therapy reviews	-20,000,000	-10,000,000	0	-10,000,000	0.0	EP
R6.17 IDD youth transitions [1]	-15,261,376	-7,630,688	0	-7,630,688	1.0	TD
R6.34 Community connector units [1]	-15,092,224	-7,546,112	0	-7,546,112	1.0	TD
R6.08 Tests for specific drugs	-14,106,232	-1,876,129	-1,035,397	-11,194,706	0.0	EK
R6.30 HCBS hours soft cap [1]	-13,891,297	-6,945,648	0	-6,945,649	3.0	TD
R6.20 Community health workers	-13,385,549	-3,196,962	-803,013	-9,385,574	0.0	EK
R6.36 IDD cost share [1]	-12,641,818	-6,320,909	0	-6,320,909	0.0	TD
R6.25 Biosimilars	-12,316,324	-2,357,591	-1,240,468	-8,718,265	0.0	EK
R6.26 3rd party pay for drugs	-9,770,846	-2,944,176	-645,423	-6,181,247	0.0	EK
R6.18 IDD waitlist [1]	-6,497,170	-3,248,585	0	-3,248,585	1.0	TD
R17 Community connector age limit [1]	-5,229,310	-2,632,702	17,147	-2,613,755	0.0	TD
R6.29 LTSS presumptive eligibility [1]	-2,775,871	-1,471,558	0	-1,304,313	0.0	TD
R6.31 Caregiving hours soft cap [1]	-2,266,749	-1,133,374	0	-1,133,375	1.0	TD
R6.19 Senior dental grants	-2,000,000	-2,000,000	0	0	0.0	EK
R6.32 Homemaker hours soft cap [1]	-446,102	-223,051	0	-223,051	0.0	TD
Total	-$203,585,062	-$82,866,991	-$5,345,281	-$115,372,790	7.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R6.17 IDD youth transitions: The Department asks to reduce funding for the automatic enrollment to the DD waiver of youth who age out of the CES waiver.

The Department anticipates implementing this change July 1, 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: An increase of $72,922 total funds, including $36,461 General Fund, and 0.5 FTE.
- Year 1: A net reduction of $15.3 million total funds, including $7.6 million General Fund, and an increase of 1.0 FTE.
- Year 2: A net reduction is $43.7 million total funds, including $21.8 million General Fund, and an increase of 1.0 FTE.

The Department proposed ending the practice of automatically enrolling into the DD waiver youth who age out of the CES and CHRP waivers. The Department is required by statute to enroll youth who are served through child welfare services and turning 18 years old into the DD waiver without being placed on the waitlist. The proposal does not change this policy. The change will necessitate non-exempt individuals aging out of the CES

and CHRP waivers to seek services through other waivers. These individuals are eligible to be placed on the DD wavier waitlist.

The Department requests an additional staff position to train and support case management agencies, to assist with emergency enrollment authorizations review, and to review appeals decisions. The proposal also requires changes to the Care and Case Management system to track emergency requests and denials.

R6.34 Community connector units: The Department asks to reduce funding for the community connector rate for implementing a lower annual cap on the number of units covered.

The Department anticipates implementing this change in the Spring of 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: A net reduction of $2.5 million total funds, including $1.2 million General Fund, and an increase of 0.5 FTE.
- Year 1 and ongoing: A net reduction of $15.1 million total funds, including $7.5 million General Fund, and an increase of 1.0 FTE.

Community connector services help individuals enrolled in the CES and CHRP waivers participate in typical childhood activities and to become more fully integrate into their communities. These services help members develop skills and abilities to be active participants in their communities, build relationships and natural supports, and interact one-on-one with non-familial persons without disabilities. Examples of engagement supported by this benefit are volunteering, attending enrichment classes, and going to the library alongside peers without disabilities.

The Department is planning a 50.0 percent reduction to the annual cap for community connector services to 1,040 units. Community connector services are billed in 15-minute increments, so the new cap equates to 260 hours per year per member. The Department anticipates hundreds of exception requests and requests an addition staff position to support the review process for this change to the community connector benefit.

R6.30 HCBS hours soft cap: The Department asks to reduce funding for select Home- and Community-Based Services (HCBS) for the implementation of caps on annual use.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: A net reduction of $2.3 million total funds, including $1.2 million General Fund, and an increase of 1.5 FTE.
- Year 1 and ongoing: A net reduction of $13.9 million total funds, including $6.9 million General Fund, and an increase of 3.0 FTE.

Personal care, homemaker, and health maintenance activities are core HCBS benefits and are available under Community First Choice. These services are not currently limited and are authorized base on assessed need. Personal care services assist with activities such as bathing, dressing, eating, mobility, and hygiene. Homemaker services provide assistance with household tasks including meal preparation, cleaning, laundry, and shopping. Health maintenance activities include supports such as medication administration, catheter care, or respiratory assistance that can be safely performed in the home or community setting.

The Department proposes implementing soft caps for these services. The cap will limit annual utilization, but a process for requesting an exception will be established. The Department requests three staff positions to manage the exceptions process.

Annual HCBS Service Limits

Service	Limit (units)	Daily Hours
Personal care	10,000	6.5
Homemaker	4,500	3.0
Health maintenance activities	19,000	13.0

R6.36 IDD cost share: The Department asks to reduce funding for the DD waiver for the implementation of a policy to require members on the waiver to contribute financially for their residential services.

The Department anticipates implementing this change on July 1, 2026. The change reduces the Department's forecast by:

- Year 1: $12.6 million total funds, including $6.3 million General Fund.
- Year 2: $26.3 million total funds, including $13.1 million General Fund.

The Department plans to institute post eligibility-treatment of income (PETI) for individuals enrolled in the DD waiver. PETI is the process used to determine how much of a member's income must be contributed toward the cost of their long-term care in programs that provide residential services. The current policy is to allow individuals enrolled in the DD waiver to retain all income beyond what they pay for room and board, while Medicaid covers the full cost of residential services. Members enrolled in other HCBS residential services are subject to PETI requirements. The PETI process accounts for a personal needs allowance and other allowable deduction and expenses permitted by regulations.

R6.18 IDD waitlist: The Department asks to reduce funding for DD waiver enrollments.

The Department anticipates implementing this change July 1, 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year: An increase of $72,922 total funds, including $36,461 General Fund, and 0.5 FTE.
- Year 1: A net reduction of $6.5 million total funds, including $3.2 million General Fund, and increase of 1.0 FTE.
- Year 2: A net reduction of $18.7 million total funds, including $9.4 million General Fund, and increase of 1.0 FTE.

The DD waiver currently has a waitlist. When an individual leaves the DD waiver, the next person on the waitlist is authorized to replace them. The process of filling vacant enrollment with new enrollments from the waitlist is referred to as "churn." The Department monthly approves churn enrollments from the waitlist for individuals based on the date they were determined eligible and placed on the waitlist. The process maintains a rolling enrollment list, based on the previous month's reported vacancies.

The Department proposes reducing churn enrollments by 50.0 percent. For every two members that disenroll from the DD waiver, the Department would enroll one individual. As of September 2025, 2,749 individuals were identified as needing DD services as soon as available. While the majority of these individuals receive services through other programs, including the SLS waiver, some may not be receiving the level of services required to meet their needs. This proposal will increase the length of time and number of individuals on the waitlist. The Department requests an additional staff position to support the review of emergency enrollment authorizations and the appeals process.

R17 Community connector age limit: The Department asks to reduce funding by limiting access to community connector benefit to minor members ages 6 years or older.

The Department anticipates implementing this change in the Spring or Summer of 2026.The change reduces the Department's forecast by:

- Year 1 and ongoing: $5.2 million total funds, including $2.6 million General Fund.

The Department reports that utilization and expenditures for community connector service, particularly for children under the age of 6 years, have significantly increased since FY 2018-19. In that last six fiscal years:

- Total average monthly utilization has increased from 508 to 2,102, while total expenditures have increase from $5.0 million to $67.0 million.
- Total average monthly utilization for member under 6 years old has increase from 45 to 523, while total expenditures for this group has increase from $0.5 million to $11.2 million.

