The Home and Community Based Services Developmental Disabilities (HCBS-DD) Waiver In Crisis

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Introduction

The Home and Community Based Services Developmental Disabilities (DD) Waiver, the only comprehensive adult Medicaid waiver in Colorado, provides the most severely Intellectually and Developmentally Disabled (IDD) adults with access to 24-hour, 7-day residential care.

Rising costs due to increased enrollment, increased utilization, increased cost of direct care workers, and misguided policy changes have created a funding crisis for this waiver. The DD waiver is expensive because it serves the most severely disabled adults in the State, and as the state strives to balance its budget with Medicaid eating up one third of the State budget, it is a tempting target for funding cuts.

In this paper, we will describe the current crisis, how it came to be, and the impact the crisis and subsequent proposed cuts to balance the state's budget have on severely developmentally disabled adults in Colorado and their families. We will then provide several alternatives that should be considered in lieu of cutting funding for the direct support Members have under the DD waiver.

While external forces such as the passing of H.R.1 in July 2025 have placed acute pressure on the entire Medicaid system and forced extensive unforeseen spending reductions in Colorado, the DD waiver itself has been specifically targeted. Recent cuts and changes in regulations have put the DD wavier at a crossroads. We hope this report helps unite stakeholders, policy makers, and legislators to restore this waiver to the funding levels it needs and requires to keep individuals with IDD safe and well-cared for in the community, which saves the State of Colorado money in the long-term.

I. The State of the DD Waiver in 2025

A. Definition, History, and Current Snapshot

The Home and Community-Based Services Waiver for Persons with Developmental Disabilities (DD), also known as the Comprehensive Adult Services Waiver, is designed to provide access to 24 hours per day, 7 days per week support through Residential Habilitation and Day Habilitation Services and Supports. The DD Waiver serves the most severely disabled adults in Colorado, including those with Intellectual and Developmental Disabilities (IDD), and is supposed to fulfill their needs for comprehensive services. Benefits include Residential Habilitation, Day Habilitation, Specialized Habilitation, Behavioral Services, Prevocational Services, Supported Employment, and a few other smaller, niche services.

The DD waiver was established in 1983, making it one of the oldest in the country. It was designed to offer a community-based alternative to the isolating, expensive, and low quality-of-care institutions that traditionally housed the developmental disabled population with significant care needs. The DD waiver was established just two years after the 1981 Omnibus Budget Reconciliation Act authorizing the home and community-based waiver programs, "waiving" federal requirements and giving freedom to states to provide personal care and other services to people in the community. Because Colorado was an early adopter of the DD waiver, it has shut down its institutions – otherwise known as Intermediate Care Facilities for Individuals with Intellectual Disabilities.[1]

[1] The State of Colorado maintains three "Regional Centers" that are Intermediate Care Facilities for Individuals with IDD. These facilities no longer provide long-term placement and are only for "short-term stabilization."

Until 2008, home-and community-based supports were limited to unrelated staff and providers. In 2008, recognizing the shortage of caregivers and the importance of family caregivers, Colorado passed the Family Caregiver Act, which authorized family caregivers to provide certain supports for individuals who were already authorized to receive services funded by the Colorado Department of Health Care Policy and Financing (HCPF), who oversees the Medicaid waivers. This law was fully implemented in 2010 and updated to include legal guardians of adults in 2011.

The DD Waiver currently has an 8+ year waitlist with some exceptions. Two pediatric waivers allow Members to bypass the DD waitlist when they reach age 18: the Children's Extensive Supports (CES) Waiver, and the Children's Habilitation Residential Program (CHRP) Waiver. In addition, two complex emergency placement scenarios can immediately enroll vulnerable DD adults on the waiver. Enrollment on the DD waiver has nearly doubled since 2014 as shown in Table 1. This should surprise no one, because the State ended the pediatric CES waiver waitlist with a funding increase in FY 2012-2013.

Table 1: DD Waiver Enrollment by Year

Fiscal Year	Total DD Waiver Cost ($)	Enrollment (FPE)
2012-13	261,817,957	4,156
2013-14	282,475,249	4,339
2014-15	314,878,205	4,617
2015-16	330,217,987	4,832
2016-17	347,057,913	4,933
2017-18	372,706,454	5,119
2018-19	422,166,719	5,664
2019-20	493,903,708	6,291
2020-21	500,009,085	6,666
2021-22	580,126,261	7,265
2022-23	659,218,333	7,700
2023-24*	760,619,294	7,709
2024-25**	890,727,622	8,404

S-5 FY 2025-26 Office of Community Living Cost and Caseload Adjustments, App. A, P. 18, Table D.2
*R-5 FY 2023-24 Office of Community Living Cost and Caseload, App. A1.1
**Estimate only, from documents cited

Costs to fund the DD Waiver have grown over the past decade for a variety of reasons. One of the most significant reasons is the general growth in the State population, which has doubled the number of enrollees on the waiver in the past decade. The second reason is that each year, a majority of new enrollees to the DD Waiver are higher support-level Members (Levels 5, 6, and 7). This is because most of the additions to the waiver each year are pediatric patients on the CES and CHRP pediatric waivers. The requirements for a Member to be enrolled onto the CES and CHRP waivers are full support with all or most Activities of Daily Living (ADLs) and the need for continuous support 24/7, particularly overnight. This phenomenon creates a form of adverse selection where the DD Waiver skews toward the most complex, high-support need Members who require more funding. Another important reason for increasing costs is that the life expectancy for developmentally disabled people is increasing, so they are living longer on the DD Waiver.[2] One of the most important reasons for increasing costs, however, is the need to adequately compensate the Direct Care Professional workforce. Traditionally, these jobs were at or near minimum wage. Direct Care Professionals were (and still are) difficult to find because the job requires a special blend of intelligence, empathy, patience, and adaptability that requires pay far above minimum wage. HCPF has taken steps to address this problem by increasing pay, but this continues to be a major challenge. HCPF reported as recently as February of 2025 that there is still a direct care provider workforce shortage.[3]

