



Eligibility for Medicaid Long-Term Services & Supports

September 2026

At a glance: An individual generally must meet three requirements to receive Medicaid Long-Term Services and Supports (LTSS): financial eligibility, the required level of care, and the criteria for the specific program. *Meeting one requirement alone does not automatically mean an individual can enroll in a program.*

Three eligibility requirements

Financial eligibility

Does the individual meet the Medicaid financial eligibility rules for the program?

LTSS programs have special income and asset requirements.

Level of care

Does the individual have the level of need, not just a disability, required of the program?

Level of care measures how much help a person needs with daily activities, health-related tasks, supervision, and other supports. For many LTSS programs, the person must have needs significant enough that they could otherwise require care in an institution

Targeting criteria

Does the individual meet the requirements for the specific program?

These may include age, diagnosis, disability type, specific support needs, or other program requirements.

How eligibility is determined

County/eligibility site

Determines Medicaid financial eligibility and, when needed, verifies disability.

Case Management Agency

Completes the functional level of care assessment, confirms waiver targeting criteria, and develops the service plan.

Program-specific review

Some programs have additional enrollment requirements

Program for All Inclusive Care for the Elderly (PACE) organizations determine whether an individual can safely enroll in PACE. Waiver capacity or waitlist rules also affect enrollment for waivers.

Medicaid Buy-In allows individuals with higher incomes/assets to access Medicaid & some LTSS.

How the major programs differ

Program	Financial eligibility	Level of care	Targeting criteria	Key distinctions
Home & Community Based Services (HCBS) waivers	Income below 300% of Social Security (SSI) Federal Benefit Rate (FBR); countable resources below \$2,000 for one person or \$3,000 for a couple.	Must meet the institutional level of care specified for the waiver.	Must meet the waiver's age, diagnosis/disability, & functional or support-need criteria.	Adds targeted services to Medicaid so an individual can be served in the community. An individual can only enroll in one waiver at a time.
Community First Choice (CFC)	Must be financially eligible for Medicaid through any path. CFC is not a separate Medicaid eligibility group.	Hospital, nursing facility, Intermediate Care Facility (ICF/IID), or inpatient psychiatric facility for individuals under 21.	All ages: must have an assessed need for at least one CFC service.	State Plan benefit available statewide; may be used with a waiver when services are not duplicated.
Program for All Inclusive Care for the Elderly (PACE)	Income below 300% of SSI FBR; countable resources below \$2,000 for one person or \$3,000 for a couple.	Must meet nursing facility level of care.	Age 55+; live in a PACE service area; able to live safely in the community; meet PACE organization criteria.	Integrated Medicare & Medicaid medical and LTSS benefit delivered through the PACE organization.
Nursing Facilities	Income below 300% of SSI FBR; countable resources below \$2,000 for one person or \$3,000 for a couple.	Must meet nursing facility level of care.	No targeting criteria. Admission is based on medical/functional need & facility admission requirements.	Institutional Medicaid benefit providing 24-hour nursing facility services.

Important: Buy-In may establish Medicaid eligibility, but an individual seeking waiver or CFC services must separately meet the applicable level-of-care and targeting requirements.

HCBS waiver level of care and targeting criteria overview

Waiver	Age	Primary targeting criteria	Required level of care
Brain Injury (BI)	16+	Brain injury meeting specified diagnostic criteria.	Hospital or nursing facility
Community Mental Health Supports (CMHS)	18+	Major mental illness and need for a community alternative to nursing facility care.	Nursing facility
Complementary & Integrative Health (CIH)	18+	Qualifying spinal cord or neurologic condition with inability to walk independently.	Hospital or nursing facility
Developmental Disabilities (DD)	18+	I/DD determination and need for 24-hour services and supports.	ICF/IID
Elderly, Blind & Disabled (EBD)	18+	Age 65+ with functional impairment; or age 18-64 and blind/physically disabled; or age 18+ with HIV/AIDS.	Nursing facility
Supported Living Services (SLS)	18+	I/DD determination; can live independently with limited supports or receives extensive support from other sources.	ICF/IID
Children's Extensive Support (CES)	Under 18	I/DD, or developmental delay before age 5, determination; intensive behavioral or medical support needs requiring frequent direct physical intervention verified by a third-party.	ICF/IID
Children's Habilitation Residential Program (CHRP)	Under 21	I/DD determination or serious emotional disturbance* and at risk of out-of-home placement; residential habilitation need.	ICF/IID or inpatient psychiatric facility (under 21), as applicable
Children with Complex Health Needs (CwCHN)	Under 19	Life-limiting illness or complex health needs*; meets qualifying medical and program criteria.	Hospital or nursing facility

*Requires attestation by a treating licensed medical professional.

Developmental Disabilities (DD) Waiver

Background

Colorado's DD waiver is the state's only HCBS waiver with a waitlist. Unlike most Medicaid benefits, federal rules allow states to limit the number of people enrolled in an HCBS waiver. Colorado funds a specific number of DD waiver enrollment slots. When all funded slots are filled, eligible individuals may have to wait for an opening.

Average time on the waitlist

On average, individuals currently wait seven years on the HCBS-DD waiver waitlist before receiving an enrollment authorization.

Accessing services

90% of individuals on the DD waitlist receive Colorado Medicaid services, and 79% are receiving other HCBS waiver services — including Supported Living Services (SLS), Elderly, Blind, Disabled (EBD), and Community First Choice (CFC).

Currently, there are two mechanisms for members to gain access to the HCBS-DD waiver:

Waitlist enrollment when a slot becomes available

When a member leaves the DD waiver, routine “next-by-date” enrollments (churn) are made available. Once two ‘slots’ become available, the next individual on the statewide waitlist is authorized based on their placement date.

Reserved capacity enrollment

Some enrollment slots are reserved for specific circumstances and do not follow the standard waitlist order. Reserved Capacity is currently limited to three defined circumstances:

Emergency: The individual meets DD waiver criteria and is experiencing an emergency that threatens health or safety, such as imminent homelessness, abuse or neglect, danger to self or others, or loss or incapacitation of a primary caregiver. The situation also cannot be resolved with any other supports.

Youth Transition: The individual meets DD criteria and is aging out of the Children's Habilitation Residential Program Waiver (CHRP), Children's Extensive Support Waiver (CES), or child welfare. **As of January 1, 2027, this would be limited to children in child welfare who meet DD waiver eligibility.**

Deinstitutionalization: The individual meets DD criteria, is leaving a skilled nursing facility, mental health institute, Intermediate Care Facility, or Regional Center, and needs DD waiver services to support a safe return to the community.

Enrollments off of the Waiting List FY 2022-2023 through FY 2025-2026

Year	FY 2022-2023	FY 2023-2024	FY 2024-2025	FY 2025-2026
Churn	279	372	254	264
Emergency	182	182	164	95
Youth Transition	102	103	116	233
Deinstitutional	20	21	33	25
Total	583	678	567	617

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Case Management for Long Term Services and Supports (LTSS) Members

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At a glance: Case Management Agencies (CMAs) are a critical part of Colorado's LTSS system. They assess functional eligibility, help members develop person-centered support plans, authorize services consistent with assessed need and program requirements, connect members with providers, and monitor services over time. Medicaid financial eligibility is determined separately.

Overview

CMAs are the primary point of contact for Coloradans seeking or receiving LTSS, including Home and Community-Based Services (HCBS).

Their responsibilities include intake, determining functional eligibility, developing a person-centered support plan, helping members arrange services and connect with providers, monitoring members' services and needs, conducting annual reassessments (Continued Stay Review or CSR), and assisting when services are needed, change, or end.

For members receiving HCBS, the CMA is an ongoing point of contact that helps ensure the member receives services appropriate to their needs and that their services continue to meet program requirements.

CMAs bid on regional contracts and can be private organizations or county social/human services agencies.

Case Management Redesign

Federal Medicaid rules require states to ensure conflict-free case management for individuals receiving Home and Community-Based Services (HCBS). Colorado implemented Case Management Redesign (CMRD) to meet these federal requirements and create a case management system that separates case management responsibilities from the provision of HCBS services.

Before CMRD, Colorado's case management system was organized around specific populations and waiver programs. Different CMAs served different groups of members,

meaning a member could need to change agencies if their needs or waiver enrollment changed.

Through CMRD, Colorado moved to a geographic model in which one CMA serves as the case management entry point for LTSS programs within a designated service area. This created a more consistent point of entry across populations and programs while establishing the conflict-free case management structure required by the federal government.