The Department has expressed concern that community connector services are being utilized, in some cases, for activities that should already be provided by the child's caregiver as typical parental responsibilities. The Department reports that few states offer this service to children, and fewer compensate parents for providing the service. The Department is seeking to update its policy guiding community connector services to ensure the service is appropriately authorized.

R6.29 LTSS presumptive eligibility: The Department asks to reduce funding to delay the implementation of presumptive eligibility for long-term services and supports (LTSS) until July 1, 2027.

The change reduces the Department's forecast by:

- Current Year: $1.3 million total funds, including $0.7 million General Fund.
- Year 1: $2.8 million total funds, including $1.5 million General Fund.
- Year 2: $1.4 million total funds, including $0.7 million General Fund.

The Department is currently developing a new presumptive eligibility program for long-term support services that would allow adults with disabilities access to some community-based services while their Medicaid application is processed. The program is intended to help individuals in crisis situations to stabilize in the community, preventing unnecessary and unwanted institutionalization. The Department plans for presumptive eligibility to be initiated through a self-declaration of eligibility referral, followed by application verification.

The Department plans to implement the delay based on feedback and guidance from the Centers for Medicare and Medicaid Services (CMS). CMS gave verbal notice that the State's 1115 waiver will be renewed with a no-cost extension, which means the federal government will not consider any new additions to the waiver and has a year to review the presumptive eligibility program. The proposed delay aligns with the timing of the federal review.

R6.31 Caregiving hours soft cap: The Department asks to reduce funding for caregiving services with the implementation of a cap on the paid weekly hours per caregiver providing these services.

The Department anticipates implementing this change in the Spring of 2026. The change increases the Department's administrative expenses but reduces its forecast by:

- Current Year. A net reduction of $0.3 million total funds, including $0.2 million General Fund, an increase of 0.5 FTE.

- Year 1 and ongoing: A net reduction of $2.3 million total funds, including $1.1 million General Fund, an increase of 1.0 FTE.

The Department plans to implement a weekly limit of 56 hours per caregiver per member. The limit applies to total hours across personal care, homemaker, health maintenance activities, home health aide, and nursing services. The Department anticipates authorizing exceptions to the cap only in extraordinary and short-term circumstances and requests a staffing resource to manage policy compliance and the exception review process.

R6.32 Homemaker soft cap: The Department asks to reduce funding for homemaker services for the implementation of a cap on paid weekly hours for legally responsible persons providing these services.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: $74,350 total funds, including $37,175 General Fund.
- Year 1 and ongoing: $0.4 million total funds, including $0.2 million General Fund.

Homemaker services provide assistance with household tasks including meal preparation, cleaning, laundry, and shopping. The Department proposes reducing the cap for legally responsible persons from 10 hours per week to 5 hours per week. Legally responsible persons are typically family members who have a legal responsibility to care for the individual enrolled in Medicaid. Homemaker services are core HCBS services and are available under Community First Choice.

Provider rates

The Department requests 18 provider rate changes across four prioritized requests. Four changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Provider rates

Item	Total Funds	General Fund	Cash Funds	Federal Funds	FTE	JBC Lead
R13 Denver Health fed funds	$11,331,455	$0	$3,527,482	$7,803,973	0.0	EK
R14.2 IV nutrition rates	615,320	203,628	24,453	387,239	0.0	EP
R6.11 Provider rates -1.6%	-160,972,816	-56,992,200	-8,810,550	-95,170,066	0.0	EK
R6.23 Rates above 85% Medicare	-53,241,533	-15,046,057	-3,780,149	-34,415,327	0.0	EK
R15 Home health/nurse rates [1]	-26,582,980	-13,670,319	160,503	-13,073,164	1.0	TD
R6.16 Dental rates	-20,668,949	-3,774,150	-3,121,011	-13,773,788	0.0	EK
R6.33 Community connector -23% [1]	-18,331,864	-9,165,932	0	-9,165,932	0.0	TD
R6.24 Drug rates	-15,805,934	-3,772,279	-1,178,513	-10,855,142	0.0	EK
R6.15 Pediatric behavioral therapy rates	-13,057,068	-6,528,534	0	-6,528,534	0.0	EP
R6.02 Behavioral health incentives	-12,644,332	-3,000,000	-3,322,166	-6,322,166	0.0	EP
R6.12 Community connector -15% [1]	-12,052,939	-6,026,469	0	-6,026,470	0.0	TD
R6.13 Nursing minimum wage	-8,719,922	-4,359,961	0	-4,359,961	0.0	EK
R6.14 Individual residential srvcs & supports [1]	-5,801,116	-2,284,479	-616,079	-2,900,558	0.0	TD
R6.01 Accountable care incentives	-2,325,290	-750,000	-412,645	-1,162,645	0.0	EK
R6.28 Drug dispensing fees	-1,690,905	-509,509	-111,694	-1,069,702	0.0	EK
R6.35 Movement therapy rates	-716,467	-358,234	0	-358,233	0.0	EP
R6.27 Specialty drug rates	-516,928	-193,431	-24,809	-298,688	0.0	EK
R6.03 Primary care stabilization	0	0	0	0	0.0	EK
Total	-$341,182,268	-$126,227,926	-$17,665,178	-$197,289,164	1.0	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R15 Home health and nurse rates: The Department asks for a net reduction in funding resulting from the modification of the private duty nursing (PDN) rate structure and the home health rate structure, as well as to develop and implement a new rate negotiation strategy for the DD waiver and the CHRP waiver.

The change temporarily increases the Department's administrative expenses and reduces, on an ongoing basis, the Department's forecast by:

- Year 1: $26.6 million total funds, including $13.7 million General Fund, and 0.9 FTE.
- Year 2: $58.4 million total funds, including $27.8 million General Fund, and 1.0 FTE.
- Year 3 and ongoing: $58.7 million total funds, including $28.8 million General Fund.

Private duty nursing provides skilled nursing services in a residential setting to individuals with complex medical needs. These services are billed on an hourly basis based on the level of staff providing the care (i.e., registered nurse, licensed practical nurse, or a blended rate) and the setting. A prior authorization request (PAR) is required for reimbursement of these services, which can be a barrier to service for members discharged from a hospital. The Department is proposing the creation of a blended per-diem rate and of an acute care period for PDN services. The blended per-diem rate is intended for use by members with a range of care needs that are provided by a range of staffing levels. Establishing an acute care period for PDN services would allow members a short window of time in which they can receive services prior to an PAR.

The home health benefit provides services from a licensed and certified home health agency for members needing intermittent home health services. Services are billed and reimbursed based on the provider type, typically on a per-visit basis. The providers for these services include certified nursing assistants, physical therapists, occupational therapists, and speech-language pathology therapists. The Department is proposing creating a single 15-minute rate for certified nursing assistant services and 30-minute rate increments for the therapy services.

Community Fist Choices services provide select home health benefits. These services are billed at a 15-minute rate interval regardless of whether the service is provided in an individual or group setting. Direct care workers are required to track their hourly work on a per-member bases, which can lead to duplication of services. The Department proposes creating a group rate for these services to be used when a direct care worker provides services in a group setting.

Members enrolled in the DD and CHRP waivers are provided access to 24/7 supervision and care. Living arrangements can range from host home settings with 1-2 persons, staffed settings of 1-3 persons, and group settings of 4-8 persons, as well as residential supports for participants who live in their own home or who live with and/or are provided services by members of their family. Reimbursement is based on a member's support level need, ranging from 1 (lowest need) to 7 (highest need). For several service categories, the level 7 rate is not set, rather it is negotiated on a per-member basis. The rate is set based on information provided by a member's case management agency. The tool used by the Department to evaluate and set the level 7 rates was developed in 2007 and has not been updated since. The Department proposes creating new negotiation strategies that could lead to more accurate reimbursement for members with a level 7 need.

R6.33 Community connector – 23%: The Department asks to reduce funding for the community connector rate to align this rate with the tier 3 supported community connections rate in the adult SLS waiver.