[2] Patja K, Iivanainen M, Vesala H, Oksanen H, Ruoppila I. Life expectancy of people with intellectual disability: a 35-year follow-up study. J Intellect Disabil Res. 2000 Oct;44 (Pt 5):591-9. doi: 10.1046/j.1365-2788.2000.00280.x. PMID: 11079356.

[3] Kaiser Family Foundation, Payment Rates for Medicaid Home Care: States' Responses to Workforce Challenges. https://www.kff.org/medicaid/payment-rates-for-medicaid-home-care-states-responses-to-workforce-challenges/

The focus of the DD waiver, and the bulk of the funding per Member, goes to Residential Habilitation, which is calculated based on the Member's level of need and their residential setting. For Individual and Group Residential Supports and Services (IRSS and GRSS), the waiver assigns a "Daily Rate" to be paid to the caregiver for care of the member, but it does not cover any housing itself. According to the Colorado Code of Regulations:

> Members receiving Residential Habilitation Service and Supports must have up to 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of the Member and the needs of the Member as determined by the Person-Centered Support Plan.[4]

Members on the DD waiver are assessed for the level of support they require and assigned a daily residential support rate based on that level and the residential setting in which they live. Until July 2025, the Supports Intensity Scale (SIS) was used to assess patients, assigning a Level 1 (minimal assistance required) through Level 6 (extensive support required) and an appeal-only Level 7 that resulted in a custom negotiated daily support rate. As of July 2025, the State of Colorado began using their own internally developed assessment tool, but there is not yet enough data to report on its validity or history, so for this discussion, we refer to SIS levels.

The Daily Rate depends on the SIS Level (1-6), the Residential Setting (IRSS, IRSS/Host Home, or GRSS), and the location of the home (inside Denver County vs. outside Denver County). Since the inception of Family Caregivers on the DD Waiver, they have been paid at the higher, IRSS rate.

While Group Homes are licensed and regulated by the state, individual settings are not licensed. They are regulated and overseen by Program Approved Supports Agencies (PASAs), who directly employ or contract with caregivers to provide IRSS and are responsible for:

[4] 10 CCR 2505-10 8.7541.C.2

1. Scheduled and unscheduled home inspections for compliance and safety, ensuring fire drills are completed;
2. Establishing, checking and updating the Medication Administration Record (MAR), controlled substances count sheets, medication disposal records, and PRN medication sheets to the client's current Medication list and authenticating and billing Medicaid for services performed.
3. Medical/therapy/mental health - Ensuring that regular, urgent and emergency needs are met, follow up is completed and visit summaries are provided.
4. Incident Reporting
5. Emergency plans & protocols

PASAs are compensated by taking 20-50% of the HCPF-established billing rate for all services billed. When rates are decreased, PASAs typically pass those decreases directly on to the provider(s). When rates increase, PASAs often do not pass the entire increase on to the provider(s), thereby taking a larger percentage of the Member's billed benefits over time. PASAs typically oversee most providers (both Host Homes and Family Caregivers) as independent contractors, which means caregivers often work 24/7 with no paid time off. Most PASAs do not help Family Caregivers find respite or back up care.[5] Host Home providers usually have the family for back up care when needed, and families often do so without pay. When a Member is hospitalized, the daily rate is not paid. Unfortunately, many higher SIS level patients are in the hospital for some portion of the year.[6] Without unemployment benefits, sick time, or PTO, caregivers are left without pay for the duration of the stay despite the fact that the caregiver is usually required to remain with the patient at all times because hospital staff cannot care for the Member continuously, as is often required.

[5] PASAs often do not provider back-up care when the family caregiver is hospitalized or ill, although the regulations require this. *See* 10 CCR 2505 8.7408.A.10. Many family caregivers are afraid to report their PASA for fear of retaliation.

[6] By contrast, nursing homes receive a bed-hold payment while a Member is hospitalized, usually up to 30 days.

B. Individuals With Higher Support Levels Are Already Underfunded

As discussed above, Members with higher-support needs are generally Levels 5, 6, and 7, although there are always people at lower support levels with complex behavorial or medical needs. HCPFs viewpoint is that the difference in compensation among SIS Levels adequately compensates for these differences in care.[7] Unfortunately, that is not the case. While the DD Waiver provides "access" to 24/7 supports, people at higher support levels need physical supports 24/7. This fact makes higher-support level individuals very difficult to place in Host Homes. Members who have skilled care needs (particularly RN/LPN visits or PDN) are basically impossible to place in Host Homes. When a nurse calls out sick or a PDN shift is left unfilled, Host Home providers are unqualified to provide back-up care provided by family members. Members who need support overnight are also going to have a difficult time finding a Host Home provider because most Host Home providers want to work in another position during the day while Members in their residence are at work or Day Programs. Aggressive behaviors and property destruction will render Members unsuitable for a Host Home. Members with high support level needs frequently do not have the ability to attend Day Programs or to participate in Supported Community Connections.

