COLORADO

Governor Jared Polis

January 29, 2026

The Honorable Representative Emily Sirota
Chair, Joint Budget Committee
Colorado General Assembly
200 E. 14th Avenue, Third Floor
Legislative Services Building
Denver, CO 80203

Subject: January 29, 2026 HCPF Supplemental Comeback Requests

Dear Chair Sirota:

On behalf of Governor Jared Polis, the Office of State Planning & Budgeting (OSPB) appreciates the Committee's support to date for the Governor's supplemental budget requests for FY 2025-26, and submits this package of comeback requests for the Committee's consideration.

The Committee delayed, denied, modified, or requested comebacks, for the following Colorado Department of Health Care Policy & Financing requests:

- Provider rates
  - S6.01 Accountable care
  - S6.11 Provider rates -1.6%
  - S6.13 Nursing minimum wage
  - S6.23 and S7j Adjusting Rates above 85%
  - S7e XL wheelchair transport
- Administration
  - S-08 / BA-08 Federal HR 1 compliance
- Behavioral health
  - S6.09 Outpatient psychotherapy prior authorization
- Office of Community Living
  - S6.12 Community connector -15%
  - S6.14 Individual residential services & supports
  - S6.17 IDD youth transitions
  - S6.18 IDD waitlist
  - S6.30 HCBS hours soft cap
  - S6.31 Caregiving hours soft cap

- S6.32 Homemaker hours soft cap
- S6.34 Community connector units
- S-13 Disability determinations

Following the passage of HR1 and the resulting loss of state revenue for FY 2025-26, state agencies were directed through SB25B-001 and the subsequent Governor's Executive Orders D 2025 014 and D 2025 020 to urgently suspend or reduce expenditures to maintain the state's statutory reserve balance. The Executive Orders (extended through February 28, 2026 in Executive Order D 2025 022) were followed by the Governor's budget requests for both FY 2025-26 and FY 2026-27 submitted on Oct 31 and January 2 to actualize the actions taken through the executive order and additional measures to make changes to programs that are driving the rapidly rising expenditures associated with the Medicaid program. While today we are considering actions for the current fiscal year, many of these items also affect the long term growth trend.

Addressing the nearly $1 billion budget deficit this fiscal year was the priority, as was curbing the trend for Long Term Services and Supports (LTSS) for the longer-term, which has driven a nearly $1 billion increase in expenditures in recent years. The LTSS system, critical to older adults and people with disabilities, is on an unsustainable trajectory. The proposed LTSS-related reductions are deliberate, strategic actions designed to preserve the system and prevent far more severe harm in the very near future. Failure to act now will not protect people. It will guarantee deeper, more chaotic, and more damaging cuts later.

The proposed LTSS adjustments are not about reducing care for people who truly need it. Instead, they are focused on alignment—bringing utilization, rates, and program design back into reasonable bounds while preserving core access. It is fiscally responsible stewardship, to restore balance, consistency, and sustainability so that essential services remain available long term.

The nuanced policy adjustments aim to target the programs and services that are most directly impacting the overall LTSS budget's rising costs. Given the urgent need to identify and realize cost savings this fiscal year to address the current budget deficit, any policy changes that were able to be implemented this year, were identified and included in the supplemental process.

Given this more targeted approach to modify policies around specific benefits and services, the administrative lift has been and will continue to be extensive. The Department would like to work with JBC members to better demonstrate why FTE resources are essential to achieving savings at figure setting. For now, the Department has revisited the request in total and worked to reduce it to the absolutely bare

minimum. We would respectfully ask that a total of two ongoing FTE be provided to the Department for this critical and highly specialized work. In particular, the Department has drastically reduced and combined the initial ask and now kindly requests the JBC to approve 1 FTE for the HCBS Soft Cap proposal and 1 for work around Community Connector (This would be 0.5 and 0.5 FTE for FY 2025-26).

Every month we postpone corrective action, the size of the eventual correction grows. What can be addressed today through policy refinement becomes, tomorrow, an emergency budget cut with little time for thoughtful implementation. OCL has been working with stakeholders to draft and revise rules, to provide training and outreach, and is fully prepared to implement on April 1, 2026 to realize immediate savings to support closing the current fiscal year budget deficit.

Colorado has the opportunity to act with intention, transparency, and care. Rejecting these changes may feel compassionate in the moment, but it would set the state on a path toward far deeper, more painful cuts that would undermine everything LTSS is meant to provide.

Sincerely,

Mark Ferrandino
Director
Office of State Planning & Budgeting

CC:
SenatorJeff Bridges, Joint Budget Committee Vice Chair
Senator Judy Amabile, Joint Budget Committee
Representative Kyle Brown, Joint Budget Committee
Senator Barbara Kirkmeyer, Joint Budget Committee
Representative Rick Taggart, Joint Budget Committee
Craig Harper, JBC Staff Director

Attachments:
Attachment A: Health Care Policy & Financing Supplemental Comebacks

Attachment A
Health Care Policy & Financing Supplemental Comebacks

Summary of Comebacks

The Committee delayed, denied, modified, or requested comebacks, for the following requests:

- Provider rates
    - S6.01 Accountable care
    - S6.11 Provider rates -1.6% (Approved, JBC requested informational comeback)
    - S6.13 Nursing minimum wage
    - S6.23 and S7j Adjusting Rates above 85%
    - S7e XL wheelchair transport (Approved, JBC requested informational comeback)
- Administration
    - S-08 / BA-08 Federal HR 1 compliance
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    - S6.18 IDD waitlist
    - S6.30 HCBS hours soft cap
    - S6.31 Caregiving hours soft cap
    - S6.32 Homemaker hours soft cap
    - S6.34 Community connector units
    - S-13 Disability determinations

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.01 Accountable care incentives

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.01 Accountable care incentives

	Original Request	JBC Action	Comeback Request
Total Funds	-2,317,086	Denied	-2,317,086
FTE	0.0		0.0
General Fund	-750,000		-750,000
Cash Fund	-408,543		-408,543
Reappropriated Funds	0		0
Federal Funds	-1,158,543		-1,158,543

(Note: FY 2026-27 GF impact is -$750,000)

Summary of JBC Action: The Joint Budget Committee denied the Department's request, as recommended by JBC staff.

