COLORADO
Department of Health Care Policy & Financing
303 E. 17th Avenue
Denver, CO 80203

August 12, 2024

Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

Thank you for your ongoing support as the State of Colorado continues to implement its Substance Use Disorder Demonstration project under Section 1115 of the Social Security Act.

With this letter, the Colorado Department of Health Care Policy and Financing is submitting for review and approval an Health Related Social Needs (HRSN) amendment to the current Section 1115 Medicaid demonstration waiver titled "Colorado Expanding the Substance Use Disorder Continuum of Care" (Project Number 11-W-00336/8). This amendment includes services to specific eligible populations:

1. Housing services including pre-tenancy & housing navigation services, tenancy sustaining services, rent/temporary housing for up to 6 months (including utilities), and one-time transition and moving costs;
2. Nutrition services including meals or pantry stocking, medically-tailored meals, and nutrition counseling/education.

The Colorado Department of Health Care Policy and Financing is requesting an effective date of July 1, 2025.

The State of Colorado appreciates your review of this waiver amendment application. Please direct any questions to Adela Flores-Brennan at 303-910-5918 or adela.flores-brennan@state.co.us.

Sincerely,

[redacted]

State Medicaid Director

CC: Sandra Phelps, Mandy Strom, Daniel Tsai, Jaycey Cooper

State of Colorado

Department of Health Care Policy & Financing

Colorado Medicaid Coverage of Services to Address Health Related Social Needs

Substance Use Demonstration Amendment Request

Pursuant to Section 1115 of the Social Security Act

August 12, 2024

Demonstration Project No. 11-W-00336/8
Effective January 1, 2021, through December 31, 2025

Section I. Program Description and Objectives

The State of Colorado (State) Department of Health Care Policy & Financing (HCPF), Colorado's single state agency for Medicaid and the Child Health Plan *Plus* (CHP+) is requesting an 1115 waiver amendment (Amendment) for its Substance Use Disorder (SUD) Demonstration "Expanding the Substance Use Disorder Continuum of Care," Waiver #: 11-W-00336/8 from the Centers for Medicare and Medicaid Services (CMS). The initial SUD demonstration period is from January 1, 2021, through December 31, 2025.

The Amendment request seeks authority to design and implement a "Health Related Social Needs (HRSN) Demonstration" that provides services to address HRSN for multiple populations throughout the State, contingent on state budget authority. This request is similar to the authority granted to several other states.

Consistent with CMS guidance on HRSN, all of which is posted to the CMS website at this link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs/index.html, the State intends to help address unmet needs related to a lack of adequate housing and nutrition support in three target populations. The lack of adequate housing and nutrition support contributes to poor health for individuals, including Medicaid eligible individuals that are: 1) homeless or at risk of homelessness, 2) transitioning from residing in nursing care facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID), or Regional Centers (RC) or 3) transitioning out of foster care. Addressing HRSN through Colorado Medicaid will lead to improved health outcomes and, ultimately, health care savings. No other eligibility, benefits, cost sharing, or delivery systems will be modified in this Amendment.

The State intends to implement the authority statewide on or after July 1, 2025. The State requests to operate the Demonstration through the end of the current SUD Demonstration approval period, which is December 31, 2025.

This Amendment request provides a detailed overview of coverage and service provisions, as well as HRSN Demonstration objectives, financing, implementation, and monitoring and evaluation.

Background

Beginning in September 2022, CMS began approving section 1115 Demonstration projects that specifically address HRSN services. Specifically, CMS approved various housing, nutrition, and case management services for Medicaid beneficiaries with the aim of improving health outcomes. The services proposed in this Amendment are consistent with the services approved in all other HRSN states.

As noted below, the State has begun to build infrastructure to address housing instability.

However, with the expiration of the Section 9817 ARPA funds and the limited nature of other funds utilized, the target populations still experience gaps that can be addressed through the approval of this HRSN Amendment. By addressing these gaps, HCPF believes that eligible individuals will experience fewer hospitalizations and emergency room visits and be in a better position to live healthy and productive lives.

Goals and Objectives

Under Section 1115 of the Social Security Act, states may implement "experimental, pilot or Demonstration projects which, in the judgment of the Secretary [of Health and Human Services] are likely to assist in promoting the objectives of [Medicaid]." The State believes this Demonstration is likely to promote the objectives of Medicaid by providing services that address HRSN thereby leading to improved health outcomes.

Consistent with the CMS policies as outlined in the November 16, 2023, CMCS Information Bulletin, and in the CMS All States presentation on December 12, 2022, the State's specific goals for the HRSN Demonstration are to:

1. **Improve the health status of Medicaid beneficiaries** by removing social barriers to health; and
    - **Objective a.** Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.
    - **Objective b.** Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.
    - **Objective c.** HRSN services will result in a reduction of readmissions within 30 days, to Emergency Departments (EDs) and hospitals.

2. **Improve connections between Medicaid beneficiaries and community services** to address physical health, behavioral health, and HRSN.
    - **Objective d.** HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.

Rationale

Prior to submitting this Amendment, the State reviewed the various HRSN 1115 Waiver approvals around the country. This Amendment is crafted in consideration of the prior approvals and aims to address Colorado-specific health related social needs in populations most in need in Colorado. The State expects the Amendment to result in increased access to both health care services and housing and nutrition services, thus leading to a positive impact on health outcomes for beneficiaries. If those positive impacts on health outcomes are realized, the State may generate savings by decreasing avoidable health care utilization.

This Amendment meets the criteria for approval by CMS and is consistent with the objectives of the Social Security Act as outlined in the CMS guidance for HRSN 1115 demonstrations as well as the previously approved HRSN demonstration authorities.

Regarding the need for housing supports, homelessness nationwide has risen since 2017, with record levels in 2022.[1] Colorado has made progress in decreasing the number of individuals experiencing homelessness, but the State still has more than an estimated 10,000 homeless individuals on any given night.[2]

Research shows that homelessness leads to poor health outcomes. According to the National Academies of Sciences, Engineering, and Medicine, "[t]he evidence of the harm caused by homelessness indicates that individuals who experience chronic homelessness are at higher risk for infections (including human immunodeficiency virus [HIV]), traumatic injuries, drug overdoses, violence, death due to exposure to extreme heat or cold, and death due to chronic alcoholism."[3] Additionally, such individuals are more likely to use the emergency department (ED) and be admitted to a hospital or psychiatric hospital.