Members with skilled care needs (CNA, LPN, RN) are facing shrinking budgets for skilled care as well. When HCPF revised the HCBS guidelines this year, they attempted to define IRSS services as "all care at CNA-level or below." There is no blanket delegation under the nurse practice at that allows unskilled people to provide CNA-level care in the DD waiver. Nor is there supervision, which is required for delegation. Moreover, PASA liability insurance does not provide coverage for skilled care. If this were possible, Class A agencies would be rendered superfluous

[7] Personal communication with HCPF Director of Office of Community Living 9/9/25, available upon request

with the stroke of a pen. Members with RN/LN level care needs, whether LTHH or PDN, are seeing marked reductions in benefits. Multiple families are reporting going from 18-23 hours of PDN a day to **zero** on the DD Waiver, only to find that PDN hours are "magically" being restored if they shift to CFC/CDASS on the SLS Waiver. This reduction of care, when coupled with the 10% reduction in residential care, puts these members in serious jeopardy of institutionalization.[8]

All these factors affect the level of funding available to support a Member in a setting. Consider a simple example of a Level 6 outside Denver who needs to live in a setting without another Member and who needs overnight support for nocturnal seizures and wandering. When one takes the daily rate at the higher IRSS rate and divides it by twenty-four, the hourly rate available is $13.91/hour, below minimum wage. And that rate does not account for employment taxes, benefits, or agency overhead. The situation becomes even worse when accounting for expenses:

Table 2: "Staffed Home" Financial Model, Outside Denver County*

	IRSS Daily Rate ($)	Daily Rate after 30% PASA overhead ($)	Staffed Home with 1 24/7 staff member and 1 Resident, Hourly rate ($)	Staffed Home with 1 24/7 staff member and 2 Residents, Hourly rate ($)
Level 1	90.66	63.46	2.64	5.29
Level 2	147.84	103.49	4.31	8.62
Level 3	182.54	127.78	5.32	10.65
Level 4	224.83	157.38	6.56	13.12
Level 5	261.82	183.27	7.64	15.27
Level 6	334.01	233.81	9.74	19.48

*Minimum wage outside Denver County starting in January 2026 is $15.16/hr, except in Boulder and Edgewater where minimum wage requirement is higher

As the foregoing example demonstrates, the scenario does not even become viable until you reach two Level 5 and 6 Members living together. As a practical matter, it will be almost

[8] 10 CCR 2505-10 8.7541C.4.a.i

impossible to find staff at or near minimum wage. This model does not work for individuals who cannot live with another Member or for Members that require 1:1 staffing. If a Family Caregiver needs to hire hourly staff to support himself during the day while he works or attends to his own medical/health needs, or the needs of other family members, at the lower Host Home rate, this becomes difficult, if not impossible. Even so-called staffed homes (i.e., PCAs) have experienced difficulty in making this funding work and have needed to resort to unusual staffing models. One company does not allow Members in the setting who need support overnight. Between the hours of 10pm-6am, the Direct Support Professional on duty sleeps, but is not paid to sleep.[9] Because that DSP is not "in residence," this model can still be considered a "staffed home" that HCPF believes deserves the higher daily IRSS rate. Paying a higher rate for a staff member who sleeps and is unpaid versus paying lower rate for a parent or staff member who is in residence at night, has no logical justification.

The rate benchmarking of the Medicaid Provider Rate Review Committee ("MPRRC") demonstrates that the escalation of rates at different SIS levels is too flat. The MPRRC performed benchmarking of rates across multiple states for services at different SIS levels. For Day Habilitation funding, the rate benchmarks found that for Level 2s, Colorado was 123% of benchmark. For Level 5s, the benchmark rates dropped to 62.8%.[10] The MPRRC also noted that they have been repeatedly told by Provider Agencies in Colorado that even where the rate is 100% or greater of benchmark, they are having difficulty hiring Direct Support Professionals to work in the settings. The MPRRC had some general rate advice that included "equalizing the Outside Denver Rate and Denver Rate" by bringing everyone up to the higher rate. They also recommended that

[9] The authors question whether this violates Federal and/or State Labor Laws, but that is beyond the scope of this paper.
[10] MPRRC, July 12, 2024 Meeting, Slide 60. Unfortunately, there was insufficient data on Residential Settings to draw any conclusions.

when there was a rate discrepancy for similar services, that the rates be aligned to the higher rate. While we disagree that Family Caregivers are a "similar service" to Host Homes, as discussed below, if HCPF needs to align rates, they should bring Host Homes up to the IRSS rate and have a single rate for all settings.

C. Family Caregivers Are Not Host Homes

As discussed above, Family Caregivers have been allowed to be paid in Colorado for the past 16 years. There was a sharp distinction drawn early on between Host Homes and Family Caregiver homes. Host Homes have been defined as recently as this year as "unrelated persons."[11] Studies show that Family Caregivers provide more stable care with better longevity.[12] As discussed above, Family Caregivers are often providing care to members who could not live in a Host Home, so they are saving the State money by providing care that is much less expensive than a more expensive and restrictive setting. The daily cost in 2024 of a Regional Center was over $1080/day,[13] over three times what a Family Caregiver makes at the Level 6 IRSS rate. In the case of a Member who requires skilled care, Family Caregivers often provide uncompensated skilled care when a skilled provider is not available. Members also lose access to certain services when they enroll in the DD Waiver (e.g., hippotherapy, movement therapy, behavioral services beyond the very narrow limit allowed on the DD Waiver). Family caregivers often take money from their own daily rate to pay for the Member to have these services. Perhaps most importantly, Family Caregivers are not just doing a job: their care comes from a loving bond and years of experience with the Member's needs.