Summary of Comeback Request: OSPB respectfully requests that the Committee approve the request as originally requested, reducing incentives for the Accountable Care Collaborative by $750,000 GF for balancing purposes.

Analysis

Regional Accountable Entities (RAEs) and primary care medical providers (PCMPs) earn incentive revenue based on different metrics in different fiscal years. The request is to take $2,317,086 TF ($750,000 GF) out of the earnable pool for the Accountable Care Collaborative incentive program in FY 2025-26, bringing the total down from $9,941,572 TF down to $7,624,486 TF. This change is small compared to the three year revenue stream available to RAEs and PCMPs, so we do not expect this to materially change previously estimated savings. RAEs and PCMPs are measured by six different sets of metrics in FY 2024-25, FY 2025-26, and FY 2026-27 (three different sets for RAEs, three for PCMPs). In the current FY 2025-26, PCMPs are incentivized on their individual performance; therefore they only have to consider their individual practice. In FY 2025-26, RAEs are incentivized on four different metrics of varying weights; the metric where they can achieve the highest incentive payment is based on the performance of their PCMP network. For this reason, the relative share of

incentives that a RAE and a PCMP can earn in FY 2025-26 is 2:1 (RAEs can earn twice as much as PCMPs). The proposed reduction was applied equally as shown in the chart on page 30 of the JBC staff supplemental briefing document. This yields a new total proposed budgeted amount of earnable incentive payments of $17.6 million as shown in the chart on page 30, of which total RAEs can earn 66% and PCMPs can earn 33%. The 75:25 (PCMP:RAE) ratio of earnable incentives does not come into play until next fiscal year, FY 2026-27, when the incentive metrics change again. As this request is for an ongoing decrease, the Department attempted to describe the out-year long term ratio but failed to clearly define the fiscal years in which the varying ratios were applied.

The JBC asked for details on how the reduction to the incentive program was calculated. The calculation details are:

- Total budget for ACC Quality Program FY 26 = $53,500,227
- Set aside (budgeted) for last year performance (contractual obligation associated with ACC Phase II KPI and performance Pool) = $43,558,654
- Incentives for activities this fiscal year (FY 2025-26) = $9,941,572
- Proposed reduction of 23.3% applied to remaining budget of $9,941,572 = $2,317,086 TF ($750,000 GF) for a new total earnable pool in FY 25-26 of $7,624,486

This proposed reduction for FY 2025-26 is being applied to RAE:PCMP as a 50:50 ratio (see above calculation). The $9.9 million cited above is less than the total earnable incentives cited in the table on page 30 of the JBC staff supplemental briefing document. The reason for the discrepancy is the difference in potential earnings vs likely earnings. The Department projects that the RAEs and PCMPs will only earn $9.9 million of the total potential $17.6 million. This is based on historical earnings and the relative difficulty of the metrics.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.11 Provider rates -1.6% (Approved, JBC requested informational comeback)

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.11 Provider rates -1.6%

	Original Request	JBC Action	Comeback Request
Total Funds	-108,167,253	Approved	JBC requested informational comeback
FTE	0.0		
General Fund	-38,277,173		
Cash Fund	-5,938,052		
Reappropriated Funds	0		
Federal Funds	-63,952,028		

(Note: FY 2026-27 GF impact is -$56,992,200)

Summary of JBC Action: The Joint Budget Committee approved staff recommendation for S6.11 Provider rates -1.6%.

Summary of Comeback Request: Senator Kirkmeyer requested that more information be provided detailing the process of receiving federal approval from the Centers for Medicare and Medicaid, as well as approval from the Medical Services Board, and how the proposed rate change could be implemented before either approval process is completed.

Analysis

Given the passage of SB 25B-001, Processes to Reduce Spending During a Shortfall, the Department is following the Governor's Executive Orders (D 25-014, as amended by D 25-020 and extended through February 28, 2026 by D 25-022), to make the necessary changes that will support balancing the budget in the current fiscal year.

Medical Services Board

It is the responsibility of the Medical Services Board to adopt the rules that govern the Department's programs. This includes, but is not limited to, detailing eligibility requirements, programmatic requirements, expectations of providers, and methods for determining rates. With the exception of a couple of smaller programs, specific rates are not in rule. Thus, rate changes do not generally need to be approved by the MSB. However, some policy changes do need to be approved by the MSB. If there is not approval by the MSB, it can result in a contradiction between state or federal law and Department rules. Rulemaking under the regular process requires an initial reading and vote in one month followed by a final reading and vote in the subsequent month. The rule can then become effective in the first month following the final vote provided that there has been sufficient notice with the Secretary of State. Otherwise,

the rule becomes effective in the second month following passage. Emergency rules are sometimes used during fiscal and public health emergencies, or when the implementation timeline does not allow for the regular process. Emergency rules may be heard, passed and made effective in the same month. All rules go through a public rule review process and most also go through a more in depth stakeholdering process that allows the Department to make adjustments to the language.

CMS Approvals

Many, but not all, policy changes need CMS approval through a state plan amendment (SPA) or change to the applicable waiver. The state must submit a SPA before, or during, the calendar quarter it becomes effective. A SPA effective date may be backdated to the first day of the calendar quarter, so long as the SPA is submitted by the end of that calendar quarter. Once approved by CMS, the SPA effective date remains unchanged, even if CMS approval came after the effective date. The Department uses the retroactivity of SPAs to help meet our deadlines for implementation as mandated in state or federal laws and regulations. CMS has 90 days to respond to, or reject, the SPA submission. If CMS does not take action on a SPA within the 90-day review period, it is automatically approved. CMS may issue formal requests for additional information (RAI) that serve to pause the 90-day SPA review clock while the Department prepares its response. The Department then has 90 days to respond (which may be extended with CMS approval). The Department received a RAI for the SPA that implemented the 1.6% Across the Board rate *increase*, effective July 1, 2025, that the General Assembly passed during the 2025 session, but was rolled back as of September 30, 2025 per state Executive Order. Due to the roll back of the 1.6% increase, the Department was required to include an access to care analysis in its response to CMS's RAI. The Department provided its response on December 29, 2025, and the SPA is still pending while CMS reviews the RAI response. The Department made the necessary changes to increase rates between July 1, 2025, and September 30, 2025, while the SPA has been under consideration. For rate changes, we often put them into the system to be effective as of the legislative implementation date while awaiting CMS approval. With policy changes, especially those that have a fiscal impact, the state practice is to await CMS approval before implementing changes because there can be significant nuance to the language CMS wants in the SPA or its placement in the State Plan.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.13 Nursing minimum wage