Colorado-specific data confirms the health impact due to housing issues within the State. State sources report that about two thirds of individuals with unstable housing have poor mental health.[4]

There are additional needs for nutrition support as evidenced by the U.S. Department of Agriculture estimates that 12.8 percent of households were food insecure at some time in 2022.[5] In 2023, 11.2% of Colorado survey respondents reported eating less than they thought they should because food was unaffordable.[6] Further, 45% of Colorado Medicaid beneficiaries reported skipping a meal during 2023.[7]

Similar to homelessness, a lack of adequate food has deleterious impacts on health. According to the National Institutes of Health, "[f]ood insecurity and the lack of access to affordable nutritious food are associated with increased risk for multiple chronic conditions such as diabetes, obesity, heart disease, mental health disorders and other chronic diseases.[8]

Current Programs Addressing HRSN in Colorado

The State has begun to build infrastructure to deliver HRSN programs. This initial experience provided the State with a thorough knowledge of HRSN needs as well as experience for HCPF

[1] National Alliance to End Homelessness. 2023. State of Homelessness: 2023 Edition. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness/#key-facts.
[2] National Alliance to End Homelessness. 2023. https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-dashboards/?State=Colorado.
[3] National Academies of Sciences, Engineering, and Medicine. 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/25133.
[4] Colorado Health Access Survey, 2023.
[5] Economic Research Service, U.S. Department of Agriculture. https://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/food-security-and-nutrition-assistance/#:~:text=The%20prevalence%20of%20food%20insecurity,of%20a%20lack%20of%20resources.
[6] Colorado Health Institute. 2024. Colorado Health Access Survey. https://www.coloradohealthinstitute.org/research/2023-chas-food-security.
[7] Colorado Health Foundation. 2023 Pulse Poll.
[8] National Institute on Minority Health and Health Disparities, National Institutes of Health (NIH). 2023. Food Accessibility, Insecurity and Health Outcomes. https://www.nimhd.nih.gov/resources/understanding-health-disparities/food-accessibility-insecurity-and-health-outcomes.html.

in working in partnership across state agencies to address needs of Medicaid members. However, with limited state resources and the expiration of the federal funding utilized for some of these programs, this institutional knowledge and infrastructure could be lost.

Notably, through the use of funds under Section 9817 of the American Rescue Plan Act funding, Colorado implemented the Statewide Supportive Housing Expansion (SWSHE) pilot project which supported a portfolio of wraparound services in supportive housing for multiple housing providers (funding ends in Fall 2024). Based on data from spending in other states and local data, the state reimbursed $10,000 per member per year for the expansion of supportive housing services not currently billable to Colorado Medicaid. These tenancy support services were offered in conjunction with rental assistance provided by the Department of Local Affairs (DOLA) through new and previously available housing resources. Referrals were made for individuals who were currently unhoused or recently housed through supportive housing that also had a behavioral health including but not limited to serious mental illness, a history of homelessness, and repeated hospitalizations. Almost two thirds of those Medicaid participants had received at least one ED visit and 20% of participants had an inpatient stay prior to joining the project. A mid-project evaluation found that, as of June 2023, two-thirds of the individuals that were unhoused at the start of the program were in housing within six months.[9]

The Medicaid Statewide Supportive Housing Expansion (SWSHE) pilot was developed following the Denver Supportive Housing Social Impact Bond (Denver SIB), a multi-year study operated in the City and County of Denver beginning in 2016.[10] Through the Denver SIB, supportive housing and wraparound services were provided to individuals experiencing chronic homelessness with frequent law enforcement contact. In a randomized control trial, the Urban Institute found multiple positive impacts[11] including 77% of individuals remained in stable housing after three years of receiving the SIB housing program services.

With the end of the Public Health Emergency, the State faced the closure of two temporary housing locations that had provided housing to vulnerable individuals during the pandemic. Through a partnership between DOLA and HCPF, the State was able to leverage the existing Transition Coordination program and Community Access Team Vouchers (CATV) to provide 75 of approximately 120 individuals housing support.

In addition, there are three housing voucher programs in the State that provide on-going rental assistance with limited wraparound services and wait lists requiring bridge housing assistance.

- **Permanent Supportive Housing (PSH) vouchers** through DOLA. There are an estimated 8,000 individuals on waiting lists for these vouchers. Once a voucher has been assigned, it may take an additional three to six months to

[9] https://hcpf.colorado.gov/sites/hcpf/files/OCL-ARPA%20Update%20Webinar%20Presentation-August%2018%202022.pdf
[10] https://www.coloradocoalition.org/SIB
[11] The Urban Institute. 2023. Denver Supportive Housing Social Impact Bond Initiative. https://www.urban.org/policy-centers/metropolitan-housing-and-communities-policy-center/projects/denver-supportive-housing-social-impact-bond-initiative/what-we-learned-evaluation.

obtain housing.

- **Colorado Fostering Success (CFS) Vouchers**. This new program is jointly operated by DOLA and the Colorado Department of Human Services (CDHS). SB23-082 was signed into law on June 5, 2023,[12] and created the CFS program to aid former foster care youth in obtaining housing and case management support.

- **Community Access Team Vouchers (CATV).** DOLA works in partnership with HCPF to administer CATV. The goal of CATV is to move persons with disabilities out of nursing care facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID), and Regional Centers (RC) and into the community, and to prevent people with disabilities from being placed in an institution due to a lack of housing they can afford. Referrals to the program come from HCPF's Transition Services and Supported Living Services Waiver benefit programs.[13]

Demonstration Hypotheses and Evaluation

With the help of an independent evaluator, the State will amend the approved SUD evaluation plan to include evaluating the HRSN-related hypotheses indicated below. The State will calculate and report all performance measures under the Demonstration. The State will submit the updated evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this Demonstration and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of HRSN services in achieving the articulated goals and hypotheses of the initiative. The following goals and associated hypotheses will be tested during the approval period:

1. **Improve the health status of Medicaid beneficiaries** by removing social barriers to health; and
    a. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.
    b. Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.
    c. HRSN services will result in a reduction of readmissions within 30 days, to EDs and hospitals.
2. **Improve connections between Medicaid beneficiaries and community services** to address physical health, behavioral health, and HRSN.
    d. HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.

[12] Colorado Revised Statutes, 19-7-302 (1.3), (1.7), (16) and (17). https://leg.colorado.gov/sites/default/files/2023a_082_signed.pdf
[13] Cdola.colorado.gov/housing-voucher-programs

Table 1A: Demonstration Goals, Hypotheses and Data Sources

Goal	Research Hypothesis	Plan to Test Hypothesis	Data Sources	Evaluation Design
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective a. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.	1. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.	Measure changes in the rates of relevant health outcomes	Measure: Premature Death including Suicide or Overdose Deaths for individuals receiving Medicaid Data Source(s): Medicaid claims /encounter data; State Vital Statistics Data; Centers for Disease Control and Prevention Wonder data (suicide and overdose deaths)	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective b. Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.	2. Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.	Measure changes in the total cost of care	Measures: Total Medicaid cost associated with members receiving HRSN; Per Capita costs associated with Members receiving HRSN Data Source: Medicaid claims /encounter data.	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective c. HRSN services will result in a reduction of readmissions within 30 days, to EDs and hospitals.	3. HRSN services will result in a reduction of readmissions within 30 days, to EDs and hospitals.	Measure changes in the rates of readmissions within 30 days, to EDs and hospitals.	Measures: Inpatient and ED utilization per 1,000 Data Source: Medicaid claims /encounter data.	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.

Goal	Research Hypothesis	Plan to Test Hypothesis	Data Sources	Evaluation Design
Improve connections between Medicaid beneficiaries and community services to address physical health, behavioral health, and health-related social needs (HRSN). Objective d. HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.	4.HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.	Measure changes in the utilization rates of recommended and/or preventive care among enrollees receiving housing and nutrition supports	Measure: Access to Preventive/ Ambulatory Health Services for Medicaid beneficiaries Data Source: Medicaid claims /encounter data.	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.

Service Areas

This demonstration will operate across the entire state.

Demonstration Timeframe

The State intends to implement the HRSN services as soon as is practicable and requests to operate the Medicaid HRSN program through the end of the current SUD Demonstration approval period, which is December 31, 2025. HCPF intends to submit an application to extend the SUD Demonstration in December 2024.

Section II. Demonstration Eligibility

The proposed demonstration does not change eligibility for Medicaid coverage in the State, it only grants additional services to individuals that are already eligible for Medicaid. Every current eligibility group as defined in the State Plan could be eligible for the proposed HRSN services if the clinical and risk criteria for one of the three Demonstration eligibility categories listed below is met.