The Department anticipates implementing this change in the Spring of 2026. The change reduces the Department's forecast by:

- Current Year: $3.1 million total funds, including $1.5 million General Fund.
- Year 1 and ongoing: $18.3 million total funds, including $9.2 million General Fund.

The Department argues that the current rates are disproportionately high compared to the training and qualification required for the services and has led to unusually high profit margins for provider agencies. The proposal is the second of two cuts to the community connector rate. The first, summarized in R6.12, reduces the rates by 15.0 percent. This second rate cut makes the following changes.

- from $10.23 to $7.71 per 15-minute unit outside of Denver County, and
- from $10.51 to $7.83 per 15-minute unit within Denver County.

R6.12 Community connector rate – 15%: The Department asks to reduce funding for a community connector rate cut of 15.0 percent.

The Department anticipates implementing this change January 1, 2026. The change reduces the Department's forecast by:

- Current Year: $6.0 million total funds, including $3.0 million General Fund.
- Year 1: $12.1 million total funds, including includes $6.0 million General Fund.

The Department is implementing a rate for community connector services as a cost containment measure directed by the Governor's August 28th Executive Order. The rate cut reduces the community connector rate as follows:

- from $12.22 to $10.39 per 15-minute unit outside of Denver County, and
- from $12.56 to $10.67 per 15-minute unit within Denver County.

R6.14 Individual residential services and supports: The Department asks to reduce funding for adjustments to the rate structure for individual residential services and supports (IRSS).

The Department anticipates implementing this change April 1, 2026. The change reduces the Department's forecast by:

- Current Year: $2.9 million total funds, including $1.5 million General Fund.
- Year 1 and ongoing: $5.8 million, including $2.3 million General Fund.

Individual residential services and supports (IRSS) use a variety of living arrangements to meet the unique needs for support, guidance and habilitation of individuals enrolled in the DD waiver. Individuals may access IRSS services in several settings, including host homes, family homes, member homes, and staffed homes. The way IRSS settings are defined in regulation is unclear and does not account for the variety of settings available to members receiving these services.

There are currently two series of rates for IRSS and billing guidance has not been clear or consistent. Rate series are set by care level and setting. One rate series is intended for host homes, family homes, and member homes. This series is named Individual Residential Services and Supports/Host Home and ranges from:

- $84.91 per day to $312.56 per day outside of Denver County, and
- $91.40 per day to $343.40 per day within Denver County.

The second rate series is intended for staffed home. This series is named Individual Residential Services and Supports and ranges from:

- $92.11 per day to $339.35 per day outside of Denver County, and

- $99.32 per day to $373.65 per day within Denver County.

The Department acknowledges that confusing and unclear communication about IRSS policies and rates has led to inconsistent billing practices and higher than expected expenditures. Circumstances have led to many providers billing at the higher Individual Residential Services and Supports rate series for family caregivers for many years. The Department is in the process of clarifying billing rules through revisions to regulations and guidance updates.

Administration

The Department requests 15 administrative changes across 12 prioritized requests. Four changes are discussed in this document. Additional changes are discussed in separate staff briefings.

Administration

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE	JBC Lead
R7 Eligibility administration [1]	$16,626,704	$1,503,264	$1,560,567	$2,455,447	$11,107,426	3.0	TD
R9 Provider directory	5,955,875	451,455	248,360	0	5,256,060	0.0	EK
R10.1 Disability determinations [1]	1,381,020	837,000	-146,491	0	690,511	0.0	TD
R11 Salesforce support	700,172	223,727	120,059	0	356,386	1.8	EK
R14.1 Chronic pain management	290,738	94,867	50,502	0	145,369	1.0	EP
R12 Home health administration	95,738	31,237	16,631	0	47,870	1.0	EK
R8 Single assessment [1]	-11,668,682	-6,192,265	60,986	0	-5,537,403	2.7	TD
R6.21 Children in Rocky PRIME	-3,476,470	-1,738,235	0	0	-1,738,235	0.0	EK
R6.07 Immigrant services outreach	-750,000	-262,500	0	0	-487,500	0.0	EK
R6.06 SBIRT training grants	-500,000	-500,000	0	0	0	0.0	EP
R16 Unspent grant admin	0	-800,000	800,000	0	0	0.0	EP
R10.2 3rd party insurance	0	-781,598	-418,965	0	1,200,563	1.8	EK
R6.22 Provider credentialing ACC	0	0	0	0	0	0.0	EK
R19 Line item consolidation [1]	0	0	0	0	0	0.0	TD
R20 CHP+ Trust consolidation	0	0	0	0	0	0.0	EK
Total	$8,655,095	-$7,133,048	$2,291,649	$2,455,447	$11,041,047	11.3	

[1] Only the highlighted items are discussed in this document. Other items are discussed in separate staff briefings.

R7 Eligibility administration [legislation]: The Department asks for funding to centralize some administrative functions for the provision of medical and public assistance programs.

The change increases the Department administrative expenses by:

- Current Year: $0.6 million total funds, including includes $0.2 million General Fund, and 1.0 FTE.
- Year 1: $16.6 million total funds, including $1.5 million General Fund, and 3.0 FTE.
- Year 2: $40.8 million total funds, including $2.7 million General Fund, and 3.0 FTE.
- Year 3 and ongoing: $38.0 million total funds, including $2.1 million General Fund, and includes 3.0 FTE.

The Departments of Health Care Policy and Financing and Human Services propose to centralize four medical and public assistance administrative functions through contracts with high-performing counties: call center support, document management, quality assurance for Medicaid programs, and fraud investigations for Medicaid programs. The Department anticipates that the centralization of these services will be fully implemented beginning July 1, 2028. The proposal seeks to address increasing cost pressures on administrative, eligibility, and enrollment activities associated with medical and public assistance programs, as well as recent

federal policy changes that increase administrative burdens on counties and the risk of severe financial penalties to the State.

A staff briefing issues on this request is provided later in this document.

R10.1 Disability determinations: The Department for funding for projected caseload increases and to rebalance funding sources to accurately reflect the caseload split of traditional Medicaid members versus expansion population members.

The change increases the Department contract expenses by:

- Current Year: $1.3 million total funds, including $0.4 million General Fund.
- Year 1: $1.4 million total funds, including $0.8 million General Fund.
- Year 2: $1.5 million total funds, including $0.9 million General Fund.
- Year 3 and ongoing: $1.6 million total funds, including $0.9 million General Fund.

Disability determinations assess whether an individual's medical condition qualifies for Medicaid benefits under disability-based eligibility. Administrative costs for disability determinations should be allocated according to the proportion of cases from traditional Medicaid (General Fund) versus the expansion population (hospital provider fees). Based on current caseload projections the correct funding splits should reflect two-thirds of determinations for the traditional Medicaid population and one-third for the expansion population. To accurately reflect this split, the appropriation needs to be reweighted toward the General Fund.

Disability determinations are provided through a contract. Monthly application volume has increased substantially over the last several years, while the appropriation has not kept pace. The Department reports that 14,776 applications were processed in FY 2024-25, as compared to 8,917 in FY 2023-24 and 7,696 in FY 2022-23. Application processing costs are contracted at $285 per application. The Department's request increase appropriations to provide sufficient funding to process 15,000 applications.

R8 Single assessment: The Department asks for funding to deploy a single assessment tool in compliance with S.B. 16-192 (Assessment Tool Intellectual and Developmental Disabilities) that will replace multiple assessment tools currently used. Deployment of the single assessment tool is planned for August 2026.

The change impacts the Department administrative expenses and forecast by:

- Year 1: A net reduction of $11.7 million total funds, including $6.2 million General Fund, and an increase of 2.7 FTE.
- Year 2 and ongoing: An increase of $3.5 million total funds, including $1.4 million General Fund, and 3.0 FTE.

The single assessment tool is designed to support a person-centered approach in developing an individual's Person-centered Support Plan (PCSP or Plan). The Plan uses the results of the single assessment tool to outline the services and supports that meet the individual's care goals and preferences. The deployment of the single assessment tool will be conducted in a phased approach, with the state's 15 case management agencies grouped in three cohorts. The first cohort will begin using the tool August 2026, the second in February 2027, and the third in May 2027. The staggering of deployment is intended to ensure the transition to the single assessment tool is without major problems, while providing the opportunity to address any issues that come up during the rollout.