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.13 Nursing minimum wage

	Original Request	JBC Action	Comeback Request
Total Funds	-8,719,922	Approved	Request for legislation
FTE	0.0		
General Fund	-4,359,961		
Cash Fund	0		
Reappropriated Funds	0		
Federal Funds	-4,359,961		

(Note: FY 2026-27 GF impact is -$4,359,961)

Summary of JBC Action: The Joint Budget Committee approved staff to account for the savings from the first half of the fiscal year, but did not approve legislation to remove the obligation to make these supplemental payments from state statute.

Summary of Comeback Request: OSPB respectfully requests that the Joint Budget Committee sponsor legislation to remove the nursing facility supplemental payments for the current fiscal year from state statute.

Analysis

The Governor's Executive Orders (D 25-014, as amended by D 25-020 and extended through February 28, 2026 by D 25-022) suspended the expenditures for this program, as authorized by SB25B-001. The current executive order expires on February 28, 2026.. Because we are still in the current fiscal year, if existing statute requires these supplemental payments in the current fiscal year, the Department will be obligated to make the payments retroactively upon expiration of the Governor's Executive Order. Accounting for these savings also requires removing the obligation from statute. We respectfully request the JBC to sponsor legislation to remove this obligation from statute.

At this point in time the Department believes that continuing with the FY 2025-26 payment would be wasteful and potentially duplicative as cost reports take into account all employee wages at $15 per hour and the wage gap this payment attempted to supplement has dropped by over 92% as minimum wages and provider rates have increased.

This payment originated initially with HB 19-1210, which authorized local government minimum wage increases, then was expanded through HB 22-1333 which sought to

increase nursing facility minimum wages to $15/hour statewide. The purpose of the payment was to capture a nuance in cost reporting related solely to cash flow. Nursing facility rates are calculated on a prospective, meaning that current costs are based on past expenses. There was concern that requiring these facilities to increase wages would cause a cash flow squeeze at the initiation of new minimum wage requirements, as their rates did not reflect the higher wage. Cash flow was of extra concern during the COVID-19 recovery. This resulted in a temporary supplemental payment being approved to alleviate the issue.

It has now been 4 years since the $15 hour was put into place. All cost reports and rates now reflect expenses that include $15/hour for all employees. As a result this payment is now arguably duplicative. In addition, the appropriation is no longer in line with funding the difference between actual minimum wage and $15/hour.

- In 2022 the Colorado minimum wage was $12.56/hour, the budget for this payment was developed to fill $2.44/hour for each affected worker.
- In 2025 the Colorado minimum wage was $14.81/hour. The payment has the same budget to fill just $0.19/hour for each affected worker.

This payment is currently structured as an annual payment. The FY 2025-26 payment would typically be sent in Spring 2026 to reimburse for calendar year 2025 wages. Cost reporting confirms that labor challenges have been substantially alleviated since HB 23-1228 authorized substantial increases in rates and we are no longer observing the same cash flow concerns that advised this minimum wage payment at adoption.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions & S-07/BA-07 Additional Reductions Package, S6.23 and S7j Adjusting Rates above 85%

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions & S-07/BA-07 Additional Reductions Package, S6.23 and S7j Adjusting Rates above 85%

	Original Request	JBC Action	Comeback Request
Total Funds	-$16,320,469	Approved	Informational
FTE	0.0		
General Fund	-$4,612,165		
Cash Fund	-$1,158,753		
Reappropriated Funds	0		

	Original Request	JBC Action	Comeback Request
Federal Funds	-$10,549,551		

(Note: FY 2026-27 GF impact is -$16,180,259)

Summary of JBC Action: The Joint Budget Committee approved the Department's request to reduce rates to 85% of the Medicare benchmark on a vote of 4-2, with Senator Kirkmeyer and Representative Taggart objecting.

Summary of Comeback Request: Representative Taggart requested the Department provide estimates for the fiscal impact of increasing all applicable rates below the 85% benchmark up to the 85% benchmark.

Analysis

The estimated fiscal impact of increasing rates for procedure codes that have Medicare rates and are currently below 85% of the Medicare benchmark to 85% of the Medicare benchmark is $20.9 million General Fund as shown below.

Service Category	Fiscal Impact (TF)	Fiscal Impact (GF)
Anesthesia	$2,861	$850
Ambulatory Service Centers	$1,155,302	$343,356
Dialysis	$604,243	$179,581
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	$5,976,174	$1,776,119
Emergency Medical Transportation	$15,917,391	$4,730,649
Fee for service Behavioral Health	$14,562	$4,328
Laboratory and Pathology Services	$628,221	$186,707
Maternity	$209	$105
Outpatient PT/OT/ST	$3,337	$1,669
Physician Services	$7,591,730	$2,256,262
Surgery	$31,109,549	$9,245,758

Vision Services	$7,166,336	$2,129,835
Total	**$70,169,916**	**$20,855,218**

Comeback: Health Care Policy & Financing S-07/BA-07 Additional Reductions Package, S7e XL wheelchair transport (JBC requested informational comeback)

Department: Health Care Policy & Financing

Request Title: S-07/BA-07 Additional Reductions Package, S7e XL wheelchair transport

	Original Request	JBC Action	Comeback Request
Total Funds	-32,916,295	Approved	JBC requested informational comeback
FTE	0.0		
General Fund	-9,899,892		
Cash Fund	-6,558,355		
Reappropriated Funds	0		
Federal Funds	-16,458,048		

(Note: FY 2026-27 GF impact is -$18,189,779)

Summary of JBC Action: The Joint Budget Committee voted to approve the Department's request to decrease rates in nine metro counties for providing transportation to people in extra large wheelchairs.