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[11] 10 CCR Sec 2505-10 8.600.4, Medical Service Board Rules.

[12] Carter K, Blakely C, Zuk J, Brittan M, Foster C. Employing Family Caregivers: An Innovative Health Care Model. Pediatrics. 2022 Jun 1;149(6):e2021054273. doi: 10.1542/peds.2021-054273. PMID: 35641467; PMCID: PMC9247720.

[13] S-5 FY 2025-26 Office of Community Living Cost and Caseload Adjustments, Table E.1 (https://hcpf.colorado.gov/sites/hcpf/files/HCPF%2C%20FY%202025-26%2C%20S-5a%2C%20BA-5%20Office%20of%20Community%20Living%20Cost%20and%20Caseload%20Adjustments%20-%20rem.pdf)

II. The Cuts to the DD Waiver are Unsound

On August 28, 2025, Governor Polis issued Executive Order D 2025 14, which according to the Governor's office, "sought to manage the budget shortfall created by H.R. 1." The Executive Order made over $250 million in cuts to the state budget, with most of the cuts to education and Medicaid. There is, however, no provision in H.R. 1 that cuts the federal matching funds for HCBS services. The two budget cuts relevant to the DD Waiver (which is an HCBS waiver) are: (1) the 1.6% reduction to provider rates across the board; and (2) the reduction in the IRSS rate to Family Caregivers.[14] The cuts imposed on the DD waiver to family caregivers are significant: they total 8-9% of the Member's annual budget. Given the economic realities above, there is no way to easily absorb these dramatic changes without significant risk of harm to Members.

A. The State's Non-Transparent and Politically Unaccountable Methods

The JBC considered numerous budget cuts in attempting to achieve a balanced budget in the Spring of 2025. Tom Dermody, a staffer, received a recommendation from HCPF to have the committee consider a cut that that would "eliminate the higher IRSS rate and align with the Host Home rate." The estimated savings was $16.5 million dollars.[15] Individuals who would be negatively affected by this proposal contacted the JBC and identified how this cut would harm individuals. The JBC chose not to enact the proposed cut. In fact, when H.R. 1 passed, the JBC held a special budget session to balance the budget, it did not revisit and adopt the cut to IRSS rates. The JBC, however, did pass a bill delegating to Governor Polis the authority to take measures to reduce the budget during a shortfall by executive order. It was under this authority that the Governor issued Executive

[14] The 1.6% cut rolled back the 1.6% increase to provider pay that the JBC implemented for the 2025-2026 budget year.

[15] JBC Staff Figure Setting FY 2025-26 Dept. of HCPF (OCL),3/6/25 p.66-68 (https://leg.colorado.gov/sites/default/files/fy2025-26_hcpfig3_1.pdf)].

Order D 2025 14.[16] HCPF seized the opportunity to make this cut and to avoid stakeholder accountability. When the cut was proposed originally in the Spring during the JBC process, the anticipated savings of the cut were $16.3 million and included **all** settings at the IRSS rate. When the cut was made through the EO, it was $1.45 million for one quarter, and it was limited to reducing the rate only to Family Caregivers and other settings (e.g., Member Homes and PCAs) that did not meet HCPF's new definition of a "staffed home." Upon inquiry to Tom Dermody and HCPF regarding the savings calculation, both have admitted that they do not know the number of Family Caregivers, so it is impossible for HCPF to project and calculate the actual savings that can be achieved with this cut. What HCPF did in recommending this cut to the Governor was to take a fiscally irresponsible and "wild guess" on savings. HCPF did not even bother to gather the necessary information on its cut to understand its actual financial effects, but insists that this cut is "done," and that it is "decided" and final. If HCPF overestimated savings on this cut, then it will violate Governor's EO (presuming it is legally valid). HCPF's lack of understanding of who is actually served on the DD waiver, and how, underlies the entire problem with the cut in the first instance.

B. HCPF's Disingenuous Position Regarding IRSS Rates

After the Governor's EO, HCPF started a concerted effort to re-write history: the cut was actually an "alignment" to bring Family Caregivers down to the IRSS Host Home rate because "most family homes and host homes operate in a similar manner," and Family Caregivers were improperly billing at the higher IRSS rate, resulting in "higher than appropriate expenditures." In its initial communication with the public regarding the cut, it stated that "agencies often bill at the higher rate." Another early memorandum stated "[t]oday, some family homes have been billing at the

[16] There is currently a lawsuit pending that seeks to declare EO D 2025 14 void on its face as an unconstitutional delegation of power and violation of the separation of powers doctrine. *See Colorado Ass'n for Behavior Analysis et al. vs. Colorado Department of Health Care Policy and Financing et al.,* Case No. 2025CV33489, Dist. Ct. for the City and County of Denver.

