NORC at the University of Chicago

Case Study

HCBS Case Study: Colorado

Project Description

NORC, in partnership with the Commonwealth Fund, conducted a comprehensive analysis of Medicaid Home and Community-Based Services (HCBS) across the United States. Following a manual analysis of all active 1915(c) waivers mapped to HCBS service types, eligibility, and scope by state, as well as a study leveraging Medicaid data, Colorado and Florida were selected to be featured as case studies of successful HCBS implementation, defined as a majority of LTSS users receiving HCBS and adoption of 1915(c) waivers and/or other approaches to support a wide range of target groups. NORC conducted a comprehensive review of state waivers, HCBS state plan benefits, and relevant literature, complemented by in-depth interviews with subject matter experts. This work examined successes in serving diverse populations, adaptations to anticipated Medicaid budget changes, and distilled key lessons for sustaining HCBS programs.

Background

STATE MEDICAID OVERVIEW

The Colorado Department of Health Care Policy and Financing (HCPF) administers Health First Colorado (Colorado Medicaid), and the Office of Community Living (OCL) oversees long-term services and support (LTSS) programs, including home and community-based services (HCBS). In FY 2023 – 2024, HCBS payments were 16.2% ($2.24B) of expenditures to Colorado Health First partners, and in 2023 they were 81.8% of Colorado's LTSS expenditures.[1] OCL collaborates extensively with other state agencies, including housing, behavioral health, and corrections, to address complex needs such as integrated housing solutions, behavioral health supports, and transitions from institutional settings to the community.[2]

Colorado Medicaid Population Characteristics, FY 2023-2024

- 1 in 4 (1.46 million) Coloradans enrolled
- 33% of enrollees were Hispanic/Latino, second only to White enrollees (39%)
- 87% resided in urban counties; 14% in rural and frontier counties
- 4.7% used LTSS programs
- 86,979 members were served by the LTSS programs; 56,190 (64.6% of LTSS) were served by HCBS waivers

WAIVER AND STATE PLAN AUTHORITIES UTILIZED

Colorado's OCL manages the state's nine 1915(c) waivers and the Community First Choice 1915(k) state plan amendment (implemented in 2025). With the oldest waiver approved in July 1985, the state currently offers six waivers to adult populations and three waivers for children and youth. Appendix A provides an overview of the purpose of each waiver and a comparison of the services and target groups for each waiver. Across the 1915(c) waivers, services are provided to the following target groups: Aged

(65+), Disabled (Physical)(18-64), Brain Injury (16+), HIV/AIDS (18+), Medically Fragile (0-18), Developmental Disability (all ages), and Serious Emotional Disturbance (0-20).

Case management services are provided through a statewide network of Case Management Agencies; case managers engage waiver clients in person-centered service planning activities designed to support them in the community.[3] Services include intake, eligibility determination, service plan development, arrangement for services, delivery of services, service and support coordination, monitoring, and termination and discharge from services.[4]