To qualify for HRSN services under this waiver, a beneficiary must meet the requirements for one of the following three categories:

- Individuals eligible for Permanent Supportive Housing (PSH) vouchers experiencing a behavioral health need and/or chronic health condition.
- Individuals eligible for Colorado Fostering Success (CFS) vouchers.
- Individuals eligible for Community Access Team (CAT) vouchers.

Please see Table 1B for more details on each population including a list of qualifying conditions and associated definitions.

Table 1B. Eligible Populations, Social Risk Factors, and Clinical Criteria

Eligible Population	Social Risk Factor	Clinical Criteria for the Population
Individuals Eligible for PSH Vouchers An individual must: • Be 18 years of age or older • Have a disabling condition • Have a history of homelessness or be at risk of homelessness; and • Must be at or below 30% of the area median income. For purposes of this Demonstration, the PSH population is further divided into three distinct eligibility groups based on the individual's status vis-à-vis a PSH voucher: • Individuals matched to a PSH voucher within the past 12 months (PSHa population). • Individuals eligible for PSH but not yet matched to a voucher (PSHb population). • Individuals residing in PSH for more than one year (PSHc	"Experiencing Homelessness" refers to an individual or household that is living unsheltered, in a place not meant for human habitation, in an emergency shelter, or in temporary housing (e.g., safe haven, transitional housing, bridge housing). "At-risk of homelessness" refers to individuals and families who: • Lose their residence within 14 days of the date of application for homeless assistance and do not have a subsequent residence identified • Have an annual income below 30% of median family income for the area, as determined by the Housing and Urban Development • Do not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or place not meant for habitation; and • Exhibit one or more risk factors of homelessness, including recent housing instability or exiting a publicly funded institution or system of care such as foster care or a mental health facility.	"Behavioral health need" means either: • A diagnosed behavioral health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; or • A suspected behavioral health disorder that has not yet been diagnosed and needs of further diagnostic evaluation. Eligible chronic conditions include but are not limited to Cirrhosis, Chronic Obstructive Pulmonary Disease, Diabetes, Epilepsy, Heart Failure,

Eligible Population	Social Risk Factor	Clinical Criteria for the Population
population).		Hepatitis, HIV/aids, and Hypertension.
Individuals eligible for CFS Vouchers An individual must: • Young adults transitioning out of the foster care system on or after their 18th birthday: • Be at least 18 years of age or older but less than 26 years of age; and • Have prior foster care or kinship care involvement in at least one of the following ways: o Have been in foster care on or after the youth's 14 birthday; o Have been in noncertified kinship care on or after the youth's 14 birthday and have been adjudicated dependent and neglected; and o Have turned 18 years of age when the youth was a named child or youth in a dependency and neglect case.; • Reside in Colorado; and • Have an income level at or below 50% of the area median income based on the county where the young adult resides.	Be currently experiencing homelessness or be at imminent risk of homelessness and have voluntarily agreed to participate in services offered and provided by a case management agency. The definition of "experiencing homelessness" is the same for the CFS population as that for the PSH population. The definition of "imminent risk of homelessness" used in the CFS population is defined as a youth or young adult who is currently experiencing any of the following situations: • An individual or family who will imminently lose their primary nighttime residence, provided that all of the following apply: o Residence that may or may not be provided through a publicly funded institution or system of care (eligible placements through Division of Youth Services or Child Welfare) will be lost within 90 days of the date of application for homeless assistance; o No subsequent residence has been identified; and o The individual or family lacks the resources (housing vouchers or placement options), or support networks needed to obtain other permanent housing.; • Have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application; and • Can be expected to continue in	None

Eligible Population	Social Risk Factor	Clinical Criteria for the Population
	such status for an extended period of time. • Individuals may also qualify as being at imminent risk of homelessness if one or both of the following apply in conjunction with the situations listed above: ○ Individuals or families who are fleeing or attempting to flee intimate partner violence, dating violence, sexual assault, or stalking (or other dangerous or life-threatening conditions), and who lack resources and support networks to obtain other permanent housing. ○ Individuals who have or are experiencing, or at-risk of human and/or sexual trafficking.	
Individuals Eligible for CAT Vouchers An individual must: • Be 18 years of age or older; • Be at or below 30% of the area median income; • Meet the Housing and Urban Development (HUD) definition of a disability; and • Receive Home and Community Based (HCBS) Medicaid services or State Plan services or are eligible for such services.	• Transitioning out of a NF, ICF/IID or RC and in need of housing assistance to remain in the community; or • At risk of institutionalization and homeless or at risk of homelessness as defined by 24 CFR 91.5 .	Eligible for home- and community-based services (HCBS) or State Plan services and receiving Targeted Case Management Transition Coordination Services under Colorado Medicaid.

The table below estimates the projected enrollment of each target population for the first year of the Amendment.

Table 2. Estimated Eligibles for each Target Population for first year of the proposed Amendment

Eligibility Category	Estimated Number of Members
PSHa	1,000
PSHb	6,720
PSHc	3,280
CFS	100
CAT	300

Section III. Demonstration Benefits and Cost-Sharing Requirements

The HRSN services requested in this Amendment include housing supports and nutrition supports. The State may begin claiming Federal Financial Participation (FFP) for services covered through the initiative, expected to begin on or after July 1, 2025, once the implementation plan is approved by CMS.

Please see Table 3 for a complete list of Housing and Nutrition services available under this proposal.

Table 3. Service Definitions for the HRSN Initiative

Covered Service	Definition
HRSN Housing Services	Allowable HRSN housing services: • Rent/temporary housing for up to six months. • Utility costs including activation expenses to secure utilities for individuals receiving rent/temporary housing as described above. • Pre-tenancy services. • Housing transition navigation services. • Tenancy sustaining services, including tenant rights education and eviction prevention. • One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture). • Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification. Excluded HRSN services include, but are not limited to: • Construction costs (bricks and mortar). • Capital investments. • Room and board, except as described above. • Research grants and expenditures not related to monitoring and evaluation. • Costs for services in correctional centers (jails and courthouses) and correctional institutions (prisons), and juvenile detention centers or services for people who are civilly committed and unable to leave an institutional setting. • Services provided to individuals who are not lawfully present in the United States or are undocumented. • Expenditures that supplant services and activities funded by other state and federal governmental entities. • School-based programs for children that supplant Medicaid State Plan programs. • General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries. • Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRSN services under this Demonstration.

Not all target populations will qualify for all of the services available under this Demonstration. HCPF is proposing to limit service availability based on the individual characteristics of each target population.

Most notably, HCPF proposes to utilize rent/temporary housing service to bridge a gap for two of the target populations who have not yet secured permanent housing through the voucher: 1) individuals matched to a PSH voucher within the past 12 months (**PSHa population**) and 2) individuals eligible for the CFS program The gap between being matched with a voucher for housing and securing housing can lead to deleterious effects on those individuals. The ability

to bridge that temporary housing gap under this demonstration can prevent eligible individuals from falling through the cracks.

The CAT eligible population, while not anticipating a similar gap in being connected to a voucher, may require rental assistance of up to 6 months to cover the transition period from institution into established CAT voucher status.

By contrast the **PSHc population** eligibility group has stably established (greater than 12 months) state housing assistance. Therefore, HCPF proposes that, in terms of housing services, this group only receives Tenancy Sustaining Services to increase the probability of maintaining long-term housing.