higher rate . . . ." To be clear, providers (family homes and otherwise) **do not** bill. They are not authorized to bill – only provider agencies (in this case, PASAs) bill Medicaid for services, including residential services. Importantly, however, PASAs do not decide what to bill – that decision is made by HCPF. During initial intake or continued stay review of a Member on the DD waiver, the Case Manager of the Case Management Agency (CMA, or in the past, CCB) develops a service plan. That service plan contains the billing codes that will be utilized by the PASA for billing purposes. That service plan is submitted to HCPF as a Prior Authorization Request ("PAR"). HCPF then approves or denies the PAR.[17]

It is clear that HCPF, not the CMA, not the PASA, and certainly not the provider, decides the billing rate for a Member in service. HCPF also has an opportunity to verify that the Member's billing codes are supported by the setting in which the Member lives. HCPF, through its designated agent, CDPHE, conducts periodic audits of all PASAs and inspects the setting of Member-clients as part of that audit process.[18] The authors of this paper contacted Family Caregivers who have been caring for Members since legal guardians were allowed to be family caregivers in 2011, and all of them said that they were receiving the higher IRSS rate since the initiation of the Family Caregiver Act on the DD Waiver. That means Family Caregivers have been receiving the higher IRSS rate for over a decade. HCPF's position that this is some "mistake" that continued for over a decade strains credulity. HCPF's position is exposed as an outright falsehood when one considers Informational Memorandum 25-015.[19] This memorandum is part of a series issued by HCPF providing guidance to Provider Agencies. The memorandum issued just five months ago on May 23, 2025, is authored by Colin Laughlin, Deputy Office Director at HCPF,

[17] 10 CCR 2505 8.7202.CC, 8.7407A, 8.7410A-C
[18] 10 CCR 2505-10 8.7541.D.3
[19] HCPF Memo 25-015 does not exist online anymore, but copies available upon request

and it unambiguously and directly instructs provider agencies to bill at the higher IRSS rate for **all** other settings other than Host Homes. The memo provides:

> Enrolled Provider Agencies will use the "IRSS/Host Home" rate for a direct care provider's home when they are a **non-related person, meaning a Host Home**. **All other provider or setting types would be characterized as "IRSS."** Legally responsible persons, including non-related legal guardians, are considered family members and categorized as "IRSS" (emphasis supplied).

When stakeholders pointed this out to HCPF after their notifications about the rate "alignment," HCPFs response was to delete the Memo off its official webpage. On September 19, 2025, at approximately the same time they deleted Memo 25-015, HCPF issued a notice through the OCL digest on September 19, 2025 that states, "to reduce confusion, we have updated our fact sheets and other informational resources. In the short term, we will remove outdated communications that may have caused further uncertainty."[20] In conjunction with the deletion of Informational Memo 25-015,[21] HCPF changed is informational memoranda and communications and changed language that laid fault with providers and provider agencies for charging at the higher IRSS rate. They changed the language and decided the incorrect billing was the result of "confusing" regulations.[22] Nothing is confusing about Memo 25-015 and the long-standing practice of billing IRSS for Family Caregiver homes, Member Homes and PCAs. HCPF is simply attempting to re-write history by deleting things that do not fit with its current narrative. This all may be an attempt to circumvent Federal Code requiring any substantive changes to a Medicaid waiver, including targeted

[20] OCL Digest email available upon request

[21] The fact that HCPF can delete a previously issued memorandum and make it inaccessible, even when it issues a new memorandum that supersedes it (which it did not even do here), is a separate legal problem that is beyond the scope of this paper, but this will need to be dealt with in the context of Colorado law regarding public records and agency transparency ("sunshine laws").

[22] HCPF's Memoranda regarding the rate cuts are accessed by the public via links to the memoranda on a Google drive, so when HCPF edits a memorandum, the original language is deleted and overwritten.

rate reductions such as these and rate methodology, undergo public comment process and CMS approval.[23]

The fact remains that HCPF's initial communications and correspondence improperly placed the blame for billing at the IRSS rate on providers and provider agencies, misleading the public to believe that somehow, either or both of these groups were "cheating" the system. This has seriously damaged stakeholder trust in HCPF, and HCPF must rectify this problem.

C. HCPFs Improper Effort to Silence Stakeholder Dissent

To keep a lid on its re-write of history, HCPF is unlawfully denying stakeholders the right to be heard through public notice and comment on new regulations that will make significant changes to setting definitions (beyond "staffed homes") and rates. In its notice regarding the first stakeholder meeting, held on October 14, 2025, HCPF stated, "[w]e recognize that upcoming changes to the IRSS rate alignment may create questions or concerns; however, this rate alignment is a directive for HCPF and public comment is currently not being collected."[24] This is another false narrative by HCPF. The Governor's EO, which expires at the end of the 2025-2026 fiscal year, only suspended $1.45 million dollars in funding for the DD Waiver. It did not specify where that funding needed to come from. For example, HCPF could be totally compliant with the EO and instead cut Supported Employment rates by 2% for the remainder of the fiscal year. It is not difficult between now and the end of the fiscal year to achieve $1.45 million in savings without cutting direct care funding by 10% permanently. HCPF is using the Governor's EO, which will expire on June 30, 2026, as an excuse to create lasting changes to regulations that will harm the DD Waiver for many years to come. This is impermissible under the Colorado Administrative Procedure Act (C.R.S. Sec. 24-4-103) and under the required process under CMS's Final Settings Rule, which requires that HCPF

[23] 42 CFR 441.304(d-f)
[24] IRSS Rate Alignment Stakeholder Meeting Agenda, October 14, 2025. https://docs.google.com/document/d/12RoYoB5m30I9GygRmsN9eRal9MaBSOlV/edit

"must establish and use a public input process, for **any** changes in the services or operations of the waiver" (emphasis supplied). *See, e.g.*, 42 CFR sec. 441.304 (f).