Summary of Comeback Request: The Department is providing information, as requested by the Joint Budget Committee, that explains why the lower reimbursement rate of $65 is appropriate.

Analysis

In 2020, the Department provided guidance that providers could use the "specialty ambulance service" billing code for "extra-large wheelchair transports". For members who use bariatric or oversized wheelchairs, commonly referred to as XL Wheelchair transports, additional staffing and equipment are sometimes needed to ensure safety and accessibility. Because of the additional staffing and equipment, the Department provided guidance in 2020 that providers could use the "specialty ambulance service" billing code when XL Wheelchair services were needed. At the time the cost per pick

up was $232.44. That rate was increased in 2022 to $639.42 when the JBC approved rate increases for all types of transportation. Utilization of this code remained low until about 2023 when data began to show a marked increase in costs and utilization. This increase coincided with and was overshadowed by the explosion of fraud in the NEMT space in 2023, and was masked by the significant rate increases to both transportation types and mileage rates ($2 to $6 dollars per mile).

This 2020 guidance was only given for the nine metro counties served by our NEMT broker. In the other 55 counties, providers mostly continued using the correct NEMT wheelchair transportation code.

In 2025, when the Department was once again conducting routine, detailed data analysis of the program outside of the fraud context, we noted the problem and proceeded to carefully evaluate the policy and community needs to avoid making an overcorrection that would harm members. We researched current methods of transporting members who use a wheelchair, such as an environmental scan of the makes/models of vehicles doing this and the wages of staffing levels needed for appropriate and safe member care. The Department then issued a billing and policy correction in November 2025 directing providers to now use either base code A0130 for NEMT wheelchair transportation services requiring a single attendant, which pays at $34.41 per pickup plus $3.00 per mile traveled, or A0130+U9 for two-attendant trips, which pays $65 per pickup plus $3.00 per mile traveled. Since making this change, we have not received complaints about member access to care, and utilization data shows continued steady use of NEMT wheelchair transportation services.

The Department is increasing RAC audits within NEMT services in order to identify similar billing issues sooner.

The Department will also be taking steps to investigate whether there was any intentional upcoding by providers that would justify recoupment.

How many rides and expected savings

- Number of trips: Approximately 143,970 NEMT wheelchair transportation trips were paid at the A0434 rate from January 1, 2020 through October 2025. At this time, it is not clear how many of these trips were appropriately coded for ambulance usage versus wheelchair van.
- Through the correction and building of a two-attendant payment rate, significant savings are projected going forward ($32.9 million TF, $9.9 million GF in FY 2025-26, and $60.4 million TF, $18.2 million GF in FY 2026-27).

Comeback: Health Care Policy & Financing S-08 / BA-08 Federal HR 1 compliance

Department: Health Care Policy & Financing

Request Title: S-08 / BA-08 Federal HR 1 compliance

	Original Request	JBC Action	Comeback Request
Total Funds	5,366,498	5,366,498	5,459,556
FTE	4.0	4.0	4.0
General Fund	513,069	0	58,458
Cash Fund	0	513,069	574,940
Reappropriated Funds	0	0	0
Federal Funds	4,853,429	4,853,429	4,826,158

(Note: FY 2026-27 GF impact is $886,331 with ~$14.8 million CHASE CF)

Summary of JBC Action: The Joint Budget Committee approved staff recommendation to fund system changes, member support, and fraud prevention related to complying with H.R. 1 with cash funds from the hospital provider fee, rather than general funds as originally requested.

Summary of Comeback Request: While the Department can fund most of the work outlined in the S/BA-08 request with cash funds from the hospital provider fee, there is a small amount of work that does not relate to Medicaid expansion populations and the request will therefore need to leverage a small amount of general funds.

Representative Taggart additionally requested that the Department provide additional information detailing how the software changes outlined in the request are part of a larger strategy to improve the state's CBMS IT system.

Analysis

JBC staff recommended and the committee approved the Department's request for FY 2025-26, but shifted all state funding to come the hospital provider fee. While the Department generally agrees that the provider fee can and should pay for a significant portion of the request, there are some initiatives that are not specific to the expansion population and thus still need to be funded with the General Fund. That includes the stakeholder engagement contractor ($130k TF, $42k GF), and OCL grievances and appeals ($52k TF, $17k GF). Those initiatives are broader to Medicaid and use the full Medicaid caseload allocation.

With the shift in funding, the Department's comeback is actually an increase from the original request by about $93K TF. In the submission, and JBC staff recommendation, the CBMS related state share was being offset with CBMS roll forward General Fund. Because the systems costs are related to the expansion population, that offset no longer applies and results in a net increase of $93K TF ($93K HAS CF).

The software changes outlined in this request will ultimately inform the requirements of the broader CBMS improvements, but it's important to note that the CBMS procurement is separate from HR1 and on somewhat of a different timeline.The current request is to create a minimum viable product to meet the base CBMS requirements. The CBMS request is a separate but related request. The larger system changes and costs as articulated in the budget amendment are anticipated in later phases over several years. This is why the system cost is minimal for the base changes to meet the immediate federal requirements.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.09 Outpatient psychotherapy prior authorization

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.09 Outpatient psychotherapy prior authorization

	Original Request	JBC Action	Comeback Request
Total Funds	-15,665,471	Denied	Informational
FTE	0.0		
General Fund	-6,120,810		
Cash Fund (Name)	-479,568		
Reappropriated Funds	0		
Federal Funds	-9,065,093		

(Note: FY 2026-27 GF impact is -$12,241,619)

Summary of JBC Action: The Joint Budget Committee denied the Department's request to implement prior authorization requests (PARs) for outpatient psychotherapy, as recommended by JBC staff.