Linkage to a housing voucher has not yet occurred for the **PSHb population** eligibility group. Therefore, that group would only be eligible for the pre-tenancy and housing transition navigation services. Those services will help prepare members of the **PSHb** group for when a voucher becomes available and housing assistance is identified.

HCPF is proposing a continuum of housing services to aid these individuals in finding or maintaining housing based on their individual characteristics and the services already available within the State.

See Tables 4 and 5 for a complete list of Housing and Nutrition services by eligibility group.

Table 4. Proposed Eligibility by Housing Service

Housing Service	Population
Rent/temporary housing for up to six months including utility costs that are a part of the housing.	PSHa, CFS, and CAT
Pre-tenancy and housing transition navigation services.	PSHa, PSHb, and CFS
One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture). This also includes housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.	PSHa and CFS
Tenancy sustaining services, including tenant rights education and eviction prevention.	PSHc and CAT

Table 5. Proposed Populations by Nutrition Service

Nutrition Service	Population
Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, guidance on selecting healthy food and meal preparation for up to six months.	PSHa, PSHc, CFS, and CAT
Medically tailored, home delivered meals tailored to health risk and eligibility criteria, and/or certain nutrition-sensitive health conditions, for up to six months.	PSHa, PSHc, and CFS
Home delivered meals or pantry stocking.	PSHa, CFS, and CAT

HCPF did not include pantry stocking, nutrition counseling and medically tailored meals for the **PSHb population** eligibility group, because there is not a clear pathway to delivering this service until an individual is connected with a voucher and living in a stable location.

HCPF did not include pre-tenancy and housing transition navigation services, one-time transition and moving costs, nor medically tailored meals for CAT voucher population because these services are covered under the HCBS waiver benefit.

Section IV. Delivery System and Payment Rates

The State will deliver HRSN benefits through a mix of fee-for-service (FFS) and managed care systems to align with the population mix outlined. Although physical health claims are paid for through HCPF's Medicaid Management Information Systems (MMIS), the Managed Care Entities (MCEs) coordinate member care and pay for behavioral health services. HCPF anticipates that MCEs will be key partners in identifying members potentially eligible for HRSN services and organizing necessary screenings to make such determinations.
To the extent that FFS reimbursement rates for Demonstration services currently exist under the State Plan or HCBS, they will be the same as State Plan or HCBS provider payment rates for the same provider type. However, if certain Demonstration services are not covered under the managed care system and do not have comparable FFS rates under the State Plan or HCBS, the methodology for such services will be included in the implementation protocols submitted to CMS post-approval.

Section V. Implementation and Enrollment in Demonstration

HRSN services will be tailored to the beneficiary and based on medical appropriateness using clinical and other HRSN criteria as listed above in Table 2. The State will align clinical and social risk criteria across services and with other non-Medicaid human service agencies, such as DOLA and CDHS, to the extent possible. The HRSN services will not supplant any other available funding sources such as rental assistance or housing supports available to beneficiaries through local, state, or federal programs. The HRSN services will be the choice of the beneficiary, beneficiaries can opt out of HRSN services at any time, and HRSN services do not absolve the state of its responsibilities to provide required coverage for other medically necessary Medicaid services. The State will not condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The State will submit additional details on covered HRSN services to CMS as outlined in the approved Standard Terms and Conditions (STC) (after CMS approval). State spending on related social services prior to the approval of the 1115 Demonstration will be maintained or increased.

Quarterly, the State will report to CMS on HRSN service implementation, including progress made and challenges experienced, HRSN service utilization, quality of services, and health outcomes for individuals receiving HRSN services. The State will report on all mandatory CMS health equity metrics, stratified as required in the approved STCs.

The State requests authority to claim FFP for HRSN infrastructure investments in order to support the development and implementation of HRSN services, not to exceed 15% of the total HRSN spend. The State is requesting authority for HRSN infrastructure including administrative FFP for the following activities:

- Technology (e.g., electronic referral systems, shared data platforms, electronic health record modifications or integrations, screening tools and/or case management systems, databases/data warehouses, data analytics and reporting, data protection and privacy, accounting, and billing systems)
- Development of business or operational practices (e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, and member navigation)
- Workforce development (e.g., cultural competency training, trauma-informed care training, traditional health worker certification, and training staff on new policies and procedures)
- Outreach, education, and stakeholder convening (e.g., design and production of outreach and education materials, translation, obtaining community input, and investments in stakeholder convening).

Section VI. Proposed Waiver and Expenditure Authority

The State seeks such waiver authority as necessary under the Demonstration to receive a federal match on costs not otherwise matchable for services rendered to HRSN services-eligible individuals. The State also requests the following proposed waivers and expenditure authority to operate the Demonstration.

Table 6. Requested Waiver Authorities and Associated Reasons

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
Reasonable Promptness Section 1902(a)(8)	To allow the state to create service caps and the potential use of waiting lists for Housing and Food and Nutrition services.
Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)	To enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries depending on need, which are not otherwise available to all beneficiaries in the same eligibility group. To the extent necessary to enable the state to limit housing services and supports under the demonstration to certain targeted groups of participants.

Expenditure Authority

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals. The State requests FFP for evidence based HRSN services subject to the restrictions described below. Expenditures for HRSN services will be limited to costs not otherwise covered under Title XIX, but consistent with Medicaid Demonstration objectives that enable the State to continue to improve health outcomes and increase the efficiency and quality of care.

Table 7. Requested Expenditure Authorities

Title XIX Expenditure Authority	Expenditures
HRSN Services	Expenditures for approved evidence based HRSN services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying HRSN criteria
HRSN Services Infrastructure	Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved HRSN infrastructure activities.

Section VII. Demonstration Financing and Budget Neutrality

Refer to Budget Neutrality (BN) — Attachment 1 for the State's historical and projected expenditures for the requested period of the Demonstration.

Medicaid enrollment is not expected to change as a result of this Demonstration. Separate SPAs, including, but not limited to provisions for provider qualifications and reimbursement methodologies consistent with the services covered under the demonstration will be submitted with a fiscal impact, if needed. This Demonstration will permit Colorado to provide health related social needs (HRSN) services for qualifying individuals. The State is also requesting financial assistance for infrastructure costs associated with implementing the HRSN services.

Medicaid Eligibility Groups

These per member per month (PMPM) costs, along with an estimated caseload, non-service costs, HRSN, and HRSN infrastructure estimated costs were relied upon to establish Without Waiver (WoW) and With Waiver (WW) projections utilizing the BN spreadsheets provided by CMS.

The State is proposing only a single Medicaid Eligibility Group (MEG) for the HRSN authority. Table 8 shows the breakdown of eligible individuals by Medicaid Eligibility Category.

Table 8. Number of Eligible Individuals

Eligible Individuals for HRSN Authority	
Number meeting Demonstration Eligibility conditions requiring HRSN	11,400
Average months of utilization	12.0
Total annual member months	136,800

The HRSN population is expected to grow at 1% annually.

Budget Neutrality

The State developed the budget neutrality (BN) analysis for this Section 1115 Medicaid Demonstration Waiver Amendment. BN is a comparison of WoW expenditures to WW expenditures.

The State is requesting a hypothetical capped BN test for the HRSN services and HRSN infrastructure authorities. For this population, the WoW component is used to calculate the BN expenditure limit. Expenditures are counted against this BN expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical BN test cannot be offset by savings because the State has no savings accrued from prior 1115 waiver Demonstrations.

The BN projections were developed in alignment with CMS BN requirements.