Case Management Agencies by county

The following CMAs currently serve Colorado's 64 counties:

Case Management Agency	Counties Served
A&I Avenues	Boulder, Broomfield, Gilpin
Community Connections	Archuleta, Dolores, La Plata, Montezuma, San Juan
Developmental Pathways	Arapahoe, Douglas, Elbert
Foothills Gateway	Larimer
Garfield County Human Services	Eagle, Garfield, Pitkin, Summit
Jefferson County Department of Human Services	Clear Creek, Jefferson
Las Animas County Department of Human Services	Huerfano, Las Animas
Montrose County Human Services	Montrose, Ouray, San Miguel
Northeastern Colorado Association of Local Governments	Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Yuma
Otero County Department of Human Services	Bent, Crowley, Otero
Prowers County Public Health and Environment	Baca, Kiowa, Prowers
Rocky Mountain Health Plans	Alamosa, Chaffee, Conejos, Costilla, Custer, Delta, Fremont, Grand, Gunnison, Hinsdale, Jackson, Lake, Mesa, Mineral, Moffat, Rio Blanco, Rio Grande, Routt, Saguache

Rocky Mountain Human Services	Adams, Denver
The Resource Exchange	El Paso, Park, Pueblo, Teller
Weld County Case Management Agency	Weld

Role of the Case Manager

Case managers work with members to develop individualized plans while also ensuring that eligibility, service authorization, and service delivery comply with Medicaid requirements.

Assessment and eligibility

When an individual seeks HCBS, the case manager conducts the required assessment to determine whether the individual meets the applicable functional Level of Care requirements. The CMA also determines or documents applicable targeting criteria for the waiver or program. Financial eligibility is a separate component of Medicaid eligibility and is determined through the county eligibility system.

The Level of Care assessment examines whether the individual has the level of functional need required to qualify for LTSS and without these home and community-based services would require nursing facility or institutional level of care. HCBS waivers also have specific eligibility and targeting requirements that must be met for enrollment.

Developing the Person-Centered Support Plan- Service Authorization

Once eligibility and assessed needs are identified, the case manager works with the member and anyone the member chooses to involve to develop a Person-Centered Support Plan.

This plan reflects the member's goals, strengths, preferences, and assessed needs. The case manager uses the assessment and applicable Medicaid program requirements to determine which services are appropriate and the amount, frequency, and duration of services to be authorized. The plan also identifies how those services and other supports will work together to help the member live as independently as possible in the setting of their choice.

Case managers help members identify qualified providers to deliver authorized services, but their role is also to ensure that services included in the plan are supported by assessed need and meet Medicaid program requirements.

Ongoing monitoring and assistance

Case management continues after services are authorized. Case managers maintain regular contact with members to monitor their health and safety, confirm that authorized services are being delivered, and assess whether services continue to meet their needs.

Case managers also help address problems accessing authorized services, coordinate with providers, family members, and other supports as appropriate, and connect members with additional providers or community resources when needed. When a member's needs or circumstances change, the case manager reassesses the situation and updates the Person-Centered Support Plan and service authorizations as appropriate.

Annual Reassessment

At least annually, the case manager reassesses the member's functional eligibility and needs through a Continued Stay Review. The reassessment determines whether the member continues to meet the required Level of Care and whether changes to the member's Person-Centered Support Plan or authorized services are needed.

A reassessment may also occur before the annual review when there is a significant change in the member's needs or circumstances.

Case Management Payment Structure

CMAs are paid through three primary funding mechanisms. The funding source depends on the type of case management activity performed and the program the member receives.

CMA Contract	State Plan Targeted Case Management (TCM)	State General Fund (SGF) Case Management
Pays CMAs for specific activities related to LTSS eligibility and program administration. These include developmental disability determinations, Level of Care assessments, critical incident activities, waitlist management, and appeals. CMAs also conduct Level of Care assessments for Nursing Facilities, PACE, and Hospital Back-Up programs.	Pays CMAs for ongoing case management for members receiving HCBS waivers and CFC. Activities include service planning and coordination, developing and updating Person-Centered Support Plans, facilitating enrollment, and monitoring services.	Funds ongoing case management for the Family Support Services Program (FSSP) and State Supported Living Services (State SLS), which are supported with State General Fund rather than Medicaid funding. Case management activities are similar to those provided through TCM.

HCPF establishes reimbursement rates for required case management activities. CMAs are paid when an allowable activity is completed and documented in accordance with program requirements. Rates are intended to cover the costs of performing those activities, including

associated administrative and operational costs. CMAs do not receive a separate administrative or “overhead” payment.

The current rates were developed in 2023 using a time study, information from case management agencies, and relevant wage and labor data. Targeted Case Management rates are reviewed every three years through the Medicaid Provider Rate Review Advisory Committee (MPRRAC).

FY 2025-26 Case management payments and members served

In FY 2025-26, CMAs received approximately \$161.2 million across the three funding mechanisms:

Targeted Case Management	CMA Contract	State SLS & FSSP Case Management
\$124,668,457	\$32,024,976	\$4,496,714

During the same year, CMAs served 96,259* LTSS members:

Total LTSS Members Served	HCBS Waivers & CFC	CFC Only	Institutional Settings	PACE	State SLS & FSSP
96,259	68,403	2,715	13,297	5,815	6,029

*Count includes the total individuals that had LTSS at one point during the year (distinct counts); does not include members receiving only Long-Term Home Health and/or Private Duty Nursing

Case Management Performance

CMAs are contracted entities responsible for meeting state and federal requirements. Because CMAs also receive federal funding as subrecipients, HCPF has additional financial oversight responsibilities under federal Uniform Guidance (2 CFR Part 200).

Fiscal oversight

HCPF monitors CMA financial performance to ensure public funds are appropriately used and CMAs are paid only for allowable, completed, and documented activities. Oversight includes annual risk assessments, financial and programmatic monitoring, review of audits and financial statements, payment verification, and corrective action when requirements are not met.

HCPF uses annual risk assessments to identify CMAs that may require additional oversight, including more detailed or on-site financial reviews. These reviews evaluate whether funds

are appropriately accounted for, expenditures are properly reported, and costs are reasonable, necessary, allowable, and supported by documentation. When concerns are identified, HCPF issues findings and requires corrective action and follow-up as appropriate.

HCPF also monitors CMA payments and expenditures throughout the year. This includes quarterly payment reviews, post-payment verification, and monthly monitoring of enrollment and Targeted Case Management expenditures to identify unusual trends or outliers that may require additional review.

Quality and performance management

HCPF is responsible for overseeing the quality and performance of CMAs and ensuring they meet state and federal requirements for HCBS, including requirements under 42 CFR 441.302, 441.311, and 441.312.

HCPF monitors CMA performance throughout the year using established quality measures, performance data, targeted reviews, and holding regular meetings. In addition, every CMA receives an annual review of agency-wide practices and a representative sample of member files for individuals receiving HCBS waivers and Community First Choice (CFC). These reviews assess whether CMAs are meeting requirements related to eligibility, service planning and authorization, monitoring, member health and safety, and other case management responsibilities.

When performance concerns are identified, HCPF requires CMAs to address them and monitors progress toward improvement. Depending on the nature and severity of the concern, HCPF may provide performance coaching, issue a formal decision letter, require a corrective action plan, or take additional contractual action. Continued or significant noncompliance may ultimately result in termination of the CMA contract.

Assessment Tools

Assessment tools are a critical part of Colorado's LTSS system. They are used to determine whether a member meets functional Level of Care requirements, assess the type and level of support a member needs, and inform development of the member's Person-Centered Support Plan.

Because LTSS programs serve different populations and have different eligibility and service requirements, Colorado currently uses several assessment tools. HCPF has been working toward a more standardized approach through development of the Colorado Single Assessment (CSA).

The Commission specifically requested additional information about two assessment efforts: the Skilled Care Acuity Tool developed for use with the Nurse Assessor Program and the Colorado Single Assessment.

The Nurse Assessor Program

In 2022, HCPF contracted with the University of Massachusetts for Health Consulting (UMass) to develop Colorado's Skilled Care Acuity assessment. UMass was selected because of their skilled faculty and researchers with significant experience in developing and testing the reliability and validity of measurement scales.

The tool was developed as a clinically reliable and validated assessment of skilled care services. Historically, there had been an acuity assessment for pediatric members for Long-Term Home Health (LTHH), but not a similar assessment for adult members seeking care. The assessment includes Long-Term Home Health-Certified Nursing Assistant (LTHH-CNA), Long-Term Home Health-Registered Nurse (LTHH-RN), and Private Duty Nursing (PDN) components. Health Maintenance Activities (HMA) tasks can be identified through the completion of the Acuity Tool.

A Nurse Assessor program was developed to complete the independent clinical assessment to help members and Families better understand all of the skilled services for which they were eligible and to support informed care planning. The Nurse Assessor program was not designed as a cost savings initiative. HCPF contracted with Telligen in Spring 2025 to oversee and provide the Nurse Assessors for this purpose. The total contract amount for Telligen for the original five year contract (FY25/26 through FY27/30) was \$37.1M, of which the first fiscal year's contract costs was \$10.9M.

Shortly after implementation, HCPF identified significant operational challenges with the program. Rather than serving as a helpful resource, many members, families, and providers experienced the additional assessment as duplicative and burdensome, without consistently adding value to the care planning process. Based on that early experience, HCPF discontinued the Nurse Assessor program effective December 15, 2025, just a few months after its August 2025 launch. HCPF spent \$1.4M on the contract before its termination.