JBC staff recommendation to deny the Department's request was partially based on the interpretation that the Governor's Executive Order allows the executive branch to reduce spending by ending practices currently in place, but it does not give them the authority to start practices they are statutorily prohibited from doing. JBC staff

argues this is the case with implementing PARs for psychotherapy, as is requested in S6.09.

Summary of Comeback Request: OSPB requests that the Joint Budget Committee approve the Department's request to implement PARs for outpatient psychotherapy, as originally requested and introduce legislation to allow PARs for outpatient psychotherapy. OSPB and HCPF are happy to work with the Committee on other utilization management solutions.

Analysis

Pursuant to 24-75-201.5(1) the Governor has the discretion to suspend or discontinue the functions or services of any department. The provision of outpatient psychotherapy is such a service that the Governor has the discretion to discontinue pursuant to this statutory authority. Rather than end the Medicaid outpatient psychotherapy benefit, discontinuing the prohibition on prior authorization function is consistent with the Governor's authority under the law and helps achieve the necessary budget cut.

HCPF's utilization data on the use of outpatient therapy (individual, group and family) is a significant cost driver of BH spend, with the increases of over 26 visits disproportionately driving the increase. The Regional Accountable Entities can use retroactive reviews and pre-payments reviews to ensure that medical necessity is met, and the Department requests removing the statutory prohibition on Prior Authorizations for outpatient psychotherapy, allowing RAEs to request additional documentation as needed for levels of therapy that are significantly higher that most recommended courses of treatment.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.12 Community connector -15% (Approved, JBC requested informational comeback)

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.12 Community Connector Rate Decrease

	Original Request	JBC Action	Comeback Request
Total Funds	-$6,026,470	Approved	JBC requested informational comeback
FTE	0.0		

	Original Request	JBC Action	Comeback Request
General Fund	-$3,013,235		
Cash Fund (Name)	$0		
Reappropriated Funds	$0		
Federal Funds	-$3,013,235		

(Note: FY 2026-27 GF impact is -$6,026,469)

Summary of JBC Action: The Joint Budget Committee approved the Department's request to reduce the forecast by $6.0 million total funds, including $3.0 million General Fund, for a 15.0 percent reduction to the community connector service rate.

Summary of Comeback Request: Senator Amabile requested that the Department provide additional justification how the combination of reductions to community connector services, caps on HCBS, caregiving and homemaker hours will be done in a way that would not cause a disproportionate negative impact on families utilizing many of these services.

Analysis

While the Department recognizes that any change to programs can be difficult, there was an intentional effort to distribute the impacts of these policy adjustments across the LTSS population and to target the outliers in service utilization. Because the Department does not, in many cases, differentiate paid family caregivers from other paid providers within our data, it is difficult to quantify the family impact for some of these changes. The Department can, though, demonstrate the member impact for the new caps that will directly impact member services, including the Community Connector unit cap, the Community Connector age limit, and the HCBS Soft Caps. Data on previously utilized hours shows that approximately 92% of LTSS Members will not experience a change in their services. Among those who receive any of the included services (Community Connector, Personal Care, Homemaker, and Health Maintenance Activities), only 12% will be impacted by one of the proposed changes. A very small subset of these members, less than 1%, are expected to be impacted by two of these changes. This is an estimate based on previously utilized services and does not take into account the exceptions process that will be available for individuals who truly require the level of service that they currently receive.

Focusing on the caregiver limits that are being proposed, it is important to note that the ability for family caregivers to be paid to provide an exceptionally high number of hours per week is a new allowance within HCBS and that these proposals will bring the State back in line with what was largely the norm for these services prior to July 1,

2025. On this date, a new HCBS option, Community First Choice (CFC), became available. This new state plan option expanded many previously limited services that family caregivers were not allowed to be paid to provide or had strict limits to the number of hours in which family caregivers could be paid. With CFC, that allowance was expanded to 112 hours a week of care that could be provided by a singular caregiver. In retrospect, this number greatly exceeds what is both reasonable for the health, safety, and welfare of the individual and caregiver as well as what is appropriate within the context of the budgetary situation. In reviewing national policies, many states do not allow family caregivers to be paid to provide services at all and more have implemented caregiver limits. Though there will be an impact on the families of members who are currently providing care over 56 hours per week, the Department is working to right size this allowance to support the health and safety of members and caregivers while also appropriately reigning in the growing cost of Medicaid.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.14 Individual residential services & supports

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.14 Individual residential services & supports

	Original Request	JBC Action	Comeback Request
Total Funds	-$2,900,558	Denied	-$2,900,558
FTE	0.0		0.0
General Fund	-$1,450,279		-$1,450,279
Cash Fund (Name)	0		0
Reappropriated Funds	0		0
Federal Funds	-$1,450,279		-$1,450,279

(Note: FY 2026-27 GF impact is -$2,284,479)

Summary of JBC Action: The Joint Budget Committee denied the Department's request to reduce the forecast by $2.9 million total funds, including $1.5 million General Fund, through an adjustment to the rate structure for individual residential services and supports (IRSS).

JBC staff recommended against beginning implementation of IRSS rate restructure in April 2026, based on the assumption that this item was not included in the executive

order issued under SB25B-001 and therefore the request did not meet supplemental criteria. Staff also expressed concerns about impact on beneficiaries.

Summary of Comeback Request: OSPB respectfully requests the Joint Budget Committee approve the Department's request to restructure rate reimbursement for IRSS services, as originally requested.

Analysis

OSPB believes the request meets supplemental criteria, as the policy change was included in the Governor's October Executive Order D 2025 014 issued under the authority of SB25B-001 on August 28, 2025.

The IRSS Rate Alignment is aimed at ensuring that reimbursement for services is in alignment with our payment methodology, which has a lower rate for settings with a primary live in caregiver, where the cost for providing the service is lower, and a higher rate for settings with rotating staff, where the cost for providing the service is higher.