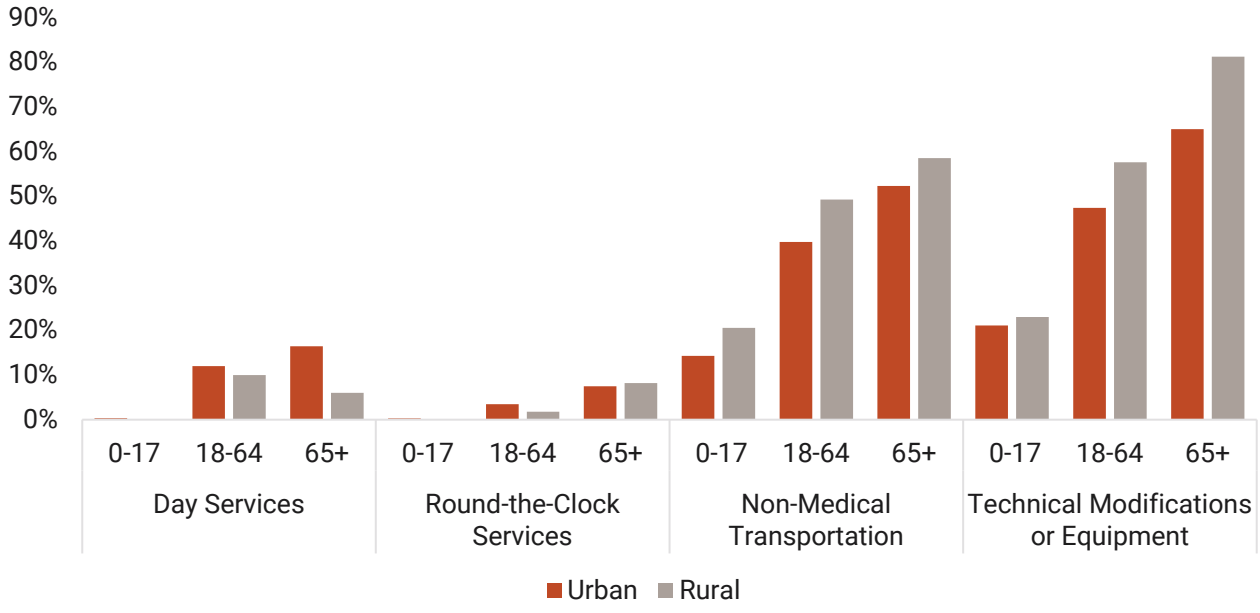
HCPF's goal over the past decade has been to expand who the waivers can serve so that access to services is less dependent on the individual's diagnosis and more focused on their needs.[5] A major milestone in this journey was the implementation of the 1915(k) Community First Choice (CFC) option in July 2025 which was delayed over the past decade by various factors, including the COVID-19 pandemic and prioritizing protecting Affordable Care Act policies through the "Repeal and Replace" conversations happening both nationally and at a state level.[6] The CFC option expands access to self-directed services to all eligible Health First Colorado members and maintains access for individuals enrolled in any HCBS waiver so long as they are receiving at least one HCBS waiver service per month and have an assessed need for CFC services.

ACCESS AND EQUITY

In 2023, using American Rescue Plan Act (ARPA) funds, HCPF conducted the ARPA 3.01 Community Access to HCBS project, which leveraged internal data analysis, literature review, and external stakeholder feedback to produce a report documenting existing gaps in enrollment and utilization. The resulting report found disparities especially prominent among Hispanic/Latino children and youth, while the following reports and virtual summits highlighted potential solutions which was used to inform the other ARPA initiatives and department activities.[7]

The NORC team conducted an analysis of 2022 T-MSIS data on HCBS utilization (see Appendix A for methodology and data) and found urban–rural disparities across age groups. Rural beneficiaries were more likely to access more "hands off" supports such as home-delivered meals, non-medical transportation, and technical modifications, while urban beneficiaries tended to receive more specialized or intensive services, including caregiver support for children, day programs for older adults, and round-the-clock care for nonelderly adults (see Exhibit 1).

Exhibit 1. Percentage of Beneficiaries Receiving Services, High Urban/Rural Usage



INNOVATIONS IN HCBS

Building upon their long-term commitment to HCBS, HCPF leveraged ARPA funds to evaluate the existing HCBS programs and invest in community-driven solutions. Colorado's approach balanced short-term responsiveness to COVID-19 impacts with strategies for sustaining HCBS improvements over time, and prioritized community and stakeholder input.

Throughout the planning, HCPF worked to ensure that the programs and initiatives they started would not encounter a loss of funding at the end of the ARPA funding period. This included conducting evaluations that could inform future activities, like the 3.01 project. It also included developing and launching trainings in disability and cultural competency and instituting competency requirements for case management agencies that could codify long-term goals without needing significant investments after ARPA funds were spent.[8]

Colorado was aware of the geographic disparities and created the Workforce and Rural Sustainability Project Investment Category within their ARPA initiatives, which was rated the highest priority area by 62% of stakeholders and for which they invested $370 million, including developing a Rural Sustainability Heatmap to help identify potential care deserts.

Overall, including the Equity Study, Colorado used its $566 million in ARPA funding, to invest in 61 initiatives that:[9]

- Engaged over 12,500 stakeholders,
- Distributed over $105 million to 2,232 partners and individuals through grants, pilots, and community funding programs,
- Created over 50 trainings, with almost 4,000 individuals completing the trainings,
- Translated 116 documents (63 unique source documents) in up to six languages,
- Increased the base wage rate for HCBS providers to $15.75 per hour.