Though the Nurse Assessor Program was not successful, HCPF remains committed to ensuring members receive appropriate clinical assessments and have access to medically necessary services. With this in mind, HCPF still intends to leverage the skilled care acuity tool in the future. This valid and reliable tool was developed specifically for use within Colorado's program and aligns with the state's policies and rules for skilled nursing services.

Colorado Single Assessment & Person Centered Support Plan

Colorado currently uses multiple assessments to determine eligibility and identify support needs across LTSS programs. In 2016, the General Assembly directed HCPF to develop a standardized assessment to create a more consistent approach across populations and programs.

The Colorado Single Assessment (CSA) and accompanying Person-Centered Support Plan (PCSP) are intended to replace more than 30 existing assessment and planning tools. Together, they are designed to assess functional eligibility and support needs and inform service planning and resource allocation.

HCPF and stakeholders chose to develop an assessment specifically for Colorado rather than adopt an existing national tool because of the differences among Colorado's LTSS programs and the populations they serve. Development has included stakeholder design, testing with members, refinement of the assessment, and significant technology development to integrate the CSA into Colorado's Care and Case Management (CCM) system.

Implementation has taken longer than originally anticipated. Several major changes impacting the LTSS system have affected the timeline, including the COVID-19 pandemic, changes in IT vendors, development and stabilization of the CCM system, Case Management Redesign, among others. HCPF delayed statewide implementation rather than introduce another major operational change before the underlying technology and case management system were ready.

Development timeline

FY 2018-19 through FY 2019-20

HCPF and stakeholders refined the CSA and PCSP and tested them with approximately 650 HCBS members. The COVID-19 pandemic disrupted in-person assessments and affected the pilot and its results.

FY 2020-21 through FY 2023-24

Work shifted from designing the assessment to building it into the new CCM system. Progress was affected by IT vendor changes, system development delays, and the need to stabilize CCM following its 2023 implementation.

FY 2024-25 through FY 2026-27

HCPF continued development of the CSA while prioritizing stabilization of the case management system and other major LTSS changes. During this period, HCPF implemented the Interim Support Level Assessment (ISLA) for adults with intellectual and developmental disabilities. The ISLA uses a subset of CSA questions and serves as an interim step toward the full assessment.

Current status

HCPF is completing the program and technology requirements necessary to integrate the CSA and PCSP into the CCM system. HCPF is also working with stakeholders and CMAs on testing, operational readiness, training, and implementation planning. Statewide implementation is currently planned for FY 2027-28.

External vendor support- CSA and PCSP

HCPF has leveraged external vendors during the development of the CSA and PCSP. The IT vendor, AssureCare, is assisting with integrating and testing the CSA and PCSP into the Care and Case Management (CCM) System. The CCM is the daily work management system that the Case Managers use to support LTSS members.

HCPF has paid and allocated AssureCare for the CSA/PCSP integration and testing:

	CSA and PCSP Related Work	Interim Support Level Assessment & Resource Allocation Related Work
Spent to Date	\$0	\$0
Remaining to Be Paid	\$885,780 (estimated to be paid in FY 2027/2028)	\$335,160 (estimated to be paid in FY 2027/2028)

HCPF is currently working with the two vendors who initially developed the CSA and the resource allocation algorithm (HCBS Strategies and Meyers & Stauffer) to build on the Interim Support Level Assessment and the associated Algorithm. This continues to be an iterative process, in anticipation of the Targeted Soft Launch of the Colorado Single Assessment, where both the assessment and the algorithm will be automated in the CCM system. The ISLA is a subset of the CSA items and thus is a step toward full implementation of the CSA. Additionally, HCPF is in the final stages of design with the IT vendor to develop the automation to transition from what is a manual process with the ISLA to a fully automated process for the CSA and CSA Support Level Algorithm, within the CCM system.

	HCBS Strategies	Optumas/MSLC
Spent to Date (July 2019-June 30, 2026)	\$1,412,752	\$2,047,414
Remaining to Be Paid (July 1, 2026-June 30, 2029)	\$600,000	\$731,000

External vendor support- Care and Case Management System

HCPF has an existing five year contract with AssureCare for ongoing operations, maintenance, and licenses for the CCM. The contract has two extension options for a maximum contract period of 10 years. The total amount not to exceed for the 10 years is \$35.26M. HCPF has significantly underspent in the first two fiscal years of the contract (39% of the total contracted amount over those two years) due to vendor deliverables not being

completed or accepted. Below is the total paid to date and remaining funds available in the contract:

	AssureCare
Paid to Date (FY24/25-September 2026)	\$9,393,621
Remaining (FY26/27-FY29/30)	\$25,870,527

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Medicaid Service Package for Members Receiving Long-Term Services & Supports

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At a glance: Members receiving Medicaid Long-Term Services and Supports (LTSS) often receive services through several parts of the Medicaid program at the same time. Depending on their individual needs and eligibility, a member may receive medical and behavioral health care, Community First Choice services, services through an HCBS waiver, and other services such as Private Duty Nursing or Long-Term Home Health.

How Medicaid Services Work Together

There is no single package of services that every LTSS member receives. Services are based on each member's eligibility and individual needs and may come from different parts of the Medicaid program.

For example, a member may receive:

- Medical and behavioral health care through the Medicaid State Plan;
- Personal care, homemaker, and other services through Community First Choice (CFC);
- Specialized services through one Home and Community-Based Services (HCBS) waiver; and
- Other State Plan LTSS, such as Private Duty Nursing or Long-Term Home Health.

These services are designed to work together to meet different needs. Medicaid does not pay for the same service twice, but a member may receive different services at the same time.

Important Things to Know

- Members may only be enrolled in one HCBS waiver at a time.
- A member may receive both HCBS waiver services and CFC services when the services do not duplicate one another.
- The combination of services a member receives depends on their eligibility, assessed needs, and applicable program requirements.
- Changes to one service or program may affect members differently depending on the other services they receive.

Service Delivery Models

Within CFC, there are three distinct service delivery options by which members may receive care for particular services, including: agency-based, in-home support services (IHSS), and consumer directed attendant support services (CDASS). IHSS and CDASS are both participant directed models, meaning that the member has more control over who provides the service and how it is provided. Under IHSS, a provider agency is still involved to provide support with employee responsibilities, like background checks and payroll, but the member can select their own caregiver and direct their daily tasks. Under CDASS, the member oversees all hiring, training, scheduling, and directing of their caregiver's responsibilities. A financial management agency is involved to handle taxes and payroll, but the member maintains primary responsibilities. The rate paid for services varies by the service delivery option though all are required to follow the base wage requirements for direct care workers ensuring workers across the options receive similar wages.

Service Mix

Medicaid enrolled members that receive long term services and supports have diverse and often complex needs. Members include children, working-age adults, and older adults, and many have multiple chronic conditions in addition to a disability. As a result, members often receive several different types of Medicaid services at the same time.

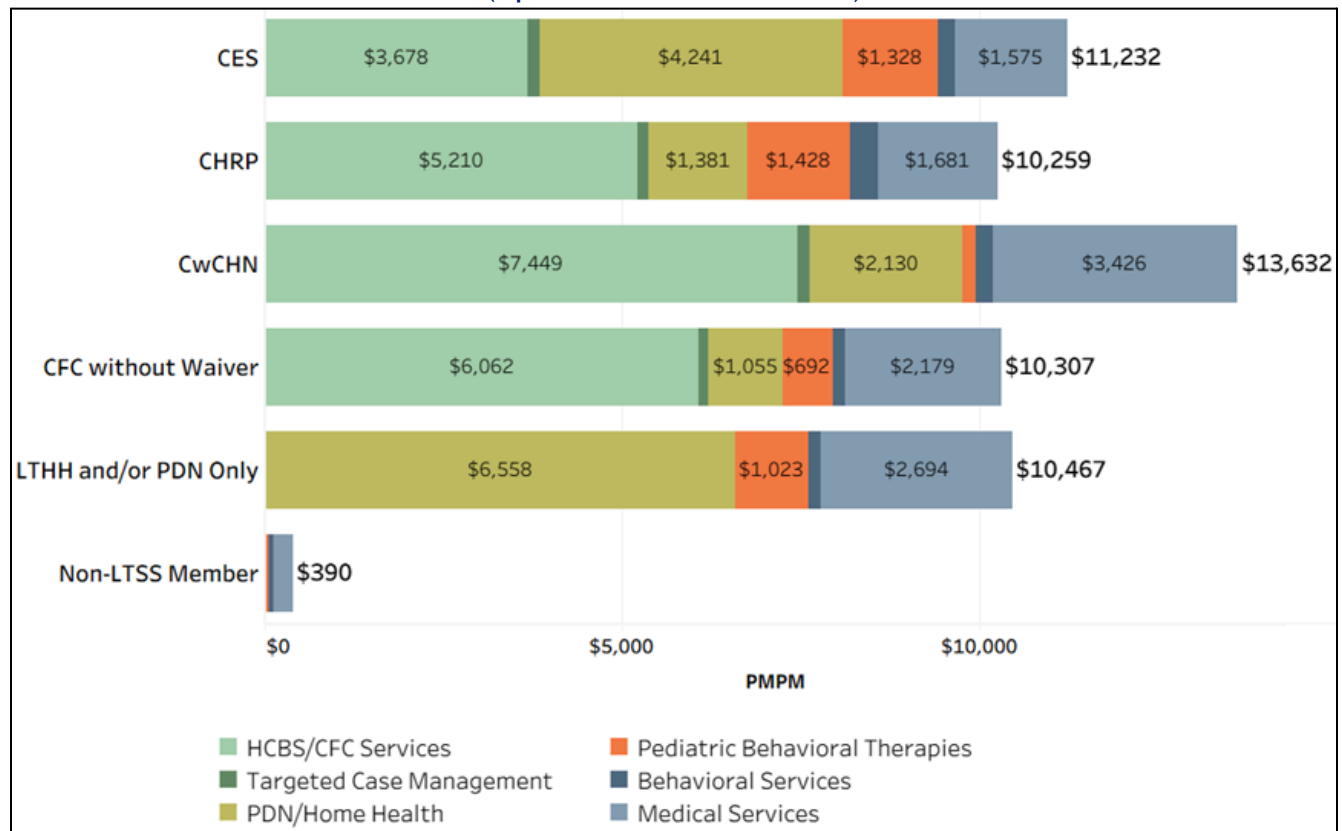
Program	Most Common Services
HCBS Waivers & CFC	Waivers: Respite, residential, supported employment, day programs CFC: Personal care, homemaker
Medical Services	Physician, home health, therapies
Behavioral Services	Clinical Services, Support Services, Individual/Group Therapy
Pediatric Behavioral Therapies	Applied Behavior Analysis (ABA) therapy
Targeted Case Management	Transition coordination, service planning and monitoring