The Department requests term-limited state staffing and contract resources. The state staff term is proposed from August 2026 through August 2029 and will provide system support, training and technical assistance, and

provide quality assurance reviews. The contract resources will assist the Department with launching the new tool and provide system support.

The single assessment tool has had a long and difficult road to deployment. The Department was tasked with the effort to create the tool beginning in FY 2016-17. The COVID-19 pandemic forced a pause in development and deployment, then the 2023 launch of the Care and Case Management (CCM) IT system needed to be stabilized, and finally implementation of case management redesign and Community First Choice took priority. The single assessment tool will be integrated into the CCM.

R19 Line item consolidation: The Department asks for a budget neutral restructure of its section of the Long Bill to consolidate the appropriations for the IDD waiver services into the Medical Services Premium line item.

Year 1 and ongoing: The request is budget neutral.

The Department contends that the current Long Bill structure creates an administrative burden in managing appropriations and reconciling accounting. The current Long Bill structure, which includes a separate budgetary section for the Office of Community Living's waiver programs for individuals with intellectual and developmental disabilities, was created with the FY 2014-15 Long Bill in response to H.B. 13-1314 (Transfer Developmental Disabilities to HCPF). The Office of Community Living also oversees long-term services and support programs through their physical disability waivers, which are appropriated funding in the Medical Services Premium line item. Additionally, recent policy changes including implementation of Community First Choice and conflict-free case management have shifted the appropriations for some services and case management between budgetary sections in the Long Bill. The Department argues that consolidating appropriations for IDD waiver services into the Medical Services Premium line item will reduce their administrative burdens.

Prior year actions

The request includes a net increase of $2.1 million total funds for the impact of prior year budget decisions and legislation for the Office of Community Living budgetary division. The table below only reflects impacts for the division rather than the entire Department.

Prior year actions

Item	Total Funds	General Fund	Cash Funds	Reapprop. Funds	Federal Funds	FTE
FY 25-26 Provider rates 1.6% adjustment	$1,721,985	$846,659	$25,403	$0	$849,923	0.0
FY 23-24 BA7 Community access	1,403,874	539,108	0	0	864,766	0.0
FY 25-26 R11 OCL benefits	-1,019,166	-509,583	0	0	-509,583	0.0
Total	$2,106,693	$876,184	$25,403	$0	$1,205,106	0.0

Budget Reduction Options

The Executive budget request includes reductions of $74.5 million General Fund for the Department of Health Care Policy and Financing, Office of Community Living, representing 10.6 percent of the current General Fund appropriations in this section of the budget.[1] This issue brief reviews these proposals and additional options identified by staff.

Summary

The Department of Health Care Policy and Financing, Office of Community Living, represents 4.1 percent of total state General Fund appropriations in FY 2025-26. The Executive budget request includes proposed reductions of $74.5 million, representing 10.6 percent of the General Fund appropriations in this section of the budget. These reductions are offset by proposed increases, so that the Office's total General Fund is requested to increase by 1.6 percent.

Discussion

Funding History FY 2018-19 to FY 2025-26

The Department Health Care Policy and Financing, Office of Community Living, represents 4.1 percent of total state General Fund appropriations in FY 2025-26. As reflected in the table below, General Fund in this section of the budget has increased by 82.5 percent since FY 2018-19 after adjusting for inflation. This is more than the statewide increase of 13.6 percent over the same period.[2]

FY 2018-19 to FY 2025-26 Appropriations Comparison - Adjusted for Inflation

Fund	FY 2018-19 Nominal	FY 2018-19 Adjusted	FY 2025-26	$ Change from FY 2018-19 Adjusted	% Change from FY 2018-19 Adjusted
General Fund	$294,875,096	$383,741,179	$700,209,770	$316,468,591	82.5%
Total Funds	$569,722,235	$741,418,604	$1,423,720,451	$682,301,847	92.0%

The growth in the cost of Home- and Community Based Services waivers for individuals with developmental disabilities has been a topic of interest for the Committee for several years. In response to Committee questions on this issue during their FY 2025-26 hearing, the Department noted that growth is due to several factors, including rate increases, increases in utilization of services, and population growth that drives enrollment growth. The Department also highlighted that policy changes in the last decade have emphasized the shift in preference for and access to care delivery in home and community-based settings.

[1] Current FY 2025-26 appropriations do not include mid-year reductions in executive orders.

[2] Fiscal year 2018-19 appropriations are adjusted for inflation, calculated based on the Legislative Council Staff September 2025 forecast, which reflects an increase in the Denver-Aurora-Lakewood consumer price index of 30.1 percent between FY 2018-19 and FY 2025-26.

Budget Requests for General Fund Relief

For this section of the budget, the budget request includes proposals for General Fund relief totaling $74.5 million, representing 10.6 percent of the General Fund appropriations. These reductions are offset by proposed increases, so that the Office's total General Fund is requested to increase by 1.6 percent. The proposals for General Fund relief are summarized in the table below.

Budget Requests for General Fund Relief

Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
None				
Subtotal - Revenue	$0	$0		
Expenditure Reductions				
R15 Home health/nurse rates	-$13,670,319	-$12,912,661		Establish a per-diem blended rate for private duty nursing and update rate structure for home health and Community First Choice benefits
R6.33 Community connector -23%	-9,165,932	-9,165,932		Align rate with the Tier 3 supported community connections rate
R6.17 IDD youth transitions	-7,630,688	-7,630,688		End automatic enrollment for youth aging out of CES waiver
R6.34 Community connector units	-7,546,112	-7,546,112		Reduce annual cap on number of units covered
R6.30 HCBS hours soft cap	-6,945,648	-6,945,649		Cap annual hours for personal care, homemaker, and health maintenance activities
R6.36 IDD cost share	-6,320,909	-6,320,909		Require members on DD waiver to contribute financially to their residential services
R6.12 Community connector -15%	-6,026,469	-6,026,470		Reduce community connector rate by 15.0%
R8 Single assessment	-6,192,265	-5,476,417		Deploy single assessment tool in compliance with S.B. 16-192, replaces multiple assessment tools
R6.18 IDD waitlist	-3,248,585	-3,248,585		Reduce DD enrollments from waitlist by 50%
R6.14 Individual residential srvcs & supports	-2,284,479	-3,516,637		Align family caregiver rate with host home rate
R17 Community connector age limit	-2,632,702	-2,596,608		Limit community connector services to children 6 year of age and older
R6.29 LTSS presumptive eligibility	-1,471,558	-1,304,313		Delay start until 7/1/27
R6.31 Caregiving hours soft cap	-1,133,374	-1,133,375		Cap paid weekly hours per caregiver
R6.32 Homemaker hours soft cap	-223,051	-223,051		Cap paid weekly hours for legally responsible persons providing services
Subtotal - Expenditures	-$74,492,091	-$74,047,407		
Net General Fund Relief	$74,492,091			

Additional Options for JBC Consideration

The table below summarizes options identified by the JBC staff that the Committee could consider in addition to or instead of the options presented in the budget request.

A General Fund reduction of 5.0 percent to the sections of the budget covered in this briefing would require a reduction of $35.0 million.

Additional Options for General Fund Relief

Option	General Fund	Other Funds	Bill? Y/N	Description
Revenue Enhancements				
None				
Subtotal - Revenue	$0	$0		
Expenditure Reductions				
5% OCL admin	-$107,070	-$90,278	N	Reduction to OCL administration based on FY 2025-26 appropriation
5% State-only programs	-$1,106,134	$0	N	Reduction to state-only programs based on FY 2025-26 appropriation
Transportation incentive	-360,000	-360,000	N	HB 22-1114 created incentive to increase non-medical transportation provider participation for persons enrolled in DD and SLS waivers
Service limits for job coaching and development	-575,233	-575,233	Y	SB 21-039 removed service limits for job coaching and development for persons enrolled in DD waiver
Skill and therapeutic respite services for CES and CHRP waivers	-$1,769,429	-$1,769,429	N	Remove services added in FY 2023-24 through budget action (FY 23-24 R10), build into forecasts
Subtotal - Expenditures	-$3,342,633	-$2,219,707		
Net General Fund Relief	$3,342,633			

Revenue Enhancements

None.