D. These Cuts Are Not Dictated by H.R. 1

The Governor's E.O. purports to make these cuts due to budget shortfalls created by H.R. 1. Nothing in H.R. 1 however, that will take effect now or in the future, reduces federal matching funds for HCBS. HCPF did a stakeholder presentation on August 12, 2025 that admitted as such. It identified several threats to funding from H.R. 1.[25] One is the reduction of federal funding to states for Medicaid fee for service through a reduction of 0.5% reduction per year of the Medicaid Provider Tax starting in 2028. The reduction of something that may never occur, and that certainly will not occur for another three fiscal years is certainly not something that warrants an emergent reduction of 10% to HCBS provider funding. Another major threat cited by HCPF from H.R. 1 is the reduction of federal matching funds ("CHASE") funding for the Medicaid expansion population – the population of adults that are at 100%-138% of the federal poverty level – which HCPF estimates are 377,000 Coloradans. HCPF also cites the work requirements for adults and the increased eligibility determinations every six months instead of annually as imposing additional administrative funding requirements. The loss of expansion funding does not include individuals on the DD waiver, because they are not qualified through Modified Adjusted Gross Income (MAGI) criteria. Similarly, H.R. 1 exempts work requirements and recertification every six months for adults deemed disabled by the federal government (this would include all individuals on the DD waiver). The work requirements and increased frequency of disability reviews are also not scheduled to start until January 1, 2027. HCPF states that its "North Star" is preventing loss of coverage to the expansion population – which is certainly a laudable goal. The solution, however, is not singling out and levying a cut to some of the most vulnerable disabled people in the State. HCPF could (and should) be working with the

[25] See Slide 8 of the August 12, 2025 HCPF Stakeholder Meeting

legislature to enact a special spending bill to work around TABOR and preserve coverage to the expansion population. The $1.45 million cut this year from DD Waiver funding does nothing to help with the very large hole in matching funds the federal government has created. And again, as unfortunate as H.R. 1's cuts are, none of them are directed to matching of HCBS funding on the DD Waiver.

III. The Increased Risk of Institutionalization

A. HCPF Failed to Engage in the Required Analysis Under HB 25-1017

HB 25-1017, enacted in May 2025, has an explicit requirement that the government consider the effects of any reduction in services will have in increasing the likelihood of institutionalization. This idea comes from the seminal precedent established by the Supreme Court in *Olmstead v L.C.*. 527 U.S. 281 (1999). The case, brought under the Americans With Disabilities Act (ADA), held that institutionalization of people who can safely live in the community and who desire to live in the community, is unlawful discrimination under the ADA. HB25-107 is a codification of Olmstead's holding under State law. The statute provides:

> If the Public or Governmental Entity cuts services, it **shall assess** whether the service cuts increase the risk of institutionalization for those individuals who are receiving services. In making such cuts, Public and Governmental entities **have a duty to take all reasonable steps to avoid placing qualified individuals with disabilities at risk of institutionalization**. (emphasis supplied).

HCPF has not provided the public with evidence that there is not an increased risk of institutionalization resulting from these cuts. In fact, HCPF has not even engaged in the required analysis of the risk at all.

Yet, the IRSS rate cuts do place Members at increased risk of institutionalization. Family caregivers or Members in their own settings, as discussed in Section I. in detail, rely upon hourly paid support from the daily rate and by reducing this rate in the face of rising costs, decreasing numbers of potential staff, and decreasing care options, there is an appreciable increase in the risk

that Members will no longer be able to live in the setting. Because Members who have high behavioral and medical needs are almost, without exception, unsuitable for Host Homes, these individuals will have no other setting where they can live outside of institutional care.

The State will no doubt point to the fact that HB25-107 states that it did not create any new cause of action for an *Olmstead* violation. The statute, however, acknowledges that the private right of action under the *Olmstead* precedent still exists under federal law. By logical corollary, an individual can enforce the requirements of HB25-1017 under *Olmstead*. It is a basic principle of statutory construction that the requirements of a statute must be enforceable against an entity, otherwise, the language is superfluous. Statutes should never be construed to read an intent that the legislature passed a statute with superfluous language ("verba cum effectu sunt accipienda").

B. HCPF is Improperly Shifting to Legal Guardians and Family Members

The effect of the IRSS rate reduction is to shift costs to legal guardians and Family Members either by making them: (1) to pay money out of their own funds for care; or (2) to provide more uncompensated care. For example, a Family Caregiver with a Member with skilled care needs will receive less compensation for the care they provide when skilled care cannot be found or is otherwise unavailable. A Family Caregiver who needs a few hours of respite to care for himself or herself to go a needed appointment, or to take a break from the demands of caregiving, will now have less funds to pay for that care and will either need to forgo that care or to take money out of their own pocket to pay for that care. For those who say that Host Homes also have these needs, the answer to that is families frequently provide that respite for the Host Home provider (often without being paid for it). Family Caregivers do not have similar supports to meet their own needs.