Members under 18 accessing community based LTSS

Children receiving LTSS may qualify for different combinations of services depending on their needs. A child may receive services through an HCBS waiver or CFC, along with other Medicaid benefits such as Private Duty Nursing, Long-Term Home Health, behavioral therapies, and medical care.

Figure 1 shows how these services work together for children enrolled in different LTSS programs. The mix of services varies considerably depending on the needs of the children served by each program.

Figure 1. Total Cost of Care for Members Under 18
(April 2025 to March 2026)



* “CFC without waiver” means a member who is not on an HCBS waiver, but receives CFC services and includes apx. 3,000 members total, not just members under 18.

Program Key

CES: Children’s Extensive Services Waiver

CHRP: Children’s Habilitation Residential Program Waiver (CHRP)

CwCHN: Children with Complex Health Needs Waiver

CFC without a Waiver: Members receiving Community First Choice only

LTHH and/or PDN: Members receiving Long Term Home Health and/or Private Duty Nursing only

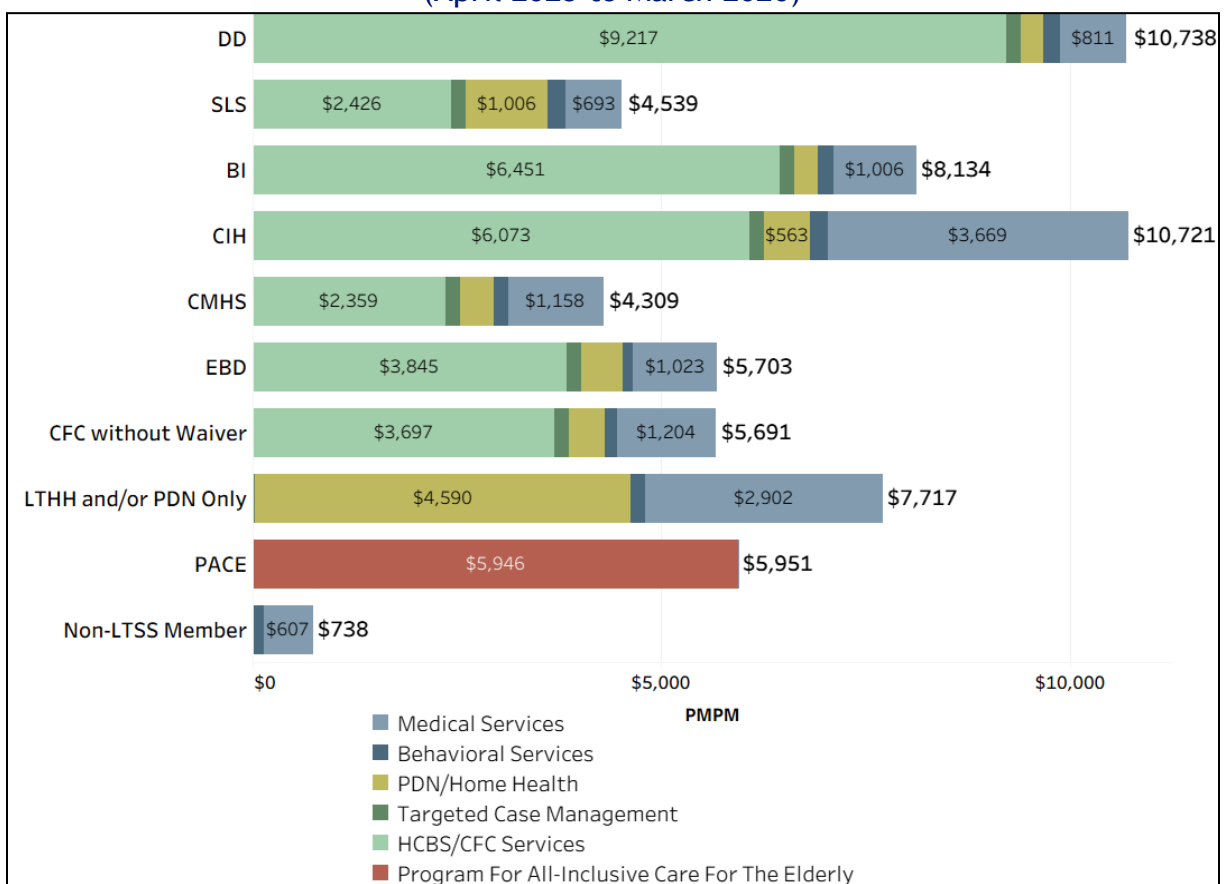
Non-LTSS Members: Medicaid members not receiving LTSS as a comparison

Members over 18 accessing community based LTSS

Adults receiving LTSS also receive different combinations of Medicaid services based on their eligibility and needs. An adult may receive services through an HCBS waiver and CFC, along with Long-Term Home Health, behavioral health services, medical care, and other Medicaid benefits.

Figure 2 illustrates how the mix and cost of services varies across different groups of adult LTSS members.

**Figure 2. Total Cost of Care for Members 18+
(April 2025 to March 2026)**



Program Key

DD: Developmental Disabilities Waiver

SLS: Supported Living Services Waiver

BI: Brain Injury Waiver

CIH: Complementary and Integrative Health Waiver
CMHS: Community Mental Health Supports Waiver
EBD: Elderly, Blind, and Disabled Waiver
CFC without a Waiver: Members receiving Community First Choice only
LTHH and/or PDN: Members receiving Long Term Home Health and/or Private Duty Nursing only
PACE: Program for All Inclusive Care for the Elderly
Non-LTSS Members: Medicaid members not receiving LTSS as a comparison