Expenditure Reductions

5.0 percent Office of Community Living administration

Description: A $0.1 million General Fund reduction to the administrative subdivision of the OCL Long Bill section.

Health/Life/Safety Impact: Low

Key Considerations: The reduction is based on the Office's FY 2025-26 enacted budget.

5.0 percent State-only programs

Description: A $1.1 million General Fund reduction to the State-only Programs subdivision of the OCL Long Bill section.

Health/Life/Safety Impact: Medium

Key Considerations: The reduction is based on the Office's FY 2025-26 enacted budget.

Additional background: This Long Bill subdivision was created five years ago and is comprised of four line items. This subdivision is funded exclusively from the General Fund and a Long Bill footnote authorizes the transfer of appropriations between its line items to prevent overexpenditures. The appropriations support programs for individuals not eligible for Medicaid, those who do not meet Home- and Community-Based Services waiver target criteria, and those where the waiver is not able to fully meet their needs. The line items and their descriptions are below.

- **Family Support Services** - The Family Support Services line item provides financial support for families who have children, including adult children, with developmental disabilities or delays with costs that are beyond those normally experienced by other families. The intent of this funding is to provide supports that help reduce the likelihood of out-of-home placements. Services include: medical and dental expenses, additional insurance expenses, respite care and child care, special equipment, home or vehicle modifications or repairs, family counseling and support groups, recreation and leisure needs, transportation, and homemaker services.
- **State Supported Living Services** - This line item funds the costs of adult supported living services for individuals who do not qualify for Medicaid. The program provides supported living services in the home or community to persons with intellectual and developmental disabilities, including: day habilitation, homemaker, personal care, respite, supported employment, dental and vision services, assistive technology, behavioral services, home accessibility adaptation, mentorship, non-medical transportation, personal emergency response systems, professional therapeutic services, specialized medical equipment and supplies, and vehicle modification.
- **State Supporting Living Services Case Management** - This line item funds Case Management Agencies and Single Entry Points that administer the supports intensity scale and provide case management, utilization review, and quality assurance. Case management is provided for the State Supported Living Services delivery option, the State Supported Family Support Services Program, and the Family Support Loan Fund. Services are delivered through community providers and two state-operated regional centers.
- **Preventive Dental Hygiene** - This line item provides funding for the Preventive Dental Hygiene Program administered by a contract with the Colorado Foundation of Dentistry for the Handicapped. The program is designed to improve oral hygiene in persons with developmental disabilities in order to prevent dental disease. Funding also supports outreach services to match individuals needing care with dentists willing to provide pro-bono dental care. Medicaid eligible children may receive dental screening through the federal Early and Periodic, Screening, Diagnosis and Treatment Program; however, Colorado does not offer adult dental care through Medicaid.

Transportation incentive

Description: A $0.4 million General Fund reduction to the funding for transportation services provided by transportation network companies.

Health/Life/Safety Impact: Low

Key Considerations: House Bill 22-1114 (Transportation Services for Medicaid Waiver Recipients) authorized the Department to seek federal approval for verified transportation network companies to provide non-medical transportation services for adult Medicaid waiver programs. Non-medical transportation is also provided by credentialed drivers, taxi services, mobility vans, and public transportation. The bill explicitly acknowledges this

expansion of transportation services is subject to budget constraints, so legislation is not required for this relief option.

Services limits for job coaching and development

Description: A $0.6 million General Fund reduction to reinstate service limits for job coaching and development for persons on the DD and SLS waivers.

Health/Life/Safety Impact: Medium

Key Considerations: Senate Bill 21-039 (Elimination of Subminimum Wage Employment) requires the Department to not place limits on access to job coaching and development services for individuals enrolled on the DD and SLS waivers. In order to reinstate these limits, legislation is required.

Skill and therapeutic respite services for CES and CHRP waivers

Description: A $1.8 million General Fund reduction to remove skill and therapeutic respite service for the Children's Extensive Services and Children's Habilitation Residential Program waivers.

Health/Life/Safety Impact: Medium

Key Considerations: The expansion of services to provide access to skilled and therapeutic respite for the CES and CHRP waivers was funded through a FY 2023-24 budget request. The expansion sought to address a gap in respite care for families with high medical and behavioral needs children.

R5 Office of Community Living

The Department of Health Care Policy and Financing submits an annual budget request for adjustments in appropriations that fund services to individuals with intellectual and developmental disabilities. Budget requests are based on projected caseload and the associated costs for the Home- and Community-Based Services: Adult Comprehensive (DD), Supported Living Services (SLS), Children's Extensive Services (CES), and Children's Habilitation Residential Program (CHRP) waivers.

Summary

- The Department requests:
  - a FY 2025-26 increase of $41.0 million total funds, including $24.9 million General Fund;
  - a FY 2026-27 increase of $94.8 million total funds, including $51.8 million General Fund; and
  - a FY 2027-28 increase of $182.0 million total funds, including $95.4 million General Fund.
- This request funding to maintain a zero-enrollment waitlist for the Adult Supported Living Services, Children's Extensive Services, and Children's Habilitation Residential Program waivers and for an additional 372 transitional enrollments for the Adult Comprehensive Services waiver.

Discussion

The Department is responsible for the administration of four Medicaid waivers through which eligible individuals with intellectual and developmental disabilities (IDD) may access services. Individuals who are not eligible for Medicaid may access IDD services through programs funded with state General Fund. The Department uses per capita costs and average full program equivalent (FPE) to calculate the funding needs for each waiver.

Comprehensive/Developmental Disabilities Waiver

The Adult Comprehensive Services waiver provides access to 24-hour/seven-day-a-week supervision through Residential Habilitation and Day Habilitation Services and Supports. The service provider is responsible for supporting individuals in securing living arrangements that can range from host home settings with 1-2 persons, individualized settings of 1-3 persons, and group settings of 4-8 persons. Support is also available for participants who live in their own home or who live with and/or are provided services by members of their family.

Annually, the Department requests funding for reserved capacity and emergency enrollments. The Departments forecasts the FY 2025-26 appropriation providing funding for 510 enrollments, including 54 transitions from institutions, 266 emergency enrollments, 12 foster care transitions, and 179 youth transitions. The Department is requesting funding for 372 additional reserve and enrollment spots in FY 2025-26, including 39 transitions from institutions, 194 emergency enrollments, 8 foster care transitions, and 131 youth transitions.

The estimated FY 2026-27 full program equivalent served in the Adult Comprehensive waiver is 9,336 members. The forecast anticipates this caseload will cost of $107,164 per FPE, totaling $1.0 billion total funds. This reflects an increase of $82.1 million total funds, including an increase of $41.1 million General Fund.

Comprehensive Waiver Waitlist

Individuals are placed on waiting lists when enrollments meet the limit of a federally-approved waiver application or when additional enrollments would exceed the General Fund appropriation for a given program. The waitlist includes four timelines:

- As soon as available (ASAA) – The individual has requested enrollment as soon as available;
- Date specific – The individual does not need services at this time but has requested enrollment at a specific future date, including those who have not yet reached the age of 18.
- Safety net – The individual does not need or want services at this time, but requests to be on the waiting list in case a need arises at a later time, including those who have not yet reached the age of 18; and
- Internal Management – Individuals who have indicated interest in SLS waiver services and are in the enrollment process.

Most individuals who are waiting for enrollment into the DD waiver as soon as available are receiving other services while they wait. The Department reports that 90.0 percent of members waiting on the ASAA waitlist are receiving Medicaid services and 79.0 percent are receiving other HCBS waiver services.

Waiver Enrollments and Expenditures

Although the Department utilizes the average full program equivalent as the basis for annual caseload forecasts, the number of individuals served through each waiver can be communicated in three ways:

- Maximum enrollment represents the allowable number of individuals that can be served in a given year.
- Average monthly enrollment represents an average of the actual number of individuals enrolled in each waiver during a 12-month period.
- Full program equivalent represents the number of clients with a paid claim in a given year. The average monthly FPE is determined by multiplying the average monthly enrollment for a 12- month period by the FPE conversion factor of 80.0 percent (because not every client who is authorized to receive services has a paid service each month).