The Department initially anticipated implementation of this action in January 2026 to secure additional savings for the state, but has been working in partnership with stakeholders to gather their feedback, hear their concerns and make adjustments to drafted regulation language based on their input. Additionally, with the announcement of additional changes to be rolled out April 1, 2026 (for example, the HCBS soft caps), the Department determined that aligning the roll out of these actions would simplify the implementation process for Case Managers and support clearer communication to members and families. This adjustment in the timeline was part of an effort to work collaboratively with community partners when implementation timelines are already very tight.

Finally, the Department understands that all of the changes being proposed are difficult for members and families. Unfortunately, despite the change having a negative impact on some members and their families, the decision to make the adjustment is based on the fact that there is no differentiation between a family caregiver and other caregivers within any of the state's waiver services, including IRSS. The Department is required to be a good steward of public funds, and determining payment rates based on familial affiliation is not a sound or equitable basis for decision-making. Instead, the Department relies on the costs to provide the service, regardless of who the provider is, and a family setting experiences the same service-related costs as a host home or other non-family residential setting.

It is also important to consider the broader compensation context: over the past five years, IRSS rates have increased by approximately 36 percent, reflecting sustained

investment across all residential settings, including family caregivers, with average annual growth of 6 to 7 percent. In many cases, these payments are tax-exempt, increasing the effective value of reimbursement, and caregivers may also receive payment for additional Medicaid services, such as day services, further contributing to total annual compensation.

Taken together, these factors support the Department's conclusion that reimbursement options remain strong for the family caregivers who may be impacted. The proposed alignment does not undo prior rate increases, but ensures that existing rates are applied consistently in accordance with the federally required rate methodology. The Department has worked extensively with the disability community and industry leaders to develop this proposal and remains confident that it represents the appropriate balance of equity, sustainability, and compliance, despite continued requests from some paid family caregivers for there to be no change to the existing policy.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.17 IDD youth transitions and S6.18 IDD waitlist (Informational)

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.17 IDD youth transitions and S6.18 IDD waitlist

	Original Request	JBC Action	Comeback Request
Total Funds	145,844	Denied	Informational
FTE	1.0		
General Fund	72,922		
Cash Fund (Name)	0		
Reappropriated Funds	0		
Federal Funds	72,922		

(Note: Amounts are combined S6.17 and S6.18, FY 2026-27 GF impact is -$7,630,688 for S6.17 and -$3,248,585 for S6.18)

Summary of JBC Action: The Joint Budget Committee voted to deny the Department's request for resources to support a policy change ending the automatic enrollment to the Adult Comprehensive (DD) waiver of youth who age out of the

Children's Extensive Support (CES) and Children's Habilitation Residential Services (CHRP) waivers, as recommended by JBC staff.

The Joint Budget Committee additionally voted to deny the Department's request for resources to support a policy change reducing by half the number of individuals automatically enrolled from the waitlist for the Adult Comprehensive (DD) waiver, as recommended by JBC staff.

Staff's recommendation and the Committee's action was focused on the current year aspect of the request and not the FY 2026-27 policy.

Summary of Comeback Request: This is an informational comeback to highlight that without FTE and contracting resources in the current fiscal year, the Department will be unable to begin implementation and realize savings necessary for balancing in FY 2026-27. OSPB is not making a supplemental comeback request for the denied FTE and contracting resources requested by the Department to support its initiatives to end automatic youth enrollment and reduce automatic monthly enrollments onto the DD waiver, beginning on July 1, 2026 and instead respectfully requests that the Committee consider a July 1, 2026 start date for the FTE and contracting resources in figure setting.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.30 HCBS hours soft cap

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.30 HCBS hours soft cap

	Original Request	JBC Action	Comeback Request
Total Funds	-335,604	Approved policy, denied FTE	$120,000
FTE	1.5		0.5
General Fund	-$1,160,504		$60,000
Cash Fund (Name)	0		0
Reappropriated Funds	0		0
Federal Funds	-$1,160,504		$60,000

(Note: FY 2026-27 GF impact is $80,000 GF, 1.0 FTE; note that the comeback amounts only reflect the FTE portion of the original request - not the full impact of the policy already approved by JBC)

Summary of JBC Action: The Joint Budget Committee approved the Department's request to implement a policy change instituting a soft cap on the use of various HCBS benefits, but denied the Department's request for FTE and resources to implement the policy.

Summary of Comeback Request: OSPB respectfully requests that the JBC approve the Department's requested resources to implement policy instituting a soft cap on these HCBS services:

- $120,000 TF/$60,000 GF and 0.5 FTE in FY 2025-26 annualizing to 1.0 FTE in FY 2026-27 and ongoing.

With consideration for limiting administrative overhead, the Department has reduced the request to 1 FTE position ongoing to oversee the exemption process associated with a soft cap on services.

Analysis

The services proposed to be included under the new HCBS soft cap are Homemaker, Personal Care, and Health Maintenance Activities (HMS). Currently 2,580 people are authorized above the new cap for Homemaker; 1,510 authorized above the cap for Personal Care; and 570 authorized above the cap for Health Maintenance Activities (HMA). Taken together, there are 4,660 members who may be eligible to submit an exception request for the newly proposed soft caps on these services. The Department estimated that approximately 50% of the members impacted would submit an exception request. These services (Personal Care, Homemaker, and HMA) support members with Activities or Daily Living and are vital services. Accordingly, we know some individuals will need to submit an exception request. Based on existing exceptions processes overseen by the Department, it is estimated that each exception can take up to 2 hours to process.

The Department believes the resources needed for this effort were accurately reflected in the initial request. However, with a commitment to continue this crucial discussion at figure setting, the Department respectfully requests 1 ongoing FTE. These staff will manage the exceptions process including: working with stakeholders to manage the exceptions process, reviewing exception requests, and approving or denying the exceptions. This includes reviewing the initial request to determine if the necessary information was received; reviewing supporting documentation; communicating with the members' case manager; requesting additional documentation or information as needed; drafting the decision notification to the case manager; modifying the approval status of the Prior Authorization Request in the MMIS; tracking approval/denial data to inform ongoing metrics and data analyses; and

working with benefit managers and internal leadership to identify trends and develop policy, practice, or training adjustments needed.