Members accessing institutional LTSS

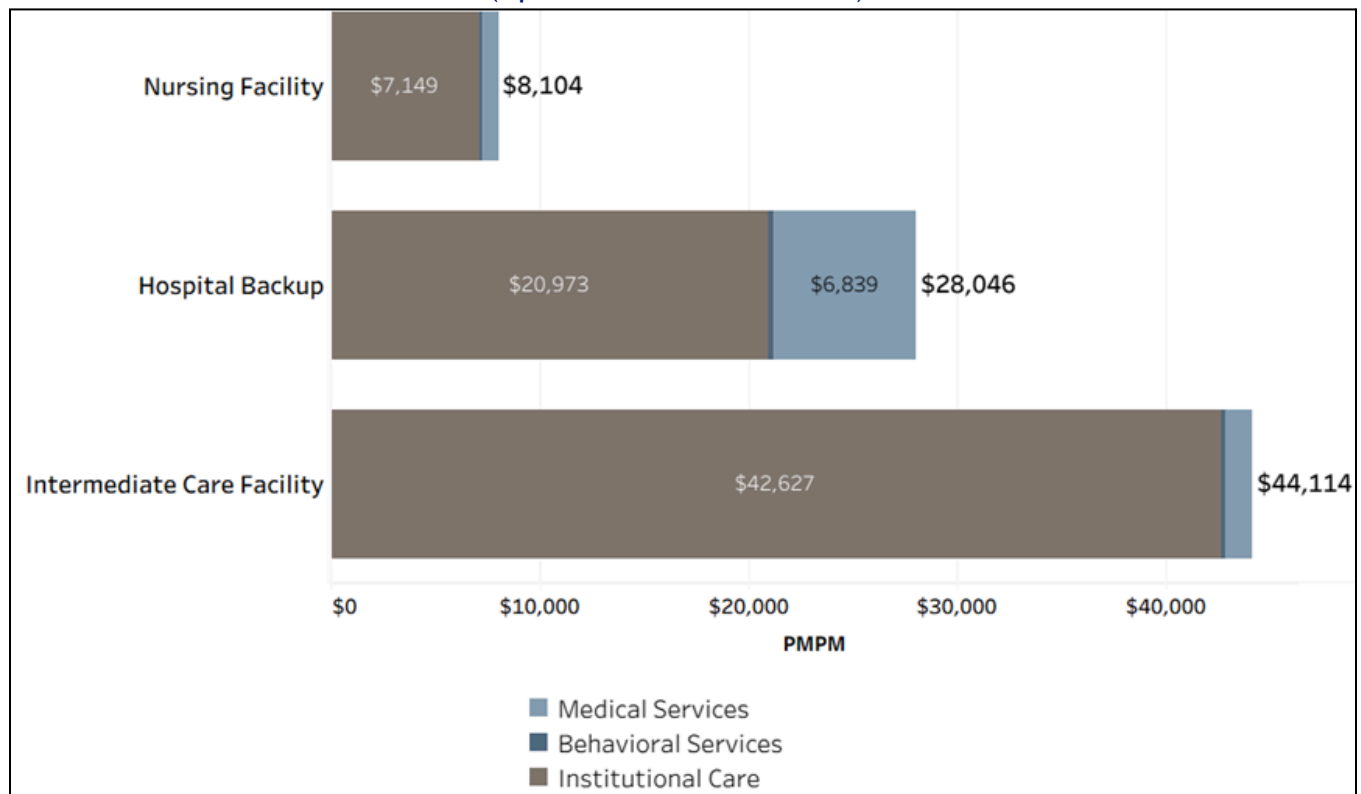
Medicaid LTSS may also be provided in institutional settings, including nursing facilities, hospital backup units, and intermediate care facilities. Members may require institutional care based on their physical, cognitive, or other support needs.

Unlike HCBS, where individual LTSS services are generally billed separately, institutional providers receive a single payment that covers the costs of LTSS provided within the facility. Medical and behavioral health services are separate Medicaid benefits and are not included in the institutional payment.

Members in institutional settings continue to receive medical and behavioral health services based on their individual needs. Many are also enrolled in Medicare. For these members, Medicare is generally the primary payer for Medicare-covered medical services. As a result, the Medicaid medical spending shown in the graph may represent only a portion of the member's total medical care.

Figure 3 shows how Medicaid spending is distributed across institutional LTSS, medical care, behavioral health, and other Medicaid services for members receiving LTSS in institutional settings.

Figure 3. Total Cost of Care for Institutional Settings
(April 2025 to March 2026)



Paid Family Caregiving in LTSS

Paid family caregiving is not a separate Medicaid benefit or service. It describes a situation in which a qualified family member is paid to provide an authorized Medicaid service to a member. The service, not the family relationship, is what is reflected in Medicaid claims and payment data.

What is paid family caregiving?

Some Medicaid services may be provided by a qualified family member when allowed under the requirements for that service and delivery model. The family member must meet the same applicable provider or caregiver qualifications required to deliver the service.

Family members may provide a range of authorized LTSS, including:

- Personal Care
- Homemaker
- Health Maintenance Activities
- Long-Term Home Health services, when the family member meets the applicable CNA or nursing qualifications

- Individual Residential Supports and Services (IRSS), commonly referred to as host home services for adults with intellectual and developmental disabilities
- Community Connector

The rules governing who may be paid, what qualifications they must meet, and any limits on the amount of care they may provide vary by service and delivery model.

How are services authorized when a family member provides the care?

Services are authorized based on the member's assessed needs and Medicaid program requirements, not simply because a family member is available or willing to provide the care.

For HCBS waiver and Community First Choice (CFC) services, the case manager assesses the member's needs and develops the Person-Centered Support Plan, including the type and amount of services to be authorized.

State Plan services that require prior authorization, such as skilled nursing services, are reviewed for medical necessity through the Prior Authorization Request (PAR) process.

Once a service is authorized, it may be delivered by a qualified family member when permitted under the rules for that service. Regardless of who provides the care, Medicaid pays for the authorized service that is delivered.

Why can't HCPF provide a complete count of paid family caregivers?

Medicaid claims and payment systems are designed primarily to track the service provided and the provider that billed Medicaid. They do not consistently capture the relationship between the individual caregiver and the member.

As a result, HCPF can generally identify:

- the service a member received;
- the amount of service authorized and delivered; and
- the provider that billed Medicaid.

However, HCPF does not have a complete statewide dataset identifying whether the individual who delivered the service was a family member.

Electronic Visit Verification (EVV) provides additional caregiver-level information for some services, but it does not provide a complete picture. For example, live-in caregivers are exempt from EVV requirements.

Because family relationships are not consistently captured across Medicaid data systems, HCPF cannot currently provide a complete statewide count of paid family caregivers, their relationships to members, or total Medicaid expenditures specifically attributable to care provided by family members.

Family caregiving policies have evolved over time

Colorado's policies governing paid family caregiving have changed significantly over time. Today's policies reflect a combination of rules that existed before the COVID-19 pandemic, flexibilities introduced during the pandemic, and changes associated with the implementation of Community First Choice (CFC).

Before the COVID-19 Pandemic

Before the pandemic, Medicaid generally placed greater limits on when family members could be paid to provide certain services. The rules varied across HCBS waivers, services, and delivery models, including:

- which family members could be paid to provide a service;
- which services family members could provide; and
- limits on the amount of paid care a family member could provide.

During and after the COVID-19 Public Health Emergency

During the pandemic, federal Medicaid policy allowed states greater flexibility to pay family members to provide certain services. Colorado adopted additional flexibilities in response to workforce challenges, infection-control concerns, and the difficulty of bringing outside caregivers into the homes of medically vulnerable members.

Some of these flexibilities continued after the federal Public Health Emergency ended. As a result, family members have continued to play a larger role in delivering some Medicaid services than they did before the pandemic.

Community First Choice

Implementation of CFC also changed Colorado's approach to paid family caregiving. Before CFC, many services were provided through individual HCBS waivers, and the rules governing family caregivers could differ depending on the waiver, service, and delivery model.

As services moved from individual waivers into CFC, Colorado established more consistent rules across populations and programs. These changes affected which family members could provide certain services and the requirements and limits that apply when they do.

Why this history matters

Current paid family caregiving policy reflects multiple periods of change. Some policy changes being considered today would restore limits that existed before the pandemic, while others address changes associated with the implementation of CFC.

Understanding this history is important when evaluating current policy proposals and trends in paid family caregiving. A change that limits paid family caregiving today may not represent an entirely new restriction; in some cases, it may represent a return to rules that existed before temporary or expanded flexibilities were adopted.

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Due Process for Long-Term Services & Supports

September 2026

At a glance: Medicaid members have the right to understand decisions about their services and, when applicable, challenge decisions that deny, reduce, suspend, or terminate services. Depending on the decision, these protections may include written notice explaining the reason for the decision, the right to appeal, and the ability to continue previously authorized services while an appeal is pending

How Service Decisions Are Made

The process for authorizing LTSS depends on the service a member is requesting.

For Home and Community-Based Services (HCBS) and Community First Choice (CFC), the case manager assesses the member's needs and develops a Person-Centered Support Plan. For certain services, the case manager uses the Direct Care Services Calculator (DCSC) to help determine the amount of support needed based on the member's individual circumstances and program requirements.

Some HCBS and CFC service authorizations require additional review. Depending on the service and amount requested, approval may be required from a case manager supervisor or HCPF. This includes requests that exceed certain service standards or limits and require an exception review.

Long-Term Home Health (LTHH) and Private Duty Nursing (PDN) follow a different authorization process. The member's provider submits a Prior Authorization Request (PAR), including the plan of care, physician order, and supporting clinical information. HCPF's contracted Utilization Review/Utilization Management vendor reviews the request to determine whether the service and amount requested meet Medicaid medical necessity requirements.

These reviews serve different purposes and apply different criteria. An HCBS or CFC exception review determines whether a request meets established policy criteria for an exception. A LTHH or PDN review determines whether the requested service meets medical necessity requirements.

When an authorization decision results in an appealable denial, reduction, suspension, or termination of services, the member has due process rights, including the right to appeal.

Exception requests

Some HCBS waiver and Community First Choice (CFC) services have established service standards or limits. These help promote consistency across members, support program integrity, and ensure responsible use of Medicaid funds.

An exception process allows for an individualized review when a member's circumstances may support services outside an established standard or limit. A service limit does not automatically mean that services above that amount will be denied.