Table 9. Budget Neutrality Projections

MEG	Expenditure Type	Annual Amount DY5	Trend Rate	Test
HRSN	Total Expenditure	$37,094,750	5.1%	Agg. Capped Hypothetical
HRSN Planning and Implementation (Non-Services)	Total Expenditure	$6,546,132	15% of Total HRSN	Agg. Capped Hypothetical

The BN worksheets prepared by the State are attached as Attachment 1.

The State has relied upon certain data and information provided by state agencies, including DOLA. Differences between the State's projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the finite assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the BN form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Per CMS' feedback, HRSN Infrastructure MEG costs are capped to 15% of the total cost of HRSN services and infrastructure costs.

Modeling Assumptions

The state fiscal year (SFY) 2024 (base year) per capita costs as outlined above were projected forward one year to demonstration year (DY) 5, which represents the fifth year of demonstration year of the State's current SUD 1115 waiver. Note that the State is requesting an effective date for its Waiver Amendment of July 1, 2025, or upon CMS approval, whichever is later. Beyond DY05 for the next four years, PMPMs are trended forward on an annual basis using a blend of the already approved SUD Demonstration trend rates for the mix of populations in the population MEG as shown below:

Table 10. Modeling Assumptions Trend

MEG	Approved Trend from CO SUD 1115
Legacy	4.9%
Expansion	5.6%
Weighted Average CO Demonstration Trend Rate	5.1%

Results

Across the remaining one-year waiver period (DY5), the State cost projection was for HRSN services and $6,546,132 for infrastructure. The caseload, aggregate capped expenditure and per capita estimates by DY for both the WoW and WW projections are provided in Attachment 1 and are broken out separately in the projections for HRSN versus HRSN Planning and Implementation (Non-Services).

Section VIII. Compliance with Public Notice and Tribal Consultation

Summary of Public Comments

A summary of feedback from commenters received during the public comment period will be provided in appendix after the public comment period has been completed.

Public Notice Process

Information on the Amendment and a copy of the public notice is available on the HCPF website at this link: https://hcpf.colorado.gov/1115sudwaiver. Additional information regarding the public notice process, including public hearings, will be updated after the public comment period has been completed.

Tribal Consultation

There are two federally recognized Tribes within the State of Colorado, the Southern Ute Indian Tribe and the Ute Mountain Ute Tribe. The State will solicit feedback and carry out recommendations from both Tribes by sending emails to the Tribal representatives and pertinent program staff with a summary of the Demonstration, plus a copy of the public

notice, and waiver application (as well as a link to the HCPF website with the relevant documents). While this process follows the State's approved tribal consultation State Plan Amendment, the Department will continue to engage the Tribes in meaningful, in-person Tribal consultation upon request. The State attended 2024 Formal Tribal Consultation meetings on July 15, 2024 to discuss the proposed amendment. Feedback during the meeting will be provided in appendix.

Section IX. Demonstration Amendment Contact

Name and Title: Adela Flores-Brennan, State Medicaid Director
Telephone Number: 303-910-5918
Email Address: adela.flores-brennan@state.co.us

Section XI. Appendix

Attachment 1: Compliance with Budget Neutrality
Attachment 2: Public Notice Requirements
Attachment 3: Full Public Notice
Attachment 4: Abbreviated Public Notice
Attachment 5: Public Notice Comments
Attachment 6: Tribal Consultation
Attachment 7: Tribal Consultation Comments

Attachment 1: Compliance with Budget Neutrality

Demonstration WoW Budget Protection: Coverage Costs for Populations								
Eligibility	**Base Year**							**Total**
Group	**CY 24**	**Trend Rate**	**DY 05**	**DY 06**	**DY 07**	**DY 08**	**DY 09**	**WoW**
Hypothesis 1 — Services								
Population Type:								
Eligible Member Months	136,800	1.0%	69,256	139,552	140,947	142,357	143,780	
PMPM Cost	$271.16	5.1%	$288.55	$299.54	$314.82	$330.88	$347.75	
Total Expenditure	$37,094,750		$19,983,420	$41,801,911	$44,373,147	$47,102,539	$49,999,816	$203,260,834
Hypothesis 2 — Planning and Implementation (Non-Services)								
Population Type:								
Total Expenditure	$6,546,132		$3,526,486	$7,376,808	$7,830,555	$8,312,213	$8,823,497	$35,869,559
Total Population: 11,400 x 12 months = 136,800 member months								

Demonstration WW Budget Projection: Coverage Costs for Populations								
Eligibility								Total
Group	CY 24	Trend Rate	DY 05	DY 06	DY 07	DY 08	DY 09	WW
Hypothesis 1 — Services								
Population Type:	Hypothetical							
Eligible Member Months		1.0%	69,256	139,552	140,947	142,357	143,780	
PMPM Cost		5.1%	$288.55	$299.54	$314.82	$330.88	$347.75	
Total Expenditure			$19,983,420	$41,801,911	$44,373,147	$47,102,539	$49,999,816	$203,260,834
Hypothesis 2 — Planning and Implementation (Non-Services)								
Population Type:	Hypothetical							
Total Expenditure			$3,526,486	$7,376,808	$7,830,555	$8,312,213	$8,823,497	$35,869,559

Hypotheticals Analysis						
Without-Waiver Total Expenditures						
	DY 05	**DY 06**	**DY 07**	**DY 08**	**DY 09**	**Total**
Hypothesis 1 — Services	$19,983,420	$41,801,911	$44,373,147	$47,102,539	$49,999,816	$203,260,834
Hypothesis 2 — Planning and Implementation (Non-Services)	$2,997,513	$6,270,287	$6,655,972	$7,065,381	$7,499,972	$30,489,125
TOTAL	$22,980,933	$48,072,198	$51,029,119	$54,167,920	$57,499,789	$233,749,959
With-Waiver Total Expenditures						
	DY 05	**DY 06**	**DY 07**	**DY 08**	**DY 09**	**Total**
Hypothesis 1 — Services	$19,983,420	$41,801,911	$44,373,147	$47,102,539	$49,999,816	$203,260,834
Hypothesis 2 — Planning and Implementation (Non-Services)	$2,997,513	$6,270,287	$6,655,972	$7,065,381	$7,499,972	$30,489,125
Total	$22,980,933	$48,072,198	$51,029,119	$54,167,920	$57,499,789	$233,749,959
Hypotheticals Variance						

Attachment 2: Public Notice Requirements

Overview

Colorado certifies that it provided public notice regarding the proposed Section 1115 waiver demonstration as required by federal regulations at 42 C.F.R.431.408, as follows. The full and abbreviated public notices can be found below.

Screenshot of Colorado Registry June 10, 2024

Non-Rulemaking Public Notices and Other Miscellaneous Rulemaking Notices

Department / Agency	Filed date	Notice
Department of Health Care Policy and Financing	06/06/2024	Medicaid Fee-for-Service Reimbursement Rate Increases
Department of Health Care Policy and Financing	06/07/2024	Colorado Medicaid Coverage of Services to Address Health Related Social Needs
Department of Health Care Policy and Financing	06/07/2024	Notice of Public Comment Process Medicaid Section 1115 Demonstration Amendment
Department of Health Care Policy and Financing	06/07/2024	Medicaid Section 1115 Demonstration Amendment

Attachment 3: Full Public Notice

COLORADO
Department of Health Care Policy & Financing

Notice of Public Comment Process
Medicaid Section 1115 Demonstration Amendment

Public Comment Period Begins: June 10, 2024, at 8:00 a.m. MST
Public Comment Period Ends: July 10, 2024, at 5:00 p.m. MST

Public notice is hereby given that the State of Colorado's Department of Health Care Policy & Financing (HCPF) is seeking public comments on an amendment to the Expanding the Substance Use Disorder (SUD) Continuum of Care Section 1115 Demonstration (Demonstration).