HCPF tracked their ARPA projects against internal metrics visualized in the ARPA Metrics Dashboard developed in the initial stakeholder discussions. Each metric was met or surpassed by the end of the ARPA funding period.

IMPACT OF H.R.1

While investments described above advanced system capacity, recent federal policy changes have introduced new fiscal challenges. Colorado is unique in that it has a Taxpayer Bill of Rights that limits how much revenue the state can retain and spend. As a result of anticipated budget cuts and eligibility requirement updates from H.R.1, the state is working to mitigate coverage losses both for Medicaid and the marketplace enrollees. Summarized in the *Facing Hard Choices. Staying True to Our Values* newsletter, OCL created a website to publish anticipated impacts of H.R.1 across Medicaid, added updates to the Medicaid Sustainability and Colorado's LTSS System webpage, issued memos/newsletters and created fact sheets about policy changes with the goal of proactively and transparently recalibrating their spending.

The state has so far published the following areas where they anticipate reductions in spending within their LTSS system on the LTSS Sustainability page and the Budget Impacts Fact Sheet:

- Eliminating the nursing facility minimum wage supplemental payment, which was in place to supplement wages prior to the minimum wage rising above $15/hour ($4.4 million).
- Rolling back the 1.6% HCBS provider rate increase passed for FY 2025-26 ($38.3 million).
- Adjusting the Community Connector waiver service rate to align with similar benefits and services ($3 million).
- Aligning the Individual Residential Services and Supports available through the HCBS-DD waiver such that provider rates are the same for host homes and family caregivers.

> **"The choices we make must balance fiscal responsibility with the human reality behind every service, benefit, and budget line."**
> - HCPF Memo Series

These published adjustments align with what Medicaid staff shared in an interview: that their goal is not to cut any programs or services fully, but rather to implement utilization management processes, including soft caps, service plan reviews, and rate adjustments to meet the budget constraints.[10]

Conclusion

Colorado's experience underscores the complexity of sustaining and expanding HCBS within a shifting policy and fiscal landscape. By investing in long-term program growth, leveraging ARPA funding opportunities, prioritizing community perspectives, and maintaining a focus on sustainability amid changing budget conditions, the state demonstrates a strong commitment to HCBS. These efforts position Colorado as a leading example of how to advance high-quality, person-centered care in home and community settings nationwide.

ACKNOWLEDGEMENTS

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Appendix A: Waiver Details

The information below outlines current Colorado HCBS waiver details and includes a concise comparison of waiver and state plan authorities by target groups and services, as summarized in Table 1.

ADULT HCBS WAIVERS:

- **Persons with Brain Injury (HCBS-BI):** Originally approved in 1995[11] and set to expire in 2029, this waiver provides HCBS services to individuals who are older than 16 years for whom a brain injury occurred before their 65th birthday and meet the level of care criteria for a nursing home or a hospital. There is no limit on the number of participants covered under this waiver.
- **Community Mental Health Supports (HCBS-CMHS):** Originally approved in 2002[12] and set to expire in 2027, this waiver provides HCBS services to individuals 18 years or older with a diagnosis of a severe and persistent mental health disorder that has resulted in functional impairment that limits one or more major activities and meets the level of care criteria for a nursing facility. This does not include intellectual or developmental disorders or substance use disorder. There is no limit on the number of participants covered under this waiver.
- **Complementary and Integrative Health (HCBS-CIH):** Originally approved in 2012[13] and set to expire in 2030, this waiver (formerly the Spinal Cord Injury (SCI) Waiver) provides HCBS services to individuals 18 years or older who have been determined to have an inability for independent ambulation resulting from a qualifying condition – including multiple sclerosis, brain injury, spina bifida, muscular dystrophy, or cerebral palsy – and meets the level of care criteria for a nursing home or hospital. There is no limit on the number of participants covered under this waiver.
- **Developmental Disabilities (HCBS-DD):** Originally approved in 2024[14] and set to expire in 2029, this waiver provides access to 24/7 supervision through Residential Habilitation and Day Habilitation Services and Supports in addition to an array of other services for individuals 18 years or older determined to have a developmental disability and meeting the level of care criteria for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). There is a waitlist for this waiver, but as of FY 23-24 less than 30 individuals were on the waiting list.[15] Eligibility is based on date of developmental disability determination or 14th birthday for children diagnosed before age 14. Youth between the ages 14 and 18 will remain on the Safety Net list until eligibility at age 18.[16]
- **Elderly, Blind and Disabled (HCBS-EBD):** Originally approved in 1985[17] and set to expire in 2027, this waiver provides HCBS services to people ages 65 and older who have a functional impairment, or are blind, or to people ages 18-64 who are physically disabled or have a diagnosis of HIV or AIDS. The individual must meet the level of care criteria for a nursing facility. There is no limit on the number of participants covered under this waiver.
- **Supported Living Services (HCBS-SLS):** Originally approved in 1996[18] and set to expire in 2029, this waiver provides support to individuals 18 and older determined to have an intellectual or developmental disability (IDD) with the goal that they can remain in their homes and have control over the tailoring of services. Individuals must meet the level of care criteria for ICF-IID but cannot require 24 hour supervision. There is no limit on the number of participants covered under this waiver.