Appropriations to line items that funds waiver services and targeted case management for individuals with intellectual and developmental disabilities are based on prior year utilization and expenditures. The Department performs forecast analyses throughout the fiscal year and uses the information to request adjustments to the appropriations for the current fiscal year and for the upcoming fiscal year. If necessary, current fiscal year adjustments are made to the appropriation through the Department's supplemental bill based on the November forecast, and through a Long Bill add-on based on the February forecast. Appropriations for the upcoming fiscal year are based on the February caseload forecast provided by the Department. Appropriations reflect the current cost per FPE and are based on current spending trends in the waiver programs.

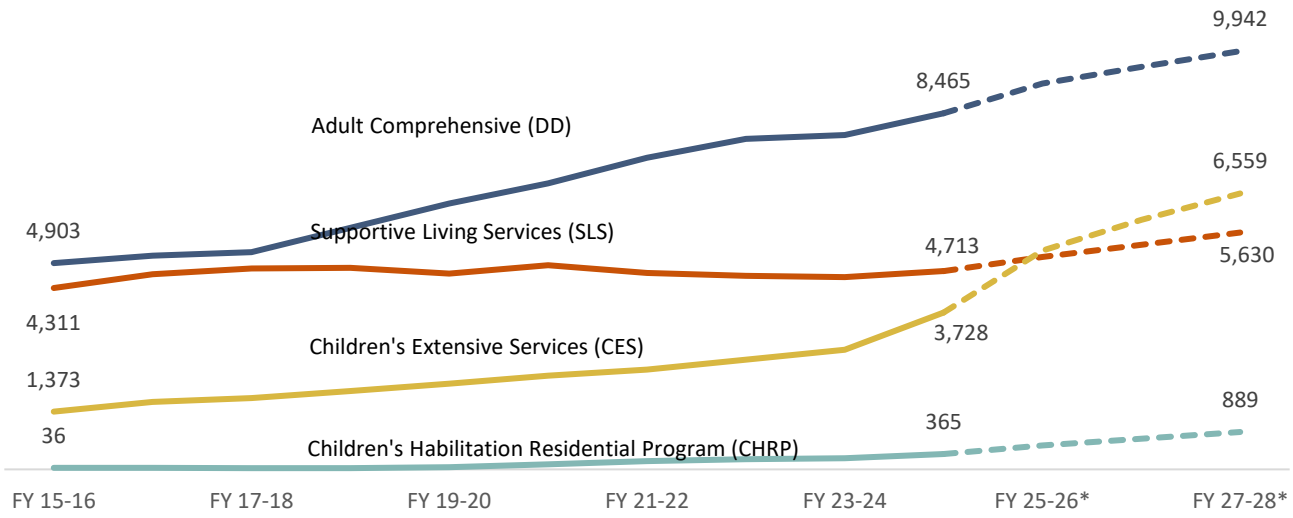
The Department requests a FY 2026-27 total appropriation of $1.3 billion, including $657.8 million General Fund, based on forecasted caseload for the four IDD waiver programs.

- Adult Comprehensive Services (DD) – $1.0 billion total funds, including $511.2 million General Fund, to support an estimated 9,336 FPE;
- Adult Supported Living Services (SLS) – $98.8 million total funds, including $38.1 million General Fund, to support an estimated 4,575 FPE;
- Children's Extensive Support Services (CES) – $169.4 million total funds, including $84.7 million General Fund, to support an estimated 5,078 FPE; and

- Children's Habilitation Residential Program (CHRP) – $50.5 million total funds, including $25.3 million General Fund, to support an estimated 550 FPE.

Average monthly enrollment for each category of waiver service has grown over the last decade. The Children's Habilitation Residential Program average monthly enrollment has grown at the fastest annual rate (26.1 percent), while Adult Comprehensive Services average monthly enrollment has grown the most in volume (3,562). Average monthly enrollment is a metric used by the Department in assessing and calculating the funding needs. The Department is forecasting substantial growth in caseloads for both the CES and CHRP waivers through the next three fiscal years. Average monthly enrollment for CHRP is anticipated to grow by 24.9 precent and for CES by 15.2 percent. This equates to 365 CHRP enrollments and 3,728 CES enrollments over FY 2024-25 levels.

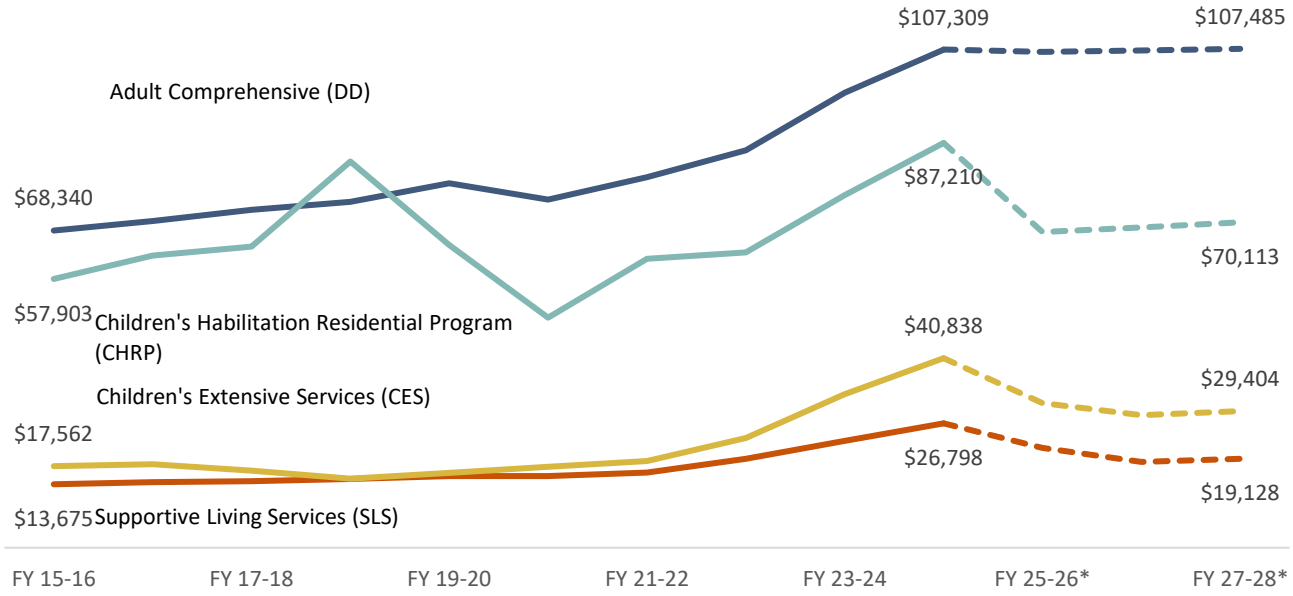
The average monthly enrollment for each services category has grown over the last decade, with Adult Comprehensive waiver enrollment growing the most in aboslute terms.



The average monthly enrollment is adjusted for the lag between enrollment and delivery of services and the lag between delivery of services and billing of claims. Adjusting for these factors converts the average monthly enrollment into the full program equivalent metric. In addition to the variables discussed above, the Department accounts for cost shifts related to changes in the State Medicaid Plan and movement of individuals from one waiver to another when forecasting costs for services.

The cost per FPE has increased for all waiver services in the last decade. The Children's Extensive Support Services cost per FPE has grown at the fastest annual rate (8.8 percent), while Adult Comprehensive Services cost per FPE has increase the most ($29,307). Costs per FPE have grown steadily over the last decade, with the exception of the CHRP waiver that shows a peak and trough from FY 2018-19 to FY 2020-21. The spike is a result of relatively flat caseload and increased expenditures in FY 2018-19, followed by substantial caseload growth by moderate expenditure growth through FY 2020-21. Beginning in FY 2021-22, the CHRP waiver has experienced growth in both caseload and expenditures, mirroring the trends in the three other waivers.