It is critical that funding for these positions begin immediately and are ongoing. Per the Governor's Executive Order, the new caps are planned to go into effect on April 1, 2026 and Case Managers are already having conversations with members, updating support plans, and submitting exceptions requests now in preparation of that implementation date. Further, relying on a contractor or third party for these HCBS (i.e. non-Medical services) will not create the process or involve the critical expertise needed to objectively review these complex services. For example, the case management system is already stretched thin and we believe, with evidence from previous service limitations, that case managers may grant far more allowances than appropriate and for the overall savings to significantly drop.

For this reason, the Department requires ongoing FTE to manage these requests to ensure that review and approval or denial of requests are individualized, based on solid documentation, and meet all exception requirements as required by the federal government. Without the resources to provide this oversight, the Department will be unable to obtain these critical savings to balance the budget and cannot in good faith commit to accomplishing these reductions.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.31 Caregiving hours soft cap

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.31 Caregiving hours soft cap

	Original Request	JBC Action	Comeback Request
Total Funds	-335,604	Denied	-335,604
FTE	0.5		0.5
General Fund	-167,802		-167,802
Cash Fund (Name)	0		0
Reappropriated Funds	0		0
Federal Funds	-167,802		-167,802

(Note: FY 2026-27 GF impact is -$1,133,374)

Summary of JBC Action: The Joint Budget Committee voted to deny the Department's request to implement a policy change instituting a soft cap on the paid weekly hours per caregiver providing services.

Summary of Comeback Request: OSPB respectfully requests that the JBC approve the Department's request to implement a soft cap on Caregiving hours, as well as the FTE and contracting resources necessary to implement the policy.

Analysis

The 56 hour weekly caregiver cap will introduce a new requirement for providers who will be required to staff individual members' care hours in a way that leverages a more diversified staffing pool. Providers must build and maintain a more robust and diverse workforce to supplement the important role of family caregivers, rather than relying on one person to do everything. Over time, this rebalancing is expected to promote more sustainable staffing patterns and support better continuity and safety for members.

The roots of this action see a return to a more thoughtful policy that was largely the norm for these services prior to July 1, 2025. On this date, a new HCBS option, Community First Choice, became available that expanded many previously limited services to allow for 112 hours a week of care to be provided by a singular caregiver. While each service and waiver may have differed slightly, the majority of these services had caps (40 hours or less) and for the majority of HCBS, legally responsible persons were unable to render those services. In retrospect, this number greatly exceeds what is both reasonable for the health, safety, and welfare of the individual and caregiver as well as what is appropriate within the context of the budgetary situation. In reviewing national policies, many states do not allow family caregivers to provide services and more have implemented caregiver limitations. For example, Idaho just ended its parental caregiving flexibility altogether. For most states that even allow family caregivers, our research shows this is capped to 40 hours a week while other states cap it on a set dollar amount. The Department sought to balance an amount that exceeds the pre-July 1st policy's allowance to allow for caregiver choice while better attending to health and safety, and appropriately supports reigning in the growing cost of Medicaid.

While the Department understands the critical budgetary situation and stands firm in the assertion that this cap on caregiver hours is the right long term policy, we understand that a more measured implementation plan may be necessary to give members, families, and providers additional time to prepare for this change. Accordingly, we would like to offer a stair-stepped implementation plan:

- Phase 1: Delay the initial implementation of a weekly caregiver cap until 7/1/26 (currently planned for 4/1/2026)
- Phase 2: 80 hour cap placed
    - Implemented 7/1/2026 through 8/31/2026
- Phase 3: 63 hour cap placed
    - Implemented 9/1/2026 through 10/31/2026
- Phase 4: 56 hour cap placed
    - Implemented November 1, 2026 ongoing

The Department wants to make clear that the administrative resources are still necessary with this newly proposed approach but commits to that conversation at figure setting.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.32 Homemaker hours soft cap

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.32 Homemaker hours soft cap

	Original Request	JBC Action	Comeback Request
Total Funds	-74,350	Denied	-74,350
FTE	0.0		0.0
General Fund	-37,175		-37,175
Cash Fund (Name)	0		0
Reappropriated Funds	0		0
Federal Funds	-37,175		-37,175

(Note: FY 2026-27 GF impact is -$223,051)

Summary of JBC Action: The Joint Budget Committee voted to deny the Department's request to implement a policy change instituting a soft cap on paid weekly hours for legally responsible persons providing these services.

Summary of Comeback Request: OSPB respectfully requests that the JBC approve the Department's request to implement a soft cap on Homemaking hours, as well as the contracting resources necessary to implement the policy.

Analysis

The Department respectfully requests reconsideration of the forecast reduction associated with instituting a cap on paid homemaker service hours for legally responsible persons (LRPs). This proposal reflects a targeted, data-driven policy adjustment intended to address rapid expenditure growth while maintaining access to core HCBS services.

Homemaker services will remain fully available to eligible members under Community First Choice. The proposed change applies only to paid services provided by legally responsible persons, not to the overall availability of homemaker services. Members may have up to two LRPs providing 5 hours per caregiver per week and any hours above the 5 hour LRP cap can be provided by an alternative caregiver. Utilization data shows that most members receiving homemaker services from LRPs use between five and six hours per week. The proposed five-hour cap reflects this distribution and was selected to minimize disruption. At the same time, expenditures for homemaker services have increased substantially, rising from $45.8 million in FY 2018-19 to $174.1 million in FY 2024-25, including 95.4 percent growth over the last three fiscal years, indicating a need for measured policy action to support program sustainability.

LRPs have an existing legal obligation to provide care independent of Medicaid reimbursement and this policy allows for a measured approach to a limit that is reasonable. The forecast assumes members currently exceeding the proposed cap will adjust utilization to the capped level. No behavioral offset was applied due to the small population affected, the clustering of utilization near the proposed limit, and the limited opportunity for substitution within this narrowly defined service. As a result, the projected savings are conservative and based on direct utilization adjustments.