CHILDREN HCBS WAIVERS:

- **Children with Complex Health Needs (CwCHN):** Originally approved in 2007[19] and set to expire in 2030, this waiver provides benefits to individuals under age 19 with complex health needs and/or life-limiting illnesses who meet the level of care for a nursing facility or hospital. In July 2025, the state combined two of their children's waivers, Children's Home and Community-Based Services (CHCBS) and Children with Life Limiting Illness (CLLI) into the CwCHN waiver, moving many of the CHCBS services into the newly implemented CFC option, and enabling CHCBS-eligible children access to all of the services under the CLLI waiver. All existing

CLLI members were transitioned to the CwCHN waiver on July 1, 2025. All CHCBS members will transition to the CwCHN waiver and CFC services between July 1, 2025 and June 30, 2026 during their Continued Stay Review (CSR) with their case manager. There is no limit on the number of participants covered under this waiver.

- **Children's Extensive Support (CES):** Originally approved in 2024[20] and set to expire in 2029, this waiver provides services to individuals under age 18 who have been determined to have a developmental disability, demonstrate a behavior or have a medical condition that requires direct human intervention, and meets the ICF-IID level of care. There is no limit on the number of participants covered under this waiver.
- **Children's Habilitation Residential Program (CHRP):** Originally approved in 2024[21] and set to expire in 2029, this waiver provides services to individuals 0-20 years old diagnosed with IDD or serious emotional disturbance (SED) who meet the ICF-IID level of care. There is no limit on the number of participants covered under this waiver.

Table 1. Colorado Waiver and State Plan Authorities Comparison [22,23]

	Adult HCBS Waivers						Children's HCBS Waivers			State Plan
Waiver	**HCBS-BI**	**HCBS-CMHS**	**HCBS-CIH**	**HCBS-DD**	**HCBS-EBD**	**HCBS-SLS**	**HCBS-CES**	**HCBS-CHRP**	**HCBS-CwCHN**	**CFC 1915(k)**
Waiver Target Group(s)	**Brain Injury**	**Mental Illness**	**Aged/Disabled**	**IDD**	**Aged/Disabled & HIV/AIDS**	**IDD**	**IDD**	**IDD or SED**	**Medically Fragile**	**Assessed Need**
Ages Served	**16+**	**18+**	**18+**	**18+**	**18+**	**18+**	**0-17**	**0-20**	**0-18**	**All Ages**
Caregiver Support	X	X	X		X	X	X	X	X	
Case Management										
Community Transition Services	X	X	X	X	X	X				X
Day Services	X	X	X	X	X	X	X	X		
Home-Based Services	X	X	X		X	X	X			X
Home-Delivered Meal Services	X	X	X	X	X	X				X
Participant Training		X	X		X	X				
Round-the-Clock Services	X	X		X	X					
Supported Employment Services						X				
Equipment, Technology, and Modifications	X	X	X	X	X	X	X			X
Services Supporting Self-Direction	X		X	X						
Non-Medical Transportation	X	X	X	X	X	X				
Nursing										
Other Health and Therapeutic Services			X	X		X	X	X	X	
Other Mental Health and Behavior Services	X	X	X	X	X	X		X	X	
Other Services	X	X	X	X		X	X	X	X	

Appendix B: Methodology

This case study relies on data gathered through a systematic review of 1915(c) waivers and Medicaid State Plan optional benefits, analysis of T-MSIS analytic files (TAF) to understand HCBS utilization across states and select candidate states for case study development, and interviews with state staff to understand lessons learned and future strategies to continue the breadth and reach of HCBS in selected states. We describe the methods used for these activities below.