Expenditures per full program equivalent have increased for each services category over the last decade, with Adult Comprehensive waiver costs growing the most in dollar amount.



The Department is forecasting a reversal in the expenditures per FPE trends for the CHRP, CES, and SLS waivers over the next three fiscal years. For the CES and SLS waivers, this is mostly due to the implementation of Community First Choice that moves some services provided by the waivers onto the State Plan to receive a more favorable federal match rate. The reversal in the CHRP expenditures per FPE trend is largely due to the Department implementing a soft cap of 2,080 units for community connector services in FY 2025-26.

R7 Eligibility administration

This issue brief discusses the Department's proposal to centralize some administrative services for eligibility determinations for medical and public assistance programs that are currently provided by counties.

Summary

- The Departments of Health Care Policy and Financing and Human Services propose to centralize four medical and public assistance administrative functions through contracts with high-performing counties: call center support, document management, quality assurance for Medicaid programs, and fraud investigations for Medicaid programs. The Department anticipates that the centralization of these services will be fully implemented beginning July 1, 2028.
- The proposal seeks to address increasing cost pressures on administrative, eligibility, and enrollment activities associated with medical and public assistance programs, as well as recent federal policy changes that increase administrative burdens on counties and the risk of severe financial penalties to the State.
- In FY 2026-27, a total of $19.1 million is requested, including $2.7 million General Fund. The appropriations increase to $48.8 million total funds, including $7.8 million General Fund, in FY 2027-28, before decreasing slightly to $45.6 million total funds in FY 2028-29. On going costs for this proposal is $45.0 million total funds, including $7.2 million General Fund.

Discussion

Colorado operates a state-supervised, county-administered system for the administration of medical and public assistance programs. Counties are responsible for all administrative, eligibility, and enrollment activities; however, the State is accountable to the federal government for meeting performance standards. The variability of county resources throughout the state (e.g., revenue, staffing, training, etc.) can create inequities for recipients of medical and public assistance and hinder the ability of counties and the State in meeting federal standards. The passage of federal H.R. 1 creates additional federal requirements and monetary penalties. New and increase work requirements for recipients, twice yearly renewals, and an increased federal focus on fraud, waste, and abuse place added burdens on counties. Counties have long argued that state funding levels are insufficient to meet their administrative needs.

The Department of Health Care Policy and Financing (HCPF), in collaboration with the Department of Human Services (DHS), is proposing the centralization of four administrative services for statewide medical and public assistance programs: call center support, document management, quality assurance for Medicaid programs, and fraud investigations for Medicaid programs. To accomplish this centralization, the departments propose contracting with high-performing counties who will provide these services statewide. The departments argue that centralizing specific services will provide operational efficiencies and assist in addressing federal policy changes to medical and public assistance programs.

Each centralized service will be managed through a separate contract. Each contract will be with a single county, with up to four counties being the primary service provider. The contracts would begin in FY 2026-27 with centralization of services being fully implemented by July 1, 2028. Appropriations for these contracts are

requested in both HCPF and DHS. To offset some of the impact of this request, HCPF is requesting reductions to the County Incentive Program, the Colorado Medical Assistance Program, and Eligibility Assistance Partner site.

In FY 2026-27, a total of $19.1 million is requested, including $2.7 million General Fund. The appropriations increase to $48.8 million total funds, including $7.8 million General Fund, in FY 2027-28, before decreasing slightly to $45.6 million total funds in FY 2028-29. On going costs for this proposal is $45.0 million total funds, including $7.2 million General Fund.

Total Cost for Centralized Services (HCPF and DHS)

Fiscal year	Total Funds	General Fund	Cash Funds	Reappropriated Funds	Federal Funds	FTE
2025-26	$636,866	$206,979	$111,452	$0	$318,435	1.0
2026-27	19,082,151	2,652,893	1,665,904	2,455,447	12,307,907	3.0
2027-28	48,785,219	7,775,256	4,125,759	7,950,874	28,933,330	3.0
2028-29	45,616,277	7,376,217	3,808,837	7,588,527	26,842,696	3.0
2029-30 and ongoing	45,023,999	7,183,727	3,705,188	7,588,527	26,546,557	3.0
5-year total cost	$159,144,512	$25,195,072	$13,417,140	$25,583,375	$94,948,925	n/a

HCPF requests additional staffing resources to manage and oversee these contracts.

HCPF Staffing for Contract Administration

Cost element	FY 2025-26	FY 2026-27	FY 2027-28 and ongoing
Personal Services	$103,521	$315,939	$315,939
Employee benefits	24,351	77,847	82,692
Operating costs	26,400	16,155	16,155
Total	$154,272	$409,941	$414,786
FTE	1.0	3.0	3.0

Four services proposed to be centralized

Statewide call center shared by HCPF and DHS

The Department proposes creating a two-tiered statewide call center system to replace the county-by-county call response system currently in place. Currently, there are 11 counties that have their own call centers that field eligibility-related calls. The remaining counties use less formal response systems. The first tier of the proposal is a statewide call center that would take all eligibility calls for all programs managed through the Colorado Benefits Management System (CBMS). Calls would be initially answered by an automated interactive voice response system. If this system does not address the caller's issue, then the call is forwarded to the call center staff. The staff would then attempt to address the reason for the call by accessing the individuals case information in CBMS. An unsuccessful attempt by the statewide call center staff would prompt the call to be forwarded again, this time to the relevant county call center. The county-level call centers are considered the second tier of the system; counties would be required to staff and maintain their own call center.

Statewide Call Center Costs (HCPF and DHS)

Fiscal year	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
2025-26	$51,424	$16,713	$8,999	$0	$25,712	0.3

Fiscal year	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
2026-27	13,032,793	2,576,660	886,839	2,085,608	7,483,685	1.0
2027-28	41,168,259	9,078,572	2,652,752	6,829,162	22,607,773	1.0
2028-29	39,467,537	9,070,337	2,546,018	6,542,409	21,308,773	1.0
2029-30 and ongoing	39,467,537	9,070,337	2,546,018	6,542,409	21,308,773	1.0
5-year total cost	$133,187,550	$29,795,906	$8,631,627	$21,999,588	$72,709,004	n/a

The statewide call center would be managed by a county under contract with HCPF. The request asks for funding for 251 call center agents, 40 supervisors and managers, four call center systems managers, and systems access licenses. The contracted county would be responsible for the daily operations of the statewide call center, while the Department supervised. The Department requests 1.0 FTE, starting in FY 2025-26, to act as the contract administrator and operations supervisor. The Department assumes the statewide call center will be able to address the majority of calls, thereby reducing call volumes handled by individual counties.

Document management share by HCPF and DHS

The Department propose centralizing document scanning, indexing, and character recognition work for all counties. The centralization would apply to all documents except those submitted through PEAK, the state's online application system, and those physically dropped off at county offices. This is work currently being done by each county, with varying accuracy and completion rates owing to resource constraints. The Department estimates that 12,00 pages will be scanned and indexed daily. Scanned documents will be reviewed for readability and attached to the correct case file. The request assumes that the Unified County System, which is a statewide document and workload management system, is implemented and available at the time the centralized document management service is stood up.

Document Management Costs (HCPF and DHS)

Fiscal year	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
2025-26	$0	$0	$0	$0	$0	0.0
2026-27	1,622,094	346,520	100,162	369,839	805,573	0.0
2027-28	4,748,163	1,159,033	264,104	1,121,712	2,203,314	0.0
2028-29	4,299,810	1,102,800	227,923	1,046,118	1,922,969	0.0
2029-30 and ongoing	4,299,810	1,102,800	227,923	1,046,118	1,922,969	0.0
5-year total cost	$14,969,877	$3,711,153	$820,112	$3,583,787	$6,854,825	n/a

The contract funding for the centralized document management services supports 51 staff, software and systems licenses, and the purchase and maintenance of scanning equipment. Staffing is a mix of scanning technicians, quality assurance and supervising staff, and systems maintenance personnel. The contract would be awarded to a county and supervised by HCPF.

