COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Implementation of Soft Caps on Personal Care, Homemaker, and Health Maintenance Activities (HMA)	**Topic:** Benefits
Audience: Members, Families, Advocates, Home Health Agencies (HHAs), Personal Care and Homemaker Provider Agencies, In-Home Support Services (IHSS) Agencies, Consumer Directed Attendant Support Services (CDASS) Stakeholders, Case Management Agencies (CMAs)	**Sub-Topic:** LTSS Budget Initiative – Implement a Soft Cap on Certain HCBS Services
Supersedes Number: N/A	**Division:** Benefits and Services
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Expiration Date: Jan. 15, 2028	**Program Area:** Policy
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Legal Authority: C.R.S. § 24-75-201.5(1)(a); 10 CCR 2505-10 § 8.7202;10 CCR 2505-10 8.507.5.D.1.c; C.R.S.§ 25.5-4-207(1)(c)	
Memo Author: Benefits & Services Division Staff	
Operational Memo Number: HCPF OM 26-003 **Issue Date:** Jan. 15, 2026 **Approved By:** Bonnie Silva	

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Purpose and Audience:

The purpose of this Operational Memo is to inform Members, families, advocates, provider agencies, and Case Management Agencies (CMAs) of the implementation of new annual service unit limits ("soft caps") for Personal Care, Homemaker, and Health Maintenance Activities (HMA). This memo outlines the details for the soft caps, expectations for CMAs and providers, and the exception process available for Members who require services above the established limits.

Background

Personal Care, Homemaker, and Health Maintenance Activities (HMA) are Home and Community-Based Services (HCBS) that are being transitioned from HCBS Waivers into Community First Choice (CFC). Members currently on an HCBS Waiver will transition to CFC at the time of their Continued Stay Review (CSR) between July 1, 2025 and June 30, 2026.

Currently, these services do not have formal annual unit limits. As described in the Governor's Executive Orders, the Department of Health Care Policy & Financing (HCPF) must implement strategies to ensure the long-term sustainability of the Medicaid program. Establishing soft caps for these services is one component of a broader, systemwide effort to manage increasing costs, promote equity, and support the financial stability of Medicaid while maintaining access to necessary supports.

Through review of statewide utilization patterns, HCPF identified levels of service that represent typical use for most members. The new annual limits reflect how the Department is establishing the outer range of the typical use and are intended to support more consistent, person-centered authorization. While most members use far fewer units than the established limits allow, HCPF recognizes that some individuals have exceptional needs. Accordingly, an exceptions process will be available to ensure members with higher assessed needs can receive authorizations above the limits when documentation supports doing so.

Information:

HCPF will implement annual unit limits for Personal Care, Homemaker, and HMA under HCBS waivers and CFC, with Certification Dates of April 1, 2026 and beyond. These limits apply across all service delivery models, including agency-based services, In-Home Support Services (IHSS), and Consumer-Directed Attendant Support Services (CDASS). The annual limits reflect typical statewide utilization and provide a consistent framework for authorizing these services.

Table 1. Annual Service Unit Limitations

Service	Proposed Annual Limit (units)	Approx. Daily Hours
Personal Care	10,000 units	~6.5 hours/day
Homemaker	4,500 units	~3 hours/day
Health Maintenance Activities (HMA)	19,000 units	~13 hours/day

Members are not required to follow a prescribed daily or weekly pattern of use; only the annual total applies. These limits do not change the definition of covered services, the age-appropriate task standards, or the requirement that tasks must reflect the member's assessed need and be non-duplicative as outlined in regulation.

Implementation Timeline

These annual unit limitations will be effective in Person-Centered Support Plans for certification start dates starting April 1, 2026, pending approval by the Centers for Medicare and Medicaid Services (CMS). All annual unit limits must be reflected in all Person-Centered Support Plans by November 30, 2026.

Exceptions

HCPF recognizes that some members have significant or complex needs that require service levels above the annual unit limitations. Members with needs that exceed the annual unit limits may work with their CMA to request an exception. CMAs may request authorization beyond the limitations through the Exception Process described in Operational Memo 26-001 - Direct Care Services Calculator and Age-Appropriate Task Standards.

Action To Be Taken:

Members

- No action is required unless the CMA requests additional information.
- Members with current service authorizations that exceed the new annual unit limits will work with their Case Manager during their scheduled Monitoring or Continued Stay Review (CSR) meeting between January and September 2026 to reassess service needs and submit an exception request, if appropriate.
- Members who utilize CDASS must ensure an updated Attendant Support Management Plan (ASMP) is completed if service authorizations change by 25% or more.
- Members have the right to appeal any adverse action: If you receive a Notice of Action (NOA) related to this new annual unit limit, your appeal rights will be outlined in that letter, explaining your options.

Case Management Agencies (CMAs)

- Case Managers must use the updated Direct Care Services Calculator (DCSC) with updated Task Standards and follow the Age Appropriate Guidelines, which reflect the new annual unit limits, to assess members' needs for these services. Age Appropriate Guidelines are found on the LTSS Case Management Forms and Tools webpage.
- Case Managers must apply the annual unit limits for certification start dates beginning April 1, 2026 and be reflected in all effected member Person-Centered Support Plans and Prior Authorization Requests (PARs) through a scheduled Monitoring or Continued Stay Review by November 30, 2026.
- Case Managers must submit exception requests for members whose needs exceed the annual unit limitations through the Exception Process described in Operational Memo 26-001 - Direct Care Services Calculator and Age-Appropriate Task Standards.
- Case Managers must attend all required training prior to applying annual unit limits during members assessments. Training registration information has been provided to each CMA directly. Please contact your agency leadership to register.
- For Members who utilize CDASS and the change to the service authorization is 25% or more, a new Attendant Support Management Plan (ASMP) is needed. Case Managers should support Members in obtaining a new ASMP.

Provider Agencies

- Provider agencies must adhere to the annual limits reflected in the Prior Authorization Request (PAR) and ensure that billing aligns with authorized units.
- Provider Agencies must adhere to providing services and subsequent Medicaid Fee for Services Billing according to the scope, frequency, and duration that is outlined in the member's Person-Centered Support Plan.
- Provider Agencies should update internal systems to track utilization and collaborate with CMAs when members approach the prior-approved services in the member's Person-Centered Support Plan.
- Providers delivering services must ensure that their care plans reflect the new limits unless an approved exception applies.
- Providers can find additional information in the upcoming provider training as well as billing information in the billing manual.

Provider Training Webinar Registration

Wednesday, January 21, 2026 @ 11:00 a.m. Registration Link

Thursday, January 22, 2026 @ 2:30 p.m. Registration Link

Members and advocates are encouraged to visit the Medicaid Sustainability and Colorado's LTSS System webpage for more information and look for engagement opportunities on the Stakeholder Engagement Calendar.

Definition(s):

Continued Stay Review (CSR) is a re-assessment of the Member, conducted by a Case Management Agency, to verify Medicaid, financial, and program eligibility, and is required within twelve months following any previous Assessment, as defined in 10 CCR 2505-10 Section 8.7202.F.

Notice of Action (NOA) is a formal, written statement used to inform a Member of a decision regarding their Medicaid eligibility or covered services. 10 CCR 2505-10 section 8.057.

Prior Authorization Request (PAR) is approval for an item or service that is obtained in advance either from the Health Care Policy & Financing Department, the Operating Agency, a State Fiscal Agent or the Case Management Agency.

Attachment(s):

None

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