Proposed Amendment Summary

Colorado is requesting an amendment to the Demonstration to authorize Health Related Social Needs (HRSN) Services for certain Medicaid enrollees.

The proposed HRSN services are housing and nutrition supports. The State intends to help address unmet needs related to a lack of adequate housing and nutrition support in three target populations. The lack of adequate housing and nutrition support contributes to poor health for individuals that are: 1) homeless or at risk of homelessness, 2) transitioning from residing in nursing facilities, or 3) transitioning out of foster care.

Amendment Objectives and Goals

Under Section 1115 of the Social Security Act, states may implement "experimental, pilot or Demonstration projects which, in the judgment of the Secretary [of Health and Human Services] are likely to assist in promoting the objectives of [Medicaid]." The State believes this Demonstration is likely to promote the objectives of Medicaid by providing services that address HRSN thereby leading to improved health outcomes.

Consistent with the CMS policies as outlined in the November 16, 2023, CMCS Information Bulletin, and in the CMS All States presentation on December 12, 2022, Colorado's specific goals for the HRSN Demonstration are to:

1. **Improve the health status of Medicaid beneficiaries** by removing social barriers to health; and
    - **Objective a.** Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes
    - **Objective b.** Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.
    - **Objective c.** HRSN services will result in a reduction of readmissions within

30 days, to Emergency Departments (EDs) and hospitals.

2. **Improve connections between Medicaid beneficiaries and community services** to address physical health, behavioral health, and health-related social needs (HRSN).
    - **Objective d.** HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.

HCPF is seeking to provide HRSN services beginning July 1, 2025.

Health Care Delivery

Health First Colorado, Colorado's Medicaid program, provides access to physical and behavioral health care, hospitalization, nursing facility care, prescription drugs, dental care and other benefits for qualifying adults and children. Physical health services are paid for through the traditional fee-for-service structure through HCPF. While behavioral health and care coordination services are capitated and provided by RAEs through contracts with HCPF. The RAEs have data sharing agreements with the Department of Corrections to better support members as they transition to community.

Since 2011, the Accountable Care Collaborative (ACC) has served as the core vehicle for delivering and managing member care for Health First Colorado. All full-benefit Health First Colorado members are enrolled in the ACC except for members enrolled in the Program for All Inclusive Care for the Elderly. The ACC integrates managed fee-for-service physical health care and managed care for behavioral health. The ACC's regional model allows it to be responsive to unique community needs. Key components of the ACC include care coordination and member support.

The health care delivery system is not anticipated to change under this amendment.

Eligibility

The proposed amendment does not alter Medicaid eligibility.

To qualify for HRSN services under this waiver, a beneficiary must meet the requirements for one of the following three categories for some or all of the expected HRSN Services:

- Individuals eligible for Permanent Supportive Housing (PSH) vouchers experiencing a behavioral health need and/or chronic health condition.
- Individuals eligible for Colorado Fostering Success (CFS) vouchers.
- Individuals eligible for Community Access Team (CAT) vouchers.

Individuals Eligible for Permanent Supportive Housing Vouchers

An individual must:

- Be 18 years of age or older;
- Have a disabling condition;
- Have a history of homelessness or be at risk of homelessness; and
- Must be at or below 30% of the area median income.

For purposes of this Demonstration, the PSH population is further divided into three distinct eligibility groups based on the individual's status vis-à-vis a PSH voucher:

- Individuals matched to a PSH voucher within the past 12 months ("PSHa population");
- Individuals eligible for PSH but not yet matched to a voucher ("PSHb population"); and
- Individuals residing in PSH for more than one year ("PSHc population").

HCPF anticipates 11,000 individuals eligible for services under this category in the first year of operation.

Individuals eligible for Colorado Fostering Success Vouchers

Young adults ages 18 through 26 who left foster care on or after their 18th birthday, transitioning out of the foster care system:

- Be at least eighteen years of age or older but less than twenty-six years of age;
- Have prior foster care or kinship care involvement in at least one of the following ways:
    - Have been in foster care on or after the youth's fourteenth birthday;
    - Have been in noncertified kinship care on or after the youth's fourteenth birthday and have been adjudicated dependent and neglected; or
    - Have turned eighteen years of age when the youth was a named child or youth in a dependency and neglect case;
- Reside in Colorado; and

Have an income level at or below 50% of the area median income based on the county where the young adult resides.
HCPF proposes to cap the number of individuals eligible for this category to 100 annually.

Individuals Eligible for CAT Vouchers

An individual must:

- Be 18 years of age or older;
- Be at or below 30% of the area median income;
- Meet the Housing and Urban Development (HUD) definition of a disability; and
- Receive Home and Community Based (HCBS) Medicaid services or State Plan services or are eligible for such services.

The goal of CATV is to move persons with disabilities out of nursing homes and other long term care and into the community, and to prevent people with disabilities from being placed in an institution due to a lack of housing they can afford.
HCPF anticipates that 300 individuals in this category will be eligible for services in the first year of operation.

Benefits

Housing Services

HCPF proposes to provide the following housing supports through this Waiver amendment:

- Rent/temporary housing for up to six months;

- Utility costs including activation expenses and back payments to secure utilities for individuals receiving rent/temporary housing as described above;
- Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
- Housing transition navigation services;
- One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture); and
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.

Nutrition Services

Through this amendment, HCPF proposes to provide the following nutrition services:

- Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement;
- Medically tailored, home delivered meals tailored to health risk and eligibility criteria, and/or certain nutrition-sensitive health conditions; and
- Home delivered meals or pantry stocking.

Not all target populations will qualify for all of the services available under this Demonstration. HCPF is proposing to limit service availability based on the individual characteristics of each target population. Please see the two tables below for details of the populations eligible for each service.

Please see the Tables below for a complete list of Housing and Nutrition services by eligibility group.

Table 1. Proposed Eligibility by Housing Service

Housing Service	Population
Rent/temporary housing for up to six months including utility costs that are a part of the housing.	PSHa, CFS, and CAT
Pre-tenancy and housing transition navigation services.	PSHa, PSHb, and CFS
One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture). This also includes housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.	PSHa and CFS

Tenancy sustaining services, including tenant rights education and eviction prevention.	PSHc and CAT

Table 2. Proposed Populations by Nutrition Service

Nutrition Service	Population
Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example, guidance on selecting healthy food and meal preparation for up to six months.	PSHa, PSHc, CFS, and CAT
Medically tailored, home delivered meals tailored to health risk and eligibility criteria, and/or certain nutrition-sensitive health conditions, for up to six months.	PSHa, PSHc, and CFS
Home delivered meals or pantry stocking.	PSHa, CFS, and CAT

Cost Sharing

There are no proposed changes to cost sharing under this amendment.

Delivery System

No changes to Colorado's delivery system are proposed under this amendment. The State will deliver HRSN benefits through a mix of fee-for-service (FFS) and managed care systems to align with the population mix outlined. Although physical health claims are paid for through HCPF's Medicaid Management Information Systems (MMIS), the Managed Care Entities (MCEs) coordinate member care and pay for behavioral health services. HCPF anticipates that MCEs will be key partners in identifying members potentially eligible for HRSN services and organizing necessary screenings to make such determinations.