LANDSCAPE ANALYSIS OVERVIEW:

NORC accessed and reviewed the most current waiver documentation (application or amendment) published on the Medicaid.gov website as of January 2025 for all active 1915(c) waiver programs in all 50 states and the District of Columbia.* For the scope of services, a full list of state services (as named in the waivers) were abstracted using the terms adopted by the state. Based on the names, descriptions, and existing categorization of each service, they were then coded into one of sixteen categories, using several existing taxonomy resources.[24,25,26] This coding grouped 4,521 services into the sixteen categories, any that were unclear were checked against the waiver application for the state's categorization or the full service description and then was analyzed by the frequency of categories across the 262 waivers.

HCBS SERVICE ANALYSIS:

Using CY 2022 TAF data, NORC identified LTSS users following the methodology established by Mathematica, which is used to estimate LTSS expenditures and users by state and setting (HCBS vs. institutional).[27] We produced counts of HCBS users by service type and validated counts against data tables also produced by Mathematica.[28] These data were first used to identify states with a large proportion of dollars and individuals using LTSS who got their care in the home or community setting relative to institutional settings. Based on that analysis, the top seven states were identified and then evaluated for range of target populations served, the varying number of waivers, and the additional 1915 waivers utilized.

In addition, NORC facilitated key informant interviews with subject matter experts from NASHP, MACPAC, KFF, and ADvancing States, in addition to NORC internal experts, to understand which states have taken proactive steps to expand or safeguard HCBS access. From our analyses and these discussions, NORC selected Colorado and Florida in collaboration with The Commonwealth Fund as exemplar states in their reach of populations needing LTSS in HCBS. In Colorado, 88% of LTSS users receive HCBS and 54% of HCBS users are accessing services through the nine 1915(c) waivers, which cover a wide range of target groups. Colorado also utilizes a 1915(k) waiver. In Florida, 72% of LTSS users receive HCBS and 35% of HCBS users are accessing services through the four 1915(c) waivers, which cover an equally wide range of target groups. Floria also utilizes a 1915(j) waiver.

NORC further analyzed the TAF data to understand the use of selected types of HCBS, organized by service type overall and by urban and rural locations in the state. For this analysis, each state's services were coded to 14 categories, following the methodology outlined in the CMS TAF Methodology Brief and the Supplement Billing Codes Mapping. The only difference is that that we grouped a number of HCBS-related services, including pest control, housing stabilization services, and wellness education, into an "Other Services" category. We analyzed the data to first identify Medicaid enrollees using one or more of the 14 HCBS services and then examined the relative proportion of those using each service type based on urban/rural residence, defined as metro or non-metro based on county of residence. Differences in the proportion of the population using each service type by urban/rural residence were estimated using a Chi-square test, with statistical significance reported as appropriate. Based on this analysis, we examined whether service profiles look different in urban and rural regions of the state.

* The only exception is the MS 01.R02.00 waiver and the CO 0268.R06.00 waivers which were inaccessible during the original search and were filled in later.

Tables 2-4 below details the number and percentage of beneficiaries accessing services in the different service categories in metro and non-metro Colorado.

KEY INFORMANT INTERVIEWS:

NORC identified key informants from Colorado and Florida to conduct in-depth interviews (IDI). An IDI was conducted with a member of a Colorado state agency involved with Medicaid. Another IDI was conducted with members of a Florida non-profit organization closely involved with the state's Medicaid work. During the IDIs, NORC asked questions focusing on HCBS within Medicaid. Key topics, such as the evolution and shifts within the Medicaid and HCBS space, waitlists, rural and urban differences, future priorities and lessons learned were covered during the course of the IDIs. NORC then incorporated information from the IDIs into the case studies.