HCPF's cuts are simply shifting the cost of the Members' care from Medicaid to the Family Caregiver, and this is improper. Even legal guardians of adults are not required to use their own funds to care for the ward, to have physical custody of the ward, or to provide uncompensated care

themselves. C.R.S. § 15-14-316. HCPF continually confuses the natural requirements of the parent of a minor to expend their personal funds for care with the adult population. This distinction is critical, because there will be a time in the life of every Member on the DD waiver when his parents and/or legal guardians will be unable to provide funds or care for the Member and the Member will be entirely reliant on Medicaid sources of funding. HCPF should provide for orderly and reasonable transition planning. Waiting until disaster strikes and there is an emergency only will increase the Member's costs of care. This is HCPF's current modus operandi with the DD waiver waitlist – people can currently only be brought on with an "emergency" placement. Planning by emergency is inevitably more costly.

C. The IRSS Rate Cut Will Lead to More Restrictive Settings

i. PCAs and Member Homes With Someone in Residence - The cut in the IRSS rates will force Members who need staff to be awake some or all of the night to appeal for a Level 7 to have sufficient funding. By reducing the rates for PCAs and Member Homes who have an individual in residence down to the Host Home level, these settings will lose access to the necessary funds that help the setting operate. These PCAs will need to have 24/7 hourly staff around the clock – which is far more expensive and restrictive than a PCA with an overnight person in residence.

ii. De-stabilization of Family Caregivers - In at least some cases, Family Caregivers who pay hourly staff to help them on a regular basis while they work or take care of the household will now need to find an alternate, likely more expensive setting for the Member they serve because they can no longer make the economics work.

iii. Loss of Ability to Transition - Family Caregivers will not be able to have a period of transition of a Member to a PCA or alternative setting. If the setting has the Member living there part-time for a period to transition, the economics are likely to be unworkable if the Family Caregiver is operating at the lower, Host Home rate.

iv. Available Funding Will Now Be Higher on the SLS Waiver than the DD Waiver for the Same Participant in Many Cases – This is an outcome that should NEVER occur. There have been recent changes to the SLS Waiver with the introduction of Community First Choice ("CFC"). These changes have now moved Personal Care, Homemaker, and Health Maintenance Activities (HMA) or skilled nursing services (under Long-term home health, or LTHH) into a different source of federal funds that no longer draw off the HCBS waiver. In the past, individuals had an annual budget, known as a "SPAL," and all services on the SLS waiver drew off this annual budget, except for HMA or LTHH. With the advent of CFC, HCPF has suspended the SPAL under the regulations.[26] CMAs are now telling members that their budget is $95,000 a year, exclusive of CFC services, regardless of SIS/ISLA level. Unfortunately, due to a HCPF's lack of transparency on this issue, there are no written guidelines or documents that one can cite to refer to this. The detrimental effects of overfunding the SLS waiver are easiest to understand when you examine the funding for a Member on both the DD Waiver and the SLS Waiver. Consider the case of Member A, who is a real Member.[27] Member A is on the waitlist for the DD Waiver and is currently served on the SLS Waiver. Member A is a SIS Level 5 and has the CDASS service delivery model for Personal Care, Homemaker and Health

[26] 10 CCR 2505-10 8.7202.AA.2.viii

[27] Member A's identity has been concealed to protect the Member's identity.

Maintenance Minutes. Member A lives with her parent/legal guardian in the family home outside Denver. When this Member finishes her next CSR, her budget on SLS will be as follows compared to the DD Waiver and PRE-CFC:

Table 3: Example Member under pre-CFC SLS, post-CFC SLS, and DD waiver limits

Pre-CFC SLS BUDGET ($)		**POST-CFC SLS BUDGET ($)**		**DD WAIVER BUDGET ($)**	
Monthly Homemaker	1,000	Monthly Homemaker	1,100	Monthly DD Daily Rate (after 25% agency fee)	5,606
Monthly Personal Care	1,250	Monthly Personal Care	1,150	Supported Comm. Connector (after 25% agency fee)	2,121
Monthly HMA	4,000	Monthly HMA	4,000	Supported Employment (after 25% agency fee)	1,092
Monthly Remaining SPAL Available (after 25% agency fee)	1,207	Monthly Other Budget Available (after 25% agency fee)	7,916		
Total Monthly Funds Available	**7,457**		**11,791**		**8,819**
Total Annual Funds Avail.	**89,484**		**169,992**		**105,828**

Additional amount per month available on SLS vs. DD: $2971.30

This enormous differential is only going to drive people from the DD Waiver to the SLS Waiver, shifting the funding problems from one waiver to another. It is prudent for HCPF to avoid woefully underfunding the DD Waiver and overfunding the SLS Waiver, particularly given that the SLS Waiver is not designed to be "Comprehensive." Additionally, because the SLS waiver does not provide "access to services and

supports 24/7," if anything happens to the Member's primary caregiver, they will be forced onto the DD Waiver in an emergency placement. This is highly undesirable for a variety of obvious reasons.

IV. HCPF Could Make Other Cuts That Would Preserve the DD Waiver

To achieve its end in making cuts to the budget, HCPF has a few areas where it could save much more than $1.45 million in a quarter (or $5.8 million in a fiscal year).

A. Eliminate The Wasteful Nurse Assessor Program

HCPF instituted this very expensive program to provide a skilled person to review PARs for skilled and unskilled care for CFC and some of the HCBS waivers. This program has already cost Colorado taxpayers $52 million dollars over two fiscal years. HCPF asserted this program was necessary to eliminate "conflicts of interest" in having the agencies that provide care conduct assessments for the amount of care needed.[28] After initially delaying the implementation of the program, HCPF launched the Nurse Assessor program on August 1, 2025, only to pause most of its work "until further notice."

