COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Updates to Community Connector Rate, Policy, and Limits in the Children's Extensive Supports (CES) & Children's Habilitative Residential Program (CHRP) Waivers	**Topic:** Benefits
Audience: Members, Families, Advocates, Case Management Agencies (CMAs), Provider Agencies, Stakeholders	**Sub-Topic:** LTSS Budget Initiative – Updates to Community Connector Rate, Policy, and Limits
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Expiration Date: Jan. 15, 2028	**Program Area:** HCBS Services - Policy & Rates
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Purpose and Audience:

This Operational Memo informs Members, families, provider agencies, and Case Management Agencies (CMAs) about upcoming changes to the Community Connector benefit, including a revised reimbursement rate, a new minimum age requirement, a reduced annual unit limit, and clarified authorization and exception requirements.

Background

Community Connector is a Home and Community-Based Services (HCBS) benefit that helps children with disabilities build skills, confidence, and relationships by

participating in everyday community activities. The service supports children in learning how to safely and independently access their communities alongside peers without disabilities and is intended to go beyond what is normally provided by family members or traditional paid supports.

Community Connector is available through the Children's Extensive Support (CES) and Children's Habilitation Residential Program (CHRP) waivers. Services are provided one-on-one and focus on promoting inclusion, independence, and natural community supports.

Over time, Community Connector has become one of the most frequently used children's waiver benefits, with about 80% of CES Members accessing it. Utilization has grown far faster than expected. As described in the Governor's Executive Orders, the Department of Health Care Policy and Financing (HCPF) must implement strategies to ensure the long-term sustainability of the Medicaid program. Adjustments to this benefit 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.

Information:

Changes to the Community Connector Benefit Effective April 1, 2026, pending approval by the Centers for Medicare and Medicaid Services (CMS).

Rate Update

To align the Community Connector rate with other comparable HCBS benefits and ensure sustainability, the rate will be reduced to:

- **$7.71** per 15-minute unit (outside Denver County)
- **$7.83** per 15-minute unit (Denver County)

This reflects the rate used for Supported Community Connections in adult services and better aligns with certification and training requirements of the service provider. This rate reduction will be applied directly by the Department, does not require Case Manager action, and will not initiate a Notice of Action or appeal rights for members as a rate reduction is not subject to the requirements outlined in 10 CCR 2505-10 section 8.057.

New Minimum Age Requirement

Community Connector will be limited to school-aged children, 6 years and older. Children younger than school age have needs that fall within typical parental

responsibility and are expected to be met by their parent or legal guardian and therefore will not have an assessed need for the service. Setting a minimum age requirement helps ensure the benefit remains focused on skill development rather than routine caregiving. There are no exceptions to the age limit.

Updated Annual Unit Limit

The annual unit limit for Community Connector services will be reduced by 50%, from 2,080 units (520 hours) to 1,040 units (260 hours) per Person-Centered Support Plan year.

HCPF recognizes that some Members have such significant or complex needs that they 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. Further information is provided through the Community Connector Service Guide.

Action To Be Taken:

Members

- No action is required to be taken, unless directed by the Case Manager. Case Managers will discuss all changes with Members and their families at their Continued Stay Review (CSR) or during a scheduled Monitoring meeting between January 2026 and September 2026.
- Members who are under the age of 6 will have the Community Connector service discontinued on their Person-Centered Support Plan as of April 1, 2026.
- Members may work with their Case Manager to request an exception to the Community Connector unit limit if an exceptional need is present.
- You have the right to appeal any adverse action. When you receive a Notice of Action related to these changes, your appeal rights will be outlined in that letter, explaining your options.

Case Management Agencies (CMAs)

CMAs must attend all required training prior to applying the minimum age restrictions and annual unit limits to Member's Person Centered Support Plans. Training registration information has been provided to each CMA directly. Please contact your agency leadership to register.

New Minimum Age Requirement

- Case Management Agencies must establish internal procedures to ensure all required actions are completed. Tasks include, but are not limited to:
    - Notifying each Case Manager of a member that is under the established age limit,
    - Taking all required actions for a Person-Centered Support Plan Revision at the member's next scheduled Monitoring or Continued Stay Review,
    - Entering all documentation in the Care and Case Management (CCM) system, and
    - Sending the appropriate and timely Notice of Action to the member.
- Case Managers must remove the service for affected Members and issue a Notice of Action by March 15, 2026.

Updated Annual Limit

- CMAs must apply the annual unit limits for certification start dates beginning April 1, 2026 and be reflected in all Member Person-Centered Support Plans by November 30, 2026.
    - For Members who will not have a certification start date by September 30, 2026, the Case Manager will need to apply the following proration at the Member's monitoring visit.
        - If units remain available after 1,040 limit update, no further action is required.
        - If no units are available for the remaining plan year and the Member does not request additional units, the Case Manager only needs to update the PAR to reflect the 1,040-unit limit.
        - If no units are available and the Member requests additional units, the Case Manager may submit an Exception Request. CMAs must submit exception requests for Members whose justified needs exceed the annual unit limitations. Further information is provided through the Community Connector Service Guide, found on the LTSS Training Page.

Provider Agencies

- Community Connector providers should work to identify Members that will be impacted by the minimum age requirement and stop providing services effective April 1, 2026.
    - Claims will be denied for Members who do not meet the minimum age requirement for dates of service on or after April 1, 2026.
- No action is needed related to the rate update; claims will begin to pay at this updated rate effective April 1, 2026.
- Must provide services in the scope, frequency, and duration indicated on the member's Person-Centered Service Plan and as outlined on new and revised PARs effective April 1, 2026 that reflect the new service unit limitation or prorated unit amounts.

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.

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

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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