Demonstration Hypotheses and Measures

With the help of an independent evaluator, the State will amend the approved SUD evaluation plan for evaluating the HRSN-related hypotheses indicated below. Colorado will calculate and report all performance measures under the Demonstration. The State will submit the updated evaluation plan to CMS for approval.

The State will conduct ongoing monitoring of this Demonstration and will provide information regarding monitoring activities in the required quarterly and annual monitoring reports.

The State will test, and comprehensively evaluate through robust hypotheses testing, the effectiveness of HRSN services in achieving the articulated goals and hypotheses

of the initiative. The following goals and associated hypotheses will be tested during the approval period:

3. **Improve the health status of Medicaid beneficiaries** by removing social barriers to health; and
    a. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes
    b. Addressing unmet HRSN within the Medicaid-eligible population will reduce the cost of care.
    c. HRSN services will result in a reduction in avoidable hospitalizations (e.g., lower avoidable ED visits)
4. **Improve connections between Medicaid beneficiaries and community services** to address physical health, behavioral health, and HRSN.
    d. HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.

Table 1A: Demonstration Goals, Hypotheses and Data Sources

Goal	Research Hypothesis	Plan to Test Hypothesis	Data Sources	Evaluation Design
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective a. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.	1. Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.	Measure changes in the rates of relevant health outcomes	Measure: Premature Death including Suicide or Overdose Deaths for individuals receiving Medicaid Data Source(s): Medicaid claims /encounter data; State Vital Statistics Data; Centers for Disease Control and Prevention Wonder data (suicide and overdose deaths)	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective b. Addressing unmet HRSN within the Medicaid-eligible	2. Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.	Measure changes in the total cost of care	Measures: Total Medicaid cost associated with members receiving HRSN; Per Capita costs associated with Members receiving HRSN	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.

Goal	Research Hypothesis	Plan to Test Hypothesis	Data Sources	Evaluation Design
population will reduce the total cost of care.			Data Source: Medicaid claims /encounter data.	
Improve the health status of Medicaid beneficiaries by removing social barriers to health Objective c. HRSN services will result in a reduction of readmissions within 30 days, to EDs and hospitals.	3. HRSN services will result in a reduction of readmissions within 30 days, to EDs and hospitals.	Measure changes in the rates of readmissions within 30 days, to EDs and hospitals.	Measures: Inpatient and ED utilization per 1,000 Data Source: Medicaid claims /encounter data.	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.
Improve connections between Medicaid beneficiaries and community services to address physical health, behavioral health, and health-related social needs (HRSN). Objective d. HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.	4.HRSN services (improvements in housing stability and nutrition) will result in an increase in recommended and/or preventive care.	Measure changes in the utilization rates of recommended and/or preventive care among enrollees receiving housing and nutrition supports	Measure: Access to Preventive/ Ambulatory Health Services for Medicaid beneficiaries Data Source: Medicaid claims /encounter data.	Evaluation Design: Independent evaluator will develop quantitative and qualitative measures to include in a quasi-experimental design, including an interrupted time series analysis.

In addition to the independent evaluation, HCPF will provide quarterly and annual reporting specific to this amendment and in accordance with a CMS-approved Monitoring Protocol to be submitted following approval.

Proposed Federal Demonstration Authorities

The State seeks such waiver authority as necessary under the Demonstration to receive a federal match on costs not otherwise matchable for services rendered to HRSN services-eligible individuals. The State also requests the following proposed waivers and expenditure authority to operate the Demonstration.

Requested Waiver Authorities and Associated Reasons

Waiver Authority	Reason and Use of Waiver Authority Will Enable the State To:
Reasonable Promptness Section 1902(a)(8)	To allow the state to create service caps and the potential use of waiting lists for Housing and Food and Nutrition services.
Amount, Duration, and Scope of Services and Comparability Section 1902(a)(10)(B) and 1902(a)(17)	To enable the state to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries depending on need, which are not otherwise available to all beneficiaries in the same eligibility group. To the extent necessary to enable the state to limit housing services and supports under the demonstration to certain targeted groups of participants.

The State requests expenditure authority to provide Medicaid benefits to Demonstration eligible individuals. Colorado requests FFP for evidence-based HRSN services subject to the restrictions described below. Expenditures for HRSN services will be limited to costs not otherwise covered under Title XIX, but consistent with Medicaid Demonstration objectives that enable Colorado to continue to improve health outcomes and increase the efficiency and quality of care.

Requested Expenditure Authorities

Title XIX Expenditure Authority	Expenditures
Health-Related Social Needs (HRSN) Services.	Expenditures for approved evidence-based health-related social needs services not otherwise eligible for Medicaid payment furnished to individuals who meet the qualifying HRSN criteria
Health-Related Social Needs (HRSN) Services Infrastructure.	Expenditures for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized as part of the approved HRSN infrastructure activities.

<u>Estimated Impact of the Demonstration</u>

The table below estimates the projected annual enrollment of beneficiary member months (without and with the waiver) for each Demonstration Year (DY).

Estimated Projections of Annual Enrollment

Member Months under the Amendment*	DY5	DY6	DY7	DY8	DY9	5 year total

Total projected member months without the Amendment	0	0	0	0	0	
Total projected member months under the Amendment	69,256	139,552	140,947	142,357	143,780	635,892

The table below estimates the projected annual expenditures (without and with the waiver) for each DY.

Estimated Projections of Annual Expenditures

Projected Services Costs under the Amendment*	DY5	DY6	DY7	DY8	DY9	5 year total
Total projected administration and service costs without the Amendment	0	0	0	0	0	0
Total projected service costs under the Amendment	$19,983,420	$41,801,911	$44,373,147	$47,102,539	$49,999,816	$203,260,834
Total projected non-service costs under the Amendment	$3,526,486	$7,376,808	$7,830,555	$8,312,213	$8,823,497	$35,869,559

*Using a 5.1% trend rate; effective July 1, 2025 (six-months of (DY5)

Opportunity for Public Comment

The proposed Section 1115 Demonstration amendment is available for public review and comment at:

Draft Amendment

To request a copy of the amendment, please contact HCPF by:

- Sending an email request to hcpf_1115waiver@state.co.us;
- Sending a request by fax to 303-866-4411, Attn: 1115 SUD Demonstration Amendment; or
- Obtaining in person at the Colorado Department of Health Care Policy and Financing, 303 E 17th Avenue, Denver, CO 80203.

During the public comment period, comments may be sent to hcpf_1115waiver@state.co.us. Public comments may also be submitted by post to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
303 E 17th Avenue
Denver, Colorado 80203
ATTN: Public Comment - 1115 SUD Demonstration Amendment

Additional information will be posted on HCPF's *Ensuring a Full Continuum of SUD Benefits* webpage, at https://www.colorado.gov/pacific/hcpf/ensuring-full-continuum-sud-benefits.

Public Hearings

HCPF invites the public to attend public hearings in person or join by teleconference/webinar to learn more about Colorado's Demonstration amendment and provide comments.