An exception review is a policy review. The reviewer determines whether the member's circumstances and supporting documentation meet the established criteria for an exception. It is different from a medical necessity review.

Exceptions are available for certain service limits, including:

- CFC Homemaker;
- CFC Personal Care;
- CFC Health Maintenance Activities;
- Protective Oversight provided through Personal Care;
- Community Connector; and
- The Weekly Caregiver Limit.

Reviewing exception requests

Case manager supervisors review requests that exceed task standards established through the Direct Care Services Calculator (DCSC). HCPF reviews requests that exceed applicable service soft caps and all requests to exceed the Weekly Caregiver Limit.

What is considered?

The information reviewed depends on the applicable exception criteria and may include the member's assessment, DCSC, Person-Centered Support Plan, case manager documentation, clinical or other supporting documentation, and information provided by the member, family, or providers.

Each request is reviewed individually against the applicable policy and exception criteria. The reviewer determines whether the documentation supports an exception rather than treating the established threshold as an automatic ceiling.

Utilization Review requirements

Some Medicaid services, including Long-Term Home Health and Private Duty Nursing, require prior authorization and medical necessity review. The provider submits clinical information and the requested plan of care to HCPF's utilization review/utilization management vendor. The vendor determines whether the service meets Medicaid requirements and whether the amount requested is medically necessary.

The request may be approved, partially approved, or denied. When a denial or partial approval creates an appealable adverse action, the member receives written notice explaining the decision and their appeal rights.

Notice of Action (NOA) and Appeal Rights

When an appealable decision denies, reduces, suspends, or terminates a Medicaid service, the member receives written notice explaining the decision and their appeal rights.

For decisions made by a Case Management Agency, this notice is generally called a Notice of Action (NOA). The NOA explains:

- what service or benefit is being denied or changed;
- when the change will take effect;
- why the decision was made;
- the rule or policy supporting the decision; and
- how and when the member may appeal.

An appeal asks for a State Fair Hearing, where an Administrative Law Judge reviews the decision. The member should follow the instructions and deadlines in the notice they receive.

Different notices and appeal processes may apply to decisions made outside of the CMA. For example, Medicaid financial eligibility decisions are made by the member's eligibility site or county.

Continuation of Benefits during an appeal

When a decision reduces or stops a service the member is already authorized to receive, the member may be able to continue receiving the previously authorized service while the appeal is pending. This is called continuation of benefits.

Members generally have 60 calendar days to appeal, but the deadline to request continuation of benefits may be earlier. Members who want their existing services to continue should follow the deadlines provided in their notice.

Continuation of benefits applies only to services the member was already authorized to receive. It generally does not apply when:

- a request for a new service is denied;
- a request to increase an existing service is denied, although the previously authorized amount may continue when applicable; or
- a request for new enrollment in a waiver is denied.

A member may still have the right to appeal these decisions even when there is no new or additional service to continue during the appeal.

Are all decisions appealable?

No. Not every policy requirement, review, or administrative decision creates a separate right to appeal.

Generally, appeal rights apply when an individual decision results in an adverse action affecting a member's Medicaid eligibility, benefits, or services, such as a denial, reduction, suspension, or termination. A policy or administrative requirement may affect how services are delivered without changing the total amount or type of service the member is authorized to receive.

Examples of decisions or requirements that may not, by themselves, create a separate right to appeal include:

- **Support Level Review determinations.**
- **Certain exception decisions that do not result in a denial or reduction of an authorized Medicaid service.**
- **Limits on the amount of Homemaker services that may be provided by a Legally Responsible Person (LRP).** These limits apply to who may provide the service, rather than the total amount of Homemaker services the member may be authorized to receive. Additional authorized hours may be provided by another qualified caregiver.
- **The Weekly Caregiver Limit.** This limit applies to the number of hours a particular caregiver may provide to a member. It does not, by itself, reduce the number of service hours the member is authorized to receive because additional authorized hours may be provided by another qualified caregiver.
- **Provider reimbursement rate changes.** Rate changes do not change the amount, scope, or duration of services authorized for the member.

The key distinction is whether the decision changes the member's Medicaid eligibility, benefits, or authorized services. If application of a policy or requirement results in an appealable denial, reduction, suspension, or termination of a member's services, the member receives the due process rights that apply to that adverse action.

LTSS Appeals: Volume, Backlog, and Outcomes

HCPF tracks appeals involving HCBS waiver and CFC decisions received through the Office of Administrative Courts. HCPF's current tracking is most reliable for understanding current appeal volume and backlog. Historical outcome and resolution-time data are less complete and should be interpreted with caution.

2026 Appeal volume

Between January 1 and August 19, 2026, 381 HCBS waiver and CFC appeals were filed. Of these 61 are currently identified as resolved and 320 remain open or unresolved. Appeal filings have increased during 2026, from 32 appeals filed in January to 70 in July.

Appeals pending more than 90 Days

The number of HCBS waiver and CFC appeals pending more than 90 days has also increased:

- May 2026: 137
- June 2026: 187
- July 2026: 209

Additional information about the appeals backlog is available in HCPF's *Medicaid Appeals & H.R. 1 Implementation Pressures Fact Sheet*.

Appeal outcomes

HCPF does not yet have complete outcome data for most 2026 appeals. Of the 381 appeals filed through August 19, 51 currently have a final outcome recorded:

- 1 resulted in HCPF or the agency prevailing on the merits;
- 1 resulted in the member prevailing on the merits; and
- 49 were resolved without a decision on the merits, including dismissals and withdrawals. Dismissals and withdrawals should not be interpreted as HCPF or agency wins. They indicate that the appeal ended without a final decision on the underlying dispute.

Because most 2026 appeals remain pending or do not yet have a final outcome recorded, the available data are not sufficient to draw conclusions about how often members or HCPF ultimately prevail in LTSS appeals.

Appeal resolution timelines

For the small number of appeals with both a complete filing date and resolution date, the currently recorded median time from filing to resolution is 44 days. For appeals filed in 2026, the currently recorded median is 37 days.

These figures should be interpreted cautiously. Fewer than 40 appeals currently have complete information needed to calculate resolution time. The figures therefore describe only that subset of appeals and should not be interpreted as the typical resolution time for all LTSS appeals.

Improving appeals data

HCPF's historical appeals data are incomplete, particularly for final outcomes and resolution dates. Current data are strongest for measuring appeal volume and the number of appeals that remain pending.

HCPF is strengthening its appeals tracking to improve future reporting on appeal volumes, aging, final outcomes, resolution timelines, continuation of benefits, and where delays occur in the appeal process.

Member Complaints and Escalations

Members have several ways to raise concerns about their LTSS. Depending on the issue, a member may file a complaint with their CMA, request assistance through HCPF's complaint and escalation process, or file an appeal when they disagree with an appealable decision.

Complaints about a Case Management Agency

Members may file a complaint with their CMA when they have concerns about their case management services. Concerns may include:

- difficulty reaching or receiving follow-up from a case manager;
- delays in completing required case management activities;
- problems coordinating services or communicating with providers;
- concerns about how the member's case is being handled;
- difficulty accessing authorized services; or
- other concerns about the quality or delivery of case management services.

Every CMA is required to have a formal complaint process and make information about that process available to members. A member may contact their case manager, a supervisor, or the CMA's designated member and family liaison to raise a concern.

The CMA is responsible for reviewing the concern, understanding what occurred, and working to resolve the issue. Concerns that cannot be resolved initially may be elevated to CMA leadership.

Members have the right to raise concerns without retaliation

Members have the right to raise concerns, file complaints, request HCPF assistance, and exercise their appeal rights without retaliation or intimidation.

A member's appropriate services should not be reduced, delayed, or otherwise negatively affected because the member or someone acting on their behalf raised a concern or filed a complaint.

HCPF recognizes that some members and families may be uncomfortable raising concerns directly with the organization responsible for their case management or services. **A member does not have to resolve a concern with their CMA before asking HCPF for assistance.** Members who are concerned about retaliation, believe they have experienced retaliation, or are uncomfortable raising an issue directly with their CMA may contact HCPF.

Escalating concerns to HCPF

HCPF can assist members with unresolved or significant concerns involving Medicaid, LTSS, an eligibility site, or a CMA. A member does not need to wait until a concern becomes an emergency before contacting HCPF.

Examples include:

- a significant delay affecting access to services;
- loss of services or risk of losing needed care;
- health or safety concerns;
- difficulty getting the appropriate agency to address an issue;
- concerns about retaliation or treatment after raising a concern; or
- discomfort raising the issue directly with the CMA.

Members, families, representatives, providers, and other stakeholders may submit a complaint or escalation to HCPF at HCPF_MemberComplaints@state.co.us.

What happens when HCPF receives an escalation?

HCPF uses a centralized process to review, track, and respond to member concerns. Concerns involving loss of care, risk of losing care, or significant health and safety issues receive higher priority.