Comeback: Health Care Policy & Financing S-06/BA-06 Executive Order and other Spending Reductions, S6.34 Community connector units

Department: Health Care Policy & Financing

Request Title: S-06/BA-06 Executive Order and other Spending Reductions, S6.34 Community connector units

	Original Request	JBC Action	Comeback Request
Total Funds	-$2,473,183	-$2,533,994	$60,811
FTE	0.5	0.0	0.5
General Fund	-$1,236,592	-$1,266,997	$30,405
Cash Fund	0	0	0

	Original Request	JBC Action	Comeback Request
Reappropriated Funds	0	0	0
Federal Funds	-$1,236,591	-$1,266,997	$30,405

(Note: FY 2026-27 GF impact is -$7,546,112)

Summary of JBC Action: The Joint Budget Committee approved the Department's request to place a cap on the amount of Community Connector units available to members weekly, as requested. However, the Committee denied the request for the resources (0.5 FTE, annualizing to 1.0) necessary to implement the policy.

Summary of Comeback Request: OSPB respectfully requests that the JBC approve the FTE (0.5 in FY25-26, 1.0 in FY26-27).

In addition, Senator Amabile requested that the Department provide additional justification for how the combination of reductions to community connector services, caps on HCBS, caregiving and homemaker hours could be done in a way that would not cause a disproportionate negative impact on families utilizing many of these services.

Analysis

Currently, there are 2,409 people authorized to receive services over the new Community Connector service limit. There are currently 523 members that will be under the age of six on April 1, 2026. The exception process developed by the Department will manage requests for increased units over the cap for the Community Connector service limit and for allowance to receive the service for individuals under the age of 6. Given that the age limit is new, the Department expects a large influx of requests initially, as well as ongoing as young members access the service. Though the Community Connector service limit and exception process for that limit is not new, the new lower limit will impact 55% of all members receiving the service. Given this significant decrease in the allowable units, the Department also anticipates sharp increases in exceptions requests once the new limit is live. When the Department implemented the cap of 2,080 units two years ago, there was a significant number of exception requests; with this 50% reduction in units, the Department anticipates that many members will request an exception.

Without the FTE to manage this process and review these requests, the Department will be unable to actualize the projected savings. Further, relying on a contractor or third party for these HCBS (i.e. non-Medical services) will not create the process or involve the critical expertise needed to objectively review these complex services. For example, the case management system is already stretched thin and we believe,

with evidence from previous service limitations, that case managers may grant far more allowances than appropriate resulting in a significant drop in the overall savings.

For this reason, the Department requests combining a portion of this position with another request ("HCBS Soft Caps") but still requires 1 FTE to meet its obligation. In total, OCL is dropping its total sustainability request to 2 FTE for across all denied FTE requests combined to manage these requests to ensure that review and approval or denial of requests are individualized, based on solid documentation, and meet all age and exception requirements as required by the federal government. Without the resources to provide this oversight, the Department will be unable to obtain these critical savings to balance the budget and cannot in good faith commit to accomplishing these reductions. The Department looks forward to continuing discussion with the JBC through figure setting to illustrate the need for the full FTE resources requested in the upcoming fiscal year.

Comeback: Health Care Policy & Financing S-13 Disability determinations

Department: Health Care Policy & Financing

Request Title: S-13 Disability determinations

	Original Request	JBC Action	Comeback Request
Total Funds	$1,275,000	$0	$1,275,000
FTE	0.0	0	0.0
General Fund	$802,544	$0	$802,544
Cash Fund	-$165,044	$0	-$165,0440
Reappropriated Funds	0	$0	0
Federal Funds	$637,500	$0	$637,5000

(Note: FY 2026-27 GF impact is $1,234,071)

Summary of JBC Action: The Joint Budget Committee voted to deny the Department's request for resources to address disability determinations caseload increases and to rebalance funding sources to accurately reflect the caseload split of traditional Medicaid members versus expansion population members.

Summary of Comeback Request: OSPB respectfully requests the JBC approve the Department's request as originally submitted.

Without additional resources, the Department will be unable to handle the volume of disability determination applications expected in the 2nd half of fiscal year 2025-26 and fall out of federal compliance.

Analysis

The Department does not have the option of not processing disability determination applications, as they are required for applicants to qualify for certain Medicaid programs. If the Department is not able to increase the budget for the disability determination vendor, it will negatively impact our vendor's ability to continue to process applications in a timely manner and likely will result in another backlog of applications. This will create eligibility delays because we are not able to process disability determinations in a timely manner, and each delayed application would be a potential Payment Error Rate Measurement (PERM) audit finding with a risk of federal clawbacks in the future.

The Disability Determination Services (DDS) program plays a critical role in ensuring timely access to services for individuals with disabilities. Disability determination application volume has increased significantly over the past few years, 74% since FY 2022-23. Currently, monthly application volume is approximately 1,300 cases, reflecting sustained growth in demand. However, the current contract appropriation has not kept pace with this increase, placing pressure on the vendor's ability to meet the 60-day timeliness standard required under the contract.

The current FY 2025-26 appropriation did not account for the recent surge in applications. Without an increase in funding, the Department risks continuity of services, maintaining contractual performance, and supporting the Department's statutory obligations to individuals with disabilities.

Disability determination applications must be processed within 60 to ensure enough time for counties to complete the eligibility determination process within their 90-day timeline. Prior to February 2025, the majority of disability applications were not being processed in a timely fashion because of a backlog created by the large jump in volume of applications without commensurate budget to process them. Consequently, the Department was under scrutiny from families and advocates to improve disability application processing times to ensure timely enrollment for some of the most vulnerable of our members. With a lot of additional oversight and management by the Department, the vendor was able to eliminate the backlog and bring application processing times into alignment with expected standards. Currently, the Department's vendor is processing more than 70% of disability applications within 45 days, making the overall eligibility determination process much faster for applicants, meaning individuals can access critical care much more quickly. However, without additional

funding, we will run out of funds on this contract by March. The Department would need to drastically reduce the vendor's processing to a level that will not overspend the contract. That would mean the vendor would process only 200 to 400 applications per month vs. the nearly 1,300 per month they are doing now. This will create a backlog and significant delays in eligibility determinations for applicants.