Medicaid quality assurance

The Department proposes centralizing quality assurance activities related to Medicaid programs only. Counties are currently mandated by the state to perform quality assurance reviews, but are allowed to use their own resources and technological solutions in conducting those reviews. There is a wide variance between counties in the availability of resources and technology used. Creating a shared service would consolidate quality assurance resources and standardize the systems and technology used.

The Department argues that centralizing quality assurance activities will better position the state to meet federal Payment Error Rate Measurement (PERM) standards. The federal government audits Medicaid programs and Child Health Plan Plus (CHP+) to examine eligibility decisions and payments to providers for accuracy. The federal PERM standard is a 3.0 percent error rate, non-compliance risks a loss of an estimated $186.0 million in federal funds.

Medicaid Quality Assurance Costs (HCPF only)

Fiscal year	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
2025-26	$95,296	$30,970	$16,677	$0	$47,649	0.3
2026-27	1,502,706	476,881	239,973	0	785,851	1.0
2027-28	3,961,808	1,304,249	649,673	0	2,007,886	1.0
2028-29	3,801,461	1,250,968	623,289	0	1,927,204	1.0
2029-30 and ongoing	3,801,461	1,250,968	623,289	0	1,927,204	1.0
5-year total cost	$13,162,732	$4,283,066	$2,136,224	$0	$6,648,145	n/a

Contract funding will support 20 quality assurance reviewers, 13 supervisors and managers, and contract software systems supports. The Department anticipates that centralizing quality assurance work will allow for 12,000 case reviews per year, a ten-fold increase from existing reviews. The software system used for quality assurance is the same used for fraud investigations, so the department assumes that the contract systems support will be shared, too. The Department requests 1.0 FTE, starting in FY 2025-26, to act as the contract administrator and operations supervisor.

Medicaid fraud investigations

The Department proposes centralizing fraud investigations to address variances across the state. Fraud investigations are a voluntary activity that most counties do not engage in. The Department reports that in FY 2023-24, fewer than 20 counties had active fraud investigations. The low rate of investigations is attributed to the appropriations structure for county administration, without a dedicated fraud investigation appropriation counties are required to make a priority decision between eligibility processing or fraud investigation.

The state has a policy that attempts to incentive counties to conduct fraud investigations. If a county recoups money from an individual that received benefits through fraudulent activities, those funds are repaid to the federal and state governments. Currently, counties are able to retain the State's portion of those recoupments to defray the cost of those investigations. This inventive structure has not appreciably increased the number of fraud investigations across the state. If the Department's request to centralize investigations is approved, this incentive will end and the state's portion of fraud recoupments will contribute to the funding of this centralized service.

Medicaid Fraud Investigations Costs (HCPF only)

Fiscal year	Total Funds	General Fund	Cash Funds	Reapprop Funds	Federal Funds	FTE
2025-26	$95,296	$30,970	$16,677	$0	$47,649	0.3
2026-27	4,438,382	867,853	435,130	0	3,135,398	1.0
2027-28	6,274,734	2,072,807	1,030,258	0	3,171,669	1.0
2028-29	6,007,489	1,984,006	986,283	0	3,037,200	1.0
2029-30 and ongoing	6,007,489	1,984,006	986,283	0	3,037,200	1.0
5-year total cost	$22,823,390	$6,908,672	$3,437,954	$0	$12,381,467	n/a

The request assumes funding for 40 investigators, 11 supervisors and managers, and four judicial liaisons and trainers. The Department also assumes that this contract will split the cost of contract software systems supports with the quality assurance contract. Additionally, the funding requests includes resources for an additional 16,870 pool hours for CBMS development to update the system to centralize fraud referrals, recoupments, and tax intercepts.

Reductions to offset centralization costs

County Incentive Program

The Department's County Incentive Program uses performance-based contracts with counties to improve performance. Counties that meet their performance metrics receive money to offset their local share of administrative costs. The program is supported exclusively by the General Fund and was established in FY 2014-15 with an appropriation of $5.7 million. In FY 2022-23, the appropriation for this program increased to $8.2 million. The Department proposes reducing incentive program funding by $2.0 million in FY 2026-27 and by $6.2 million in FY 2027-28 and ongoing.

Colorado Medical Assistance Program

The Colorado Medical Assistance Program operates a call center that supports members of the CHP+ program. The Department's propose to create a statewide call center system creates a redundancy in these efforts. The request seeks a 10.0 percent reduction to the Program's funding, which is funded with hospital provider fees and federal funds, to address this redundancy. The FY 2026-27 reduction is $0.2 million total funds, increasing to a reduction of $0.8 million in FY 2027-28 and ongoing.

Eligibility Application Partner Sites

Eligibility Application Partner (EAP) sites can assist an individual in completing an application for medical assistance. Counties become response for ongoing case maintenance once those applications are approved and the individual becomes a member. The support services provided by EAP sites is not required by federal regulations. The General Assembly appropriates hospital provider fees, with matching federal funds, to the Department to support the EAP sites. However, not all sites are funded, with some receiving reimbursements while others do not. The request seeks a reduction of $0.5 million total funds in FY 2026-27, increasing to a reduction of $1.5 million total funds in FY 2027-28 and ongoing.

Footnotes and Requests for Information

Update on Long Bill Footnotes

The General Assembly includes footnotes in the Long Bill to:

1. set forth purposes, conditions, or limitations;
2. explain assumptions; or
3. express legislative intent.

This section discusses a subset of the footnotes relevant to the divisions covered in the briefing. For a full list of footnotes, see the end of each departmental section of the 2026 Long Bill (https://leg.colorado.gov/bills/sb25-206)

20 Department of Local Affairs, Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, Medicaid Programs -- It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for Medicaid Programs.

Comment: This footnote provides flexibility for the Department to move money between line items within the Office of Community Living. The Department is in compliance with the footnote.

21 Department of Local Affairs, Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, State-only Programs -- It is the General Assembly's intent that expenditures for these services be recorded only against the Long Bill group total for State-only Programs.

Comment: This footnote provides flexibility for the Department to move money between line items within the Office of Community Living. The Department is in compliance with the footnote.

22 Department of Local Affairs, Health Care Policy and Financing, Office of Community Living, Division of Intellectual and Developmental Disabilities, State-only Programs, Preventive Dental Hygiene -- It is the General Assembly's intent that this appropriation be used to provide special dental services for persons with intellectual and developmental disabilities.

Comment: This footnote was first added to the FY 2022-23 Long Bill, and reflects the legislative intent that funds appropriated in this line be used for a specific purpose. The Department is in compliance with the footnote.

Update on Requests for Information

The Joint Budget Committee may submit requests for information (RFIs) to departments. The Joint Budget Committee must prioritize the requests per Section 2-3-203 (3), C.R.S.

This section discusses a subset of the RFIs relevant to the divisions covered in the briefing. For a full list of RFIs, see the letters requesting information (https://leg.colorado.gov/sites/default/files/rfi_fy_2025-26.pdf).

Requests Affecting Multiple Departments

None.

Department of Health Care Policy and Financing, Office of Community Living Requests

None.

Department Annual Performance Report

Departments must publish an **Annual Performance Report**[3] for the *previous state fiscal year* by November 1 of each year. This report summarizes the Department's performance plan and most recent performance evaluation. In addition, departments develop and submit a **Performance Plan**[4] for the *current fiscal year* to the Joint Budget Committee and the relevant Joint Committee of Reference by July 1 of each year.

Per statute[5], the Joint Budget Committee must consider performance plans submitted by departments and may prioritize budget requests intended to enhance productivity, improve efficiency, reduce costs, and eliminate waste. To find the performance plans, search the Office of State Planning and Budgeting website and select the performance plan (www.colorado.gov/pacific/performancemanagement/department-performance-plans).

[3] Section 2-7-205, C.R.S.
[4] Section 2-7-204 (3)(a), C.R.S.
[5] Section 2-7-204 (6), C.R.S.

Appendix A: Numbers Pages

Appendix A details the actual expenditures for the last two state fiscal years, the appropriation for the current fiscal year, and the requested appropriation for next fiscal year. Appendix A organizes this information by line item and fund source.