1. **HCPF reviews the concern.** Staff review the information provided, determine the urgency of the issue, and identify what assistance is needed.
2. **The concern is assigned for review.** Depending on the issue, HCPF may work with the CMA, eligibility site, or other responsible entity to research the concern and identify needed action.
3. **HCPF becomes directly involved when needed.** Issues requiring policy interpretation, specialized program knowledge, additional intervention, or concerns about how an issue is being handled may be elevated within HCPF for further review.
4. **HCPF tracks the concern through resolution.** HCPF may request additional information, coordinate with the organizations involved, and identify actions needed to address the concern.

Response standards

HCPF assigns priority levels so that the most urgent concerns are addressed first. Current standards require an attempt to resolve an escalation within:

- **2 business days** for the most urgent concerns;
- **4 business days** for high-priority concerns;
- **7 business days** for medium-priority concerns; and
- **14 business days** for lower-priority concerns.

These are response standards based on the urgency of the concern. Some complex issues may require additional investigation, coordination, or policy review before they are fully resolved.

A complaint or escalation is not the same as an appeal

A complaint or escalation is a way to raise a concern, ask for assistance, or seek resolution of a problem involving case management, eligibility processes, communication, access to care, or other Medicaid issues. An appeal is the formal legal process for challenging an appealable decision about a member's Medicaid eligibility, benefits, or services.

If a member receives a Notice of Action or other notice of an appealable decision, they should follow the appeal instructions and deadlines in that notice.

Filing a complaint or asking HCPF for assistance does not replace an appeal, extend the deadline to appeal, or by itself preserve continuation of benefits. A member may pursue both processes at the same time. If the member wants to challenge an adverse decision, they should still file the formal appeal within the deadline provided in their notice.

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Weekly Caregiver Cap

September 2026

At a glance: Colorado is phasing in a limit on the number of hours one caregiver may provide to one member each week. The policy does not reduce a member's authorized service hours. An exception process is available when a member's circumstances warrant additional flexibility.

Overview

Colorado's Weekly Caregiver Limit establishes a phased limit on the number of hours a single caregiver may provide to a single member each week for certain Long-Term Services and Supports (LTSS). The services included in this weekly caregiving limit are:

- Personal Care
- Homemaker
- Health Maintenance Activities
- Long-Term Home Health (LTHH)- Certified Nurse Aide (CNA) & Nursing Services

The weekly limit applies to how many hours one caregiver may provide, not to the total number of service hours a member is authorized to receive. A member's authorized service hours do not automatically decrease because of this policy. When a member needs more hours than one caregiver may provide under the weekly limit, those hours may be shared among caregivers or, when appropriate, the member may qualify for an exception.

HCPF recognizes that changes to caregiving arrangements can be difficult for members and families, particularly when a member has a long-standing relationship with a trusted caregiver. The exception process is intended to provide flexibility when changing caregivers would create significant challenges for the member.

Implementation began July 1, 2026. It is being phased in over time:

Phase	Population/Weekly Limit	Implementation
Phase 1	Members receiving more than 84 hours/week from one caregiver	Began July 1, 2026
Phase 2	Limit steps down to 70 hours/week from one caregiver	January 1, 2027
Phase 3	Limit steps down to 56 hours/week from one caregiver	July 1, 2027

Purpose of the Policy Change

The policy was designed to address member health and safety, and support more stable caregiving arrangements over time. The policy may also affect expenditures, and HCPF will monitor those impacts as implementation continues.

Providing very high numbers of caregiving hours week after week can place significant demands on a caregiver. The policy is intended to reduce reliance on a single caregiver and support more sustainable caregiving arrangements, including:

- **Promote member health and safety** by reducing reliance on a single individual for extremely high numbers of caregiving hours.
- **Reduce caregiver burnout** and support more sustainable caregiving arrangements.
- **Strengthen and diversify the direct care workforce** by encouraging broader caregiver networks rather than concentrating a member's care with one individual.
- **Maintain flexibility when circumstances warrant it** through an individualized exception process for members with extraordinary needs, workforce challenges, transitions or other qualifying circumstances.

Exceptions Process for those who need it

The exception process is designed for members whose individual circumstances may make it difficult or unsafe to transition to additional caregivers. Exceptions may be available when a member has complex care needs, documented difficulty recruiting additional caregivers, needs continuity of care during a temporary transition or stabilization period, has end-of-life care needs, or has other circumstances that meet the exception criteria. Each request is reviewed individually based on the member's circumstances and supporting information..

The exception process is an important safeguard within the policy:

The weekly limit is not intended to disrupt care when a member's health, safety, or access to services requires additional flexibility.

The exception process launched on July 1, 2026, with the initiation of the new policy. See the visual below for how the process works in practice.

An exception request is submitted

A provider agency or CDASS employer submits the request to HCPF with information supporting the member's circumstances.



The Case Management Agency provides input, when applicable

If the member works with a Case Management Agency (CMA)* HCPF sends the request to the CMA to confirm that what is requested aligns with their service coordination and authorization. The CMA has up to 7 calendar days to respond. A Case Manager does not approve or deny an exception; only HCPF makes the final decision.

*A member works with a CMA when they receive at least one HCBS service. If a member receives only Long-Term Home Health, they would not work with a CMA.



HCPF reviews the request

Requests are reviewed individually using standardized criteria and supporting documentation. HCPF allows up to 14 calendar days for its review after receiving the CMA attestation, when one is required. If additional information could help HCPF make a decision, HCPF may request that the provider or CDASS employer submit additional information. Supplemental information is generally due within 7 calendar days, and HCPF completes an additional review after receiving it.



HCPF issues the decision

The request may be approved or denied based on the applicable criteria and the information available. Importantly, while an exception request is under review, the caregiver may continue providing hours above the applicable weekly limit until HCPF issues a decision.

Early Results as of September 9, 2026

Because implementation began only on July 1, 2026, these data represent an early snapshot and should not be interpreted as final program outcomes. HCPF can identify members receiving more than 84 hours per week of services subject to the policy, but available claims and utilization data do not establish whether all of those hours were provided by a single caregiver. Therefore, this number represents the potentially affected population, not the number of members confirmed to be affected by the weekly caregiver limit.

Measure	Data to Date
Members receiving more than 84/hours/week	2,357
Exception requests submitted	175
Exception requests approved	140 (80%)
Exception requests denied	18 (10.3%)
Exception Requests Administratively denied ¹	10 (5.7 %)
Exception Requests still in process	8 (4.5%)
Exception Requests requiring CMA attestation	2 (1.1%)
Exception Requests requiring additional information	5 (2.9%)
Average turnaround time from submission to decision	27 days

Supporting stakeholders through the new process

HCPF recognizes that members, families, caregivers, providers, CDASS employers and Case Management Agencies are adjusting to a new policy and process. HCPF also recognizes that changes to established caregiving arrangements can be significant for members and families. During this initial implementation period, HCPF has intentionally emphasized technical assistance and opportunities to provide additional information rather than treating early documentation gaps as an automatic basis for denial.

HCPF has supported implementation through provider and Case Manager trainings, office hours, exception request reference guides, process workflows, FAQs, stakeholder communications and a dedicated channel for questions. [Guidance continues to be updated](#) as HCPF receives feedback and identifies areas where additional clarity is needed.

¹ An administrative denial means the request was not denied based on the member's circumstances or the exception criteria. Administrative denials may occur for reasons such as a duplicate or incorrectly submitted request, or when requested additional information was not provided.

What happens next?

HCPF is continuing to review exception requests, monitor turnaround times and outcomes, communicate with members and stakeholders, and refine implementation based on what HCPF learns.

As additional phases take effect, HCPF will continue evaluating the policy's impact on member safety, continuity of care, caregiver sustainability, workforce capacity, exception utilization and expenditures. HCPF will use this information, along with feedback from members, families, caregivers and stakeholders, to identify where additional guidance, process improvements or other implementation changes may be needed.

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COLORADO

Department of Health Care
Policy & Financing

Adding PETI to the Developmental Disabilities Waiver

September 2026

At a glance: DD PETI does not change whether a person qualifies for Medicaid or DD waiver services. For some people receiving DD residential services, it means they will now use a portion of their own income to help pay for those services. Required protections and deductions are applied before a contribution is calculated.

Overview

Post-Eligibility Treatment of Income (PETI) determines whether a Medicaid member must use a portion of their income to help pay for residential long-term services and supports.

PETI happens after a person has been found eligible for Medicaid and the DD waiver. It does not change Medicaid eligibility. The calculation looks at the member's income and protects certain amounts for personal needs and allowable expenses before determining whether the member has a contribution toward residential services.

Colorado already uses PETI for residential services in several other HCBS waivers. DD PETI extends this approach to residential habilitation services under the DD waiver.

Previously, DD waiver members paid room and board, while Medicaid paid the full cost of the residential service. Under DD PETI, some members will now also contribute toward the cost of their residential services, with Medicaid paying the remaining cost.

Why PETI is Used in Community Based Residential Programs

PETI has long been used in Medicaid when the program pays for comprehensive, ongoing long-term care, including care provided in nursing facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). In these settings, Medicaid pays most of the cost of care, while the member keeps protected income for personal needs and other allowable expenses. Income remaining after those protections is applied toward the cost of care.