Table 2: Access and Utilization Differences Across Rural and Urban Regions in 2022, Among Ages 0-17

Ages 0 - 17	Overall (n = 27,934 Beneficiaries)		Metro (n = 26,126 Beneficiaries)		Non-Metro (n = 1,808 Beneficiaries)	
Service	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services
Case Management Services±	9,208	33.0%	8,441	32.3%	767	42.4%
Caregiver Support Services±	1,447	5.2%	1,411	5.4%	36	2.0%
Community Transition Services	*	*	*	*	*	*
Day Services	85	0.3%	**	**	*	*
Home-Based Services±	17,048	61.0%	16,223	62.1%	825	45.6%
Home-Delivered Meal Services±	53	0.2%	19	0.1%	34	1.9%
Nonmedical Transportation±	4,107	14.7%	3,735	14.3%	372	20.6%
Nursing Services	1,057	3.8%	1,004	3.8%	53	2.9%
Participant Training	2,007	7.2%	1,880	7.2%	127	7.0%
Round-the-Clock Services	77	0.3%	**	**	*	*
Supported Employment	*	*	*	*	*	*
Services Supporting Participant-Directed Services	*	*	*	*	*	*
Technical Modifications or Equipment	5,924	21.2%	5,508	21.1%	416	23.0%
Any Other HCBS Services	17,656	63.2%	16,512	63.2%	1,144	63.3%

Table 3: Access and Utilization Differences Across Rural and Urban Regions in 2022, Among Ages 18-64

Ages 18 - 64	Overall (n = 35,232 Beneficiaries)		Metro (n = 32,288 Beneficiaries)		Non-Metro (n = 2,944 Beneficiaries)	
Service	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services
Case Management Services	8,545	24.3%	7,914	24.5%	631	21.4%
Caregiver Support Services	656	1.9%	626	1.9%	30	1.0%
Community Transition Services	70	0.2%	**	**	*	*
Day Services	4,163	11.8%	3,869	12.0%	294	10.0%
Home-Based Services±	12,820	36.4%	11,479	35.6%	1,341	45.6%
Home-Delivered Meal Services±	127	0.4%	58	0.2%	69	2.3%
Nonmedical Transportation±	14,303	40.6%	12,852	39.8%	1,451	49.3%
Nursing Services	263	0.7%	229	0.7%	34	1.2%

Ages 18 - 64	Overall (n = 35,232 Beneficiaries)		Metro (n = 32,288 Beneficiaries)		Non-Metro (n = 2,944 Beneficiaries)	
Service	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services
Participant Training	5,920	16.8%	5,442	16.9%	478	16.2%
Round-the-Clock Services±	1,166	3.3%	1,114	3.5%	52	1.8%
Supported Employment	953	2.7%	863	2.7%	90	3.1%
Services Supporting Participant-Directed Services±	1,066	3.0%	850	2.6%	216	7.3%
Technical Modifications or Equipment±	17,009	48.3%	15,312	47.4%	1,697	57.6%
Any Other HCBS Services	34,579	98.1%	31,711	98.2%	2,868	97.4%

Table 4: Access and Utilization Differences Across Rural and Urban Regions in 2022, Among Ages 65+

Ages 65+	Overall (n = 9,500 Beneficiaries)		Metro (n = 8,073 Beneficiaries)		Non-Metro (n = 1,427 Beneficiaries)	
Service	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services	Total Beneficiaries	% Beneficiaries Receiving Services
Case Management Services	781	8.2%	637	7.9%	144	10.1%
Caregiver Support Services	60	0.6%	46	0.6%	14	1.0%
Community Transition Services	25	0.3%	**	**	*	*
Day Services±	1,412	14.9%	1,326	16.4%	86	6.0%
Home-Based Services	6,534	68.8%	5,554	68.8%	980	68.7%
Home-Delivered Meal Services±	77	0.8%	17	0.2%	60	4.2%
Nonmedical Transportation±	5,062	53.3%	4,226	52.3%	836	58.6%
Nursing Services±	149	1.6%	97	1.2%	52	3.6%
Participant Training	1,273	13.4%	1,104	13.7%	169	11.8%
Round-the-Clock Services	721	7.6%	604	7.5%	117	8.2%
Supported Employment	28	0.3%	**	**	*	*
Services Supporting Participant-Directed Services±	422	4.4%	299	3.7%	123	8.6%
Technical Modifications or Equipment±	6,411	67.5%	5,251	65.0%	1,160	81.3%
Any Other HCBS Services	9,452	99.5%	8,036	99.5%	2,868	97.4%

* Data suppressed (n<11)
** Secondary suppression
± p<0.0001 (urban–rural differences were statistically significant)

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