The pause occurred because the program was a failure from the outset. People were not schedule for timely assessments to meet Continued Stay Review (CSR) deadlines. Many people who were able to get appointments with an assessor reported wildly inconsistent results with prior years – sometimes increases of thousands of dollars a month over prior years and others reported

[28] https://hcpf.colorado.gov/nurseassessor#:~:text=The%20nurse%20assessor%20will%20eliminate,need%20for%20skilled%20care%20services. Of course, what HCPF was really saying is that agencies were engaging in fraud in care assessments and overstating the amount or kind of care that was needed (mostly Class A skilled care agencies). HCPF could have solved that problem without asking for additional HCBS funds: the agency could have contacted the Attorney General and requested that Class A agencies that appeared to be engaging in Medicaid fraud be investigated. If the AG determined there was fraud, not only would HCPF be able to recoup the funds that were misspent, but the State could earn additional money in disgorgement penalties, and it could debar agencies that were found to have committed fraud from continuing to operate in the State of Colorado. This would provide additional revenue for the State and act as deterrent to engaging in Medicaid fraud.

that their PDN hours were taken from 18-23 hours a day to **zero.** People with significant reductions in services either had to appeal to the Case Manager, **who can override** the Nurse Assessor, or had to appeal to the Office of Administrative Courts, creating a massive backlog in cases currently in that system. The system we had before was not perfect, but it did not cost taxpayers millions of additional dollars a year without any measurable benefit.

B. Impose An Additional 0.5% Rate Decrease Across the Board

As discussed above, the EO rolled back the 1.6% rate increase that the JBC gave providers for fiscal year 2025-2026. The EO could have instead imposed an additional, small, across-the-board 0.5% reduction which would have achieved approximately $18,000,000 dollars in additional savings, far in excess of the $1.45 million achieved with the IRSS rate cut. It would have done so in a manner that did not heavily reduce the funding for basic and direct care for the most vulnerable Coloradans.

C. Place a Moratorium on the Cover All Coloradans Program

Under this program, undocumented children under age 18 and pregnant women (up to a year post-partum) can receive Health First Colorado. This program just began in January of 2025. HCPF could have easily recommended a freeze on new enrollment to the program, and the State could achieve budget savings in the millions this fiscal year. This program does not and cannot legally receive any federal matching funds, in contrast to the HCBS waivers. While this is a politically charged topic, and providing Medicaid to all people does help defray more expensive and inefficient Emergency Room visits and care, this program should not be funded at the expense of developmentally disabled Colorado citizens – as discussed above, these cuts will result in more expensive care and settings for them as well.

In the hearing on EO 2025 14, multiple members of the Joint Budget Committee questioned Governor Polis why he chose to "decrease provider rates" from "programs that draw down on federal funds," instead of programs that do not. Governor Polis' response was that if the JBC did not like the cuts he made, the "JBC has the opportunity to choose different cuts or modify them in the spring budget session.".[29]

D. Curb Expenditures on HCBS Funding that Are Clearly Illogical

HCPF could (and should) also eliminate policies with expenditures that make no logical sense. In Section III., above, we provided a concrete example of that with the creation of a $95,000 budget for each person on SLS. HCPF should reinstitute a SPAL by SIS (or ISLA) level that can be generous given that multiple core services no longer draw on that budget.

Another stark example is the billing rate for Community Connector under the pediatric waivers. Although HCPF has made some effort to reign in the reimbursement rate for that service,[30] even after the reduction on January 1, 2026, the provider agency billing rate for that service will be $41.56/hour outside of Denver. That is still 16.3% higher than the reimbursement rate for Supported Community Connections for a Level 6 Member outside of Denver. There is no serious argument that it requires more skill to take a child out in the community than it does to take a Level 6 adult out into the community. Although we think the real issue is that SCC rates are too low, Community Connections rates are still too high.

[29] Joint Budget Committee Meeting 8/28/25, at 2:16:08pm (https://sg001-harmony.sliq.net/00327/Harmony/en/PowerBrowser/PowerBrowserV2/20250828/-1/17621#info_)
[30] The billing rate outside Denver, prior to the reduction, is $48.88.

V. Conclusion

HCPF recommended these cuts to the Governor without the required analysis of the increased likelihood of institutionalization required under Olmstead and H.B. 25-1017. The agency's proposed "staffed home" definition also favors more restrictive settings, without any rational basis, in violation of the Final Settings Rule. To justify these actions, HCPF has inappropriately cast blame on Family Caregivers, other non-Host Home providers, and provider agencies, making it seem like HCPF is just correcting the "stealing" of funding from the system for the past decade. And HCPF is also silencing public discussion that is required by law to prevent the truth from coming to light. Furthermore, HCPFs definition of a "staffed home" belies the realities of additional expenses and uncompensated care that Family Caregivers face. HCPF chose this vulnerable population for this cut because we are small in number, we do not have powerful state lobbyists, and we love our family members on the DD Waiver and want them to be well-cared for and safe. HCPF is improperly shifting the burden of care back onto families with uncompensated care. This strategy is not only illegal, it is short-sighted, and will result in greater Medicaid expenditures in the long-term. The members of the DD Waiver community will not remain silent.