Home and Community-Based Services (HCBS) allow people who meet an institutional level of care to receive services in the community instead. Colorado's DD residential benefit provides access to comprehensive, 24-hour residential support, including supervision, personal care,

health-related supports, protective oversight, habilitation, and other assistance based on the member's needs.

Colorado is applying PETI to these residential services using the same basic Medicaid principle: protect income for expenses the member remains responsible for and then apply remaining available income toward the cost of Medicaid-funded residential care.

Importantly, the income protections are different for people living in the community because their expenses are different. In an institutional setting, room, meals, utilities, basic personal care items, and many other daily needs are generally included in the institutional service. People receiving residential HCBS live in the community and may remain responsible for expenses that are not included in their residential services. The PETI calculation therefore protects applicable room and board or housing costs, a personal needs allowance, and other allowable expenses before determining whether income remains to contribute toward the cost of care.

This does not mean that a community residential setting is an institution. HCBS is specifically designed to support people to live in the community. Rather, PETI recognizes both the comprehensive nature of the Medicaid-funded residential support and the different expenses people have when living in the community.

Member Protections

The expenses of living in the community are different from living in an institution, so certain amounts of a member's income are protected before a PETI contribution is calculated. DD PETI includes protections and deductions intended to account for expenses members remain responsible for before determining whether income is available to contribute toward residential services.

Personal Needs Allowance

The Personal Needs Allowance (PNA) is a protected amount of income that the member retains for personal expenses that are not included in room and board. The current PNA range is \$184 to \$435.46 per month, with the amount determined based on the member's income.

The PNA is the amount a member keeps for personal expenses, such as clothing, personal hygiene items, transportation, phone or internet costs, and social or recreational activities.

Housing Costs

A member's living arrangement matters in the PETI calculation. Members living in provider-operated residential settings pay room and board, which covers specified everyday living expenses provided through that arrangement.

Members who are legally and financially responsible for their own qualifying housing costs may have applicable housing expenses protected before their PETI contribution is calculated. This recognizes that people living more independently may continue to pay expenses directly that are otherwise included in a provider-operated residential arrangement.

Medical Expenses

Certain medical, dental, and vision expenses that are not covered by Medicaid or another payer may be deducted when appropriately documented.

Working Adults with Disabilities

Members enrolled in the Working Adults with Disabilities (WAWD) program are exempt from PETI. This preserves the existing WAWD structure, under which eligible members may instead pay a program premium.

Members receiving Job Coaching services are also exempt from PETI.

How DD PETI Works

The PETI calculation starts with a member's income and then applies required protections, deductions, and exemptions.

Member income

The calculation considers the member's own countable income, such as Social Security benefits, pensions, and other income recognized under Medicaid rules. Income belonging to parents, family members, or other household members is not included in the member's PETI calculation.

Protected amounts and deductions

Before determining whether a member has an obligation to contribute toward the cost of care, the calculation protects allowable expenses. These include, when applicable:

- **Personal Needs Allowance (PNA)** for everyday personal expenses.
- **Room and board** or applicable housing costs. Room and board includes housing, food, utilities and basic household items,
- **Taxes** and other allowable deductions.
- **Certain non-covered medical expenses.**
- **Certain trust-related deductions**, when applicable.

Only income remaining after these protections and deductions is considered available for the member's contribution toward the cost of residential services.

DD PETI Example

A member has \$1,500 in monthly income.

In this example:

- \$810 is set aside for room and board, which helps cover the member's housing and food costs.
- \$435.46 is protected as the member's personal needs allowance, which the member keeps for personal expenses, such as streaming subscriptions, cell phones, clothing items, or other personal items.
- \$254.54 remains and would be contributed toward the member's residential services.

The amount will be different for each person depending on their income, housing situation, and allowable deductions. The higher the income an individual has, the more personal needs allowance they have, up to the maximum of \$435.46.

For comparison, a member with \$900 in monthly income may have no PETI contribution.

In this example:

- \$810 is set aside for room and board.
- The remaining \$90 is protected for the member's personal needs.
- \$0 remains to contribute toward the member's residential services.

Who is Affected

DD PETI applies to members enrolled in the Developmental Disabilities (DD) waiver who receive residential services.

HCPF estimated that approximately 40% of DD waiver members, or about 3,100 people, would be subject to a PETI calculation based on the projected residential population and income levels. The average PETI contribution by a member is expected to be \$550.00 monthly.

Being subject to a PETI calculation does not necessarily mean a member will owe a contribution. The amount depends on the person's income and allowable protections and deductions. Some members will owe nothing; others will have a monthly contribution.

How the Process Works

The PETI process is integrated into existing case management and service planning processes. As part of service planning, case managers calculate the member's PETI amount and document the resulting contribution.

Step	What Happens
1. Income is identified	The member's applicable income is identified as part of the PETI process.
2. Protections and deductions are applied	Room and board, the personal needs allowance, and other applicable deductions are accounted for.
3. Member contribution is calculated	Any income remaining after allowable protections and deductions is identified as the member's contribution toward the cost of residential services.
4. Contribution is paid to the provider	The member or their legally authorized representative pays the required amount directly to the residential provider.
5. Medicaid pays the balance	Medicaid continues to pay the remaining cost of the residential service after the member contribution is applied.

Fiscal Impact

DD PETI reduces Medicaid spending because some of the cost of residential services that Medicaid previously paid will instead be paid by members through their PETI contributions.

HCPF estimates the policy will reduce Medicaid expenditures by:

Fiscal Year	Total Funds Savings	General Fund Savings
FY 2026-27	\$12.6 million	\$6.3 million
FY 2027-28	\$26.3 million	\$13.1 million

The first year reflects a partial-year and phased implementation as members are incorporated into the PETI process. FY 2027-28 reflects the expected full-year effect of the policy.

What DD PETI Does and Does Not Change

DD PETI Does:

May require some DD waiver members to contribute part of their income toward residential services.

DD PETI Does Not:

Change Medicaid eligibility requirements.

Protect the member's personal needs allowance and other allowable deductions.	Require members to contribute all of their income.
Require Medicaid to pay the remaining cost of the residential service after the member's required contribution.	Change the services a member is eligible to receive.
Base contributions on the member's individual financial circumstances.	Count parents' or other household members' income toward the member's PETI contribution.

What If a Member Experiences an Issue with PETI Implementation?

Members may have questions about their PETI calculation or may experience changes in circumstances that affect the information used to determine their contribution. The following information explains where members and families can go for help, how errors or changes are addressed, and what to expect if there are concerns about a PETI calculation.

Who a member contacts with questions about their calculation

Members should first contact their case manager with questions about their PETI calculation. The case manager can review the information used in the calculation, explain how the amount was determined, and identify whether information needs to be corrected or updated.

How an incorrect calculation gets corrected

If a member believes their PETI calculation is incorrect, they should contact their case manager. The case manager can review the information used in the calculation and make any necessary corrections based on accurate and current information.

What happens while a dispute is being resolved

Because the PETI calculation is not an adverse action, there is not a formal dispute or appeal process associated with the calculation itself. If a member believes the calculation is incorrect, the member should work directly with their case manager to review the information and resolve any errors or discrepancies.

Whether/how members can appeal

The PETI calculation itself is not appealable because it does not constitute an adverse action against the member. If there is an error in the calculation or the information used is inaccurate, the appropriate course is for the member to work with their case manager to have the information reviewed and corrected.

How can members report deductions or changed circumstances

Members should report changes in their financial or employment circumstances, including information relevant to applicable deductions, directly to their case manager. The case manager can update the information and ensure the PETI calculation reflects the member's current circumstances.

Where can families can get help understanding the calculation

Members and families should first contact their case manager for questions about their individual PETI calculation or circumstances.

HCPF also maintains a dedicated [PETI webpage](#) that serves as a central resource for members, families, and other stakeholders. The webpage includes detailed information about PETI, how the calculation works, what information is considered, and resources to help members better understand their responsibility. Members and families are encouraged to review the PETI webpage for general information and educational resources and work directly with their case manager when they have questions about their specific calculation, need to report a change in circumstances, or believe information used in their calculation is incorrect.

What Happens Next

HCPF recognizes that DD PETI is a significant financial change for some members and families and that implementation has raised questions and concerns. HCPF is continuing to work with members, families, case management agencies, and providers to identify and address implementation issues.

Based on feedback received, HCPF has already made several policy changes and clarifications. This includes Independently Arranged Room and Board to better account for the wide variety of living arrangements within the Individual Residential Services and Supports (IRSS) benefit and recognize members who are directly responsible for their own housing costs. HCPF has also clarified employment and Supported Employment exemptions and how certain household and other allowable expenses may be considered in the PETI calculation.

HCPF will monitor member impacts, implementation, and actual savings compared with projections. The Department will also continue to clarify guidance and address issues identified through implementation.

For more information contact

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