	Public Hearing #1	**Public Hearing #2**
Date	June 20, 2024	June 24, 2024
Time	11 a.m.-1 p.m. MST	12:30-2:30 p.m. MST
Venue	Colorado Department of Health Care Policy and Financing 303 E 17th Ave, Denver, CO 80203 Room 7B	Old Town Public Library 201 Peterson St, Fort Collins, CO 80524 Large Meeting Room 2
Teleconference	833 548 0276 Code: **394674**	833 548 0276 Code: **394674**
Webinar	https://us02web.zoom.us/webinar/register/WN_5Eai1Mm4Te6kFXAgvk_Ycg	https://us02web.zoom.us/webinar/register/WN_5Eai1Mm4Te6kFXAgvk_Ycg

Reasonable accommodations will be provided upon request. Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Please notify 303-866-3438 or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

CMS/Medicaid Demonstration Website

Relevant webpages and additional information regarding the Medicaid Demonstration can be viewed on the CMS/Medicaid website, at: https://www.medicaid.gov/medicaid/section-1115-demo/index.html

This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.

Attachment 4: Abbreviated Public Notice

COLORADO
Department of Health Care Policy & Financing

Notice of Public Comment Process

Medicaid Section 1115 Demonstration Amendment

Public Comment Period Begins: June 10, 2024 at 8:00 a.m. MST
Public Comment Period Ends: July 10, 2024 at 5:00 p.m. MST

Public notice is hereby given that the State of Colorado's Department of Health Care Policy & Financing (HCPF) is seeking public comments on an amendment to the Expanding the Substance Use Disorder (SUD) Continuum of Care Section 1115 Demonstration (Demonstration).Colorado is requesting an amendment to the Demonstration to authorize Health Related Social Needs (HRSN) Services for certain Medicaid enrollees.

The proposed HRSN services are housing and nutrition supports. The State intends to help address unmet needs related to a lack of adequate housing and nutrition support in three target populations. The lack of adequate housing and nutrition support contributes to poor health for individuals that are: 1) homeless or at risk of homelessness, 2) transitioning from residing in congregate settings, or 3) transitioning out of foster care.
HCPF is seeking to provide HRSN services beginning July 1, 2025.

Opportunity for Public Comment
The proposed Section 1115 Demonstration amendment, and a copy of the full public notice, is available for public review and comment at:

1115 SUD Demonstration HRSN Amendment Request
Full Public Notice

To request a copy of the amendment, please contact HCPF by:

- Sending an email request to hcpf_1115waiver@state.co.us;
- Sending a request by fax to 303-866-4411, Attn: 1115 SUD Demonstration Amendment; or
- Obtaining in person at the Colorado Department of Health Care Policy and Financing, 303 E 17th Avenue, Denver, CO 80203.

During the public comment period, comments may be sent to hcpf_1115waiver@state.co.us.
Public comments may also be submitted by post to:

Director, Health Programs Office
Colorado Department of Health Care Policy and Financing
303 E 17th Avenue
Denver, Colorado 80203

ATTN: Public Comment – 1115 SUD Demonstration Amendment
Additional information will be posted on HCPF's *Ensuring a Full Continuum of SUD Benefits* webpage, at https://www.colorado.gov/pacific/hcpf/ensuring-full-continuum-sud-benefits.

Public Hearings

HCPF invites the public to attend public hearings in person or join by teleconference/webinar to learn more about Colorado's Demonstration amendment and provide comments.

	Public Hearing #1	**Public Hearing #2**
Date	June 20, 2024	June 24, 2024
Time	11 a.m.-1 p.m. MST	12:30-2:30 p.m. MST
Venue	Colorado Department of Health Care Policy and Financing 303 E 17th Ave, Denver, CO 80203 Room 7B	Old Town Public Library 201 Peterson St, Fort Collins, CO 80524 Large Meeting Room 2
Teleconference	833 548 0276 Code: **394674**	833 548 0276 Code: **394674**
Webinar	https://us02web.zoom.us/webinar/register/WN_5Eai1Mm4Te6kFXAgvk_Ycg	https://us02web.zoom.us/webinar/register/WN_5Eai1Mm4Te6kFXAgvk_Ycg

Reasonable accommodations will be provided upon request. Auxiliary aids and services for individuals with disabilities and language services for individuals whose first language is not English may be provided upon request. Please notify 303-866-3438 or the 504/ADA Coordinator at hcpf504ada@state.co.us at least one week prior to the meeting to make arrangements.

CMS/Medicaid Demonstration Website

Relevant webpages and additional information regarding the Medicaid demonstration can be viewed on the CMS/Medicaid website, at: https://www.medicaid.gov/medicaid/section-1115-demo/index.html

Summary Description of Proposed Amendment

This abbreviated public notice provides information regarding the proposed amendment request to the Centers for Medicare & Medicaid Services (CMS) for approval to provide HRSN Services in the form of Housing and Nutrition Supports to certain Medicaid enrollees.
Eligible enrollees include:

1. Individuals eligible in the Permanent Supportive Housing Vouchers;
2. Individuals eligible for Colorado Fostering Success Vouchers; and

3. Individuals eligible for Community Access Team Vouchers.

HCPF proposes to provide the following housing supports through this Waiver amendment:

- Rent/temporary housing for up to six months;
- Utility costs including activation expenses and back payments to secure utilities for individuals receiving rent/temporary housing as described above;
- Pre-tenancy and tenancy sustaining services, including tenant rights education and eviction prevention;
- Housing transition navigation services;
- One-time transition and moving costs (e.g., security deposit, first month's rent, utility activation fees, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture); and
- Housing deposits to secure housing, including application and inspection fees and fees to secure needed identification.

Through this amendment, HCPF proposes to provide the following nutrition services:

- Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement;
- Medically tailored, home delivered meals tailored to health risk and eligibility criteria, and/or certain nutrition-sensitive health conditions; and
- Home delivered meals or pantry stocking.

Under Section 1115 of the Social Security Act, states may implement "experimental, pilot or Demonstration projects which, in the judgment of the Secretary [of Health and Human Services] are likely to assist in promoting the objectives of [Medicaid]." The State believes this Demonstration is likely to promote the objectives of Medicaid by providing services that address HRSN thereby leading to improved health outcomes.

Consistent with the CMS policies as outlined in the November 16, 2023, CMCS Information Bulletin, and in the CMS All States presentation on December 12, 2022, Colorado's specific goals for the HRSN Demonstration are to:

3. **Improve the health status of Medicaid beneficiaries** by removing social barriers to health; and
    - **Objective a.** Addressing unmet HRSN within the Medicaid-eligible population will improve health outcomes.
    - **Objective b.** Addressing unmet HRSN within the Medicaid-eligible population will reduce the total cost of care.
    - **Objective c.** HRSN services will result in a reduction of readmissions within 30 days, to Emergency Departments (EDs) and hospitals.

4. **Improve connections between Medicaid beneficiaries and community services** to address physical health, behavioral health, and health-related social needs (HRSN).
    - **Objective d.** HRSN services (improvements in housing stability and

nutrition) will result in an increase in recommended and/or preventive care.

This notice is submitted pursuant to Title 42 Code of Federal Regulations, Part 431.408, Subpart G, which outlines public notice processes and transparency requirements for Section 1115 Demonstrations.

Attachment 5: Public Notice Comments

Colorado (State) received 34 sets of verbal comments and 10 letters of support during the public comment period that took place from June 10, 2024, to July 10, 2024. Public hearings were had on June 20, 2024 from 11:00 am to 1:00 pm MST at the Colorado Department of Health Care Policy and Financing (HCPF) as well as on a teleconference and webinar and June 24, 2024, from 12:30 to 2:30 pm MST at the Old Town Public Library in Fort Collins, Colorado, as well as via teleconference and webinar. Below are the comments and questions received and the State's responses.

Comments/Questions	State Response
What does HRSN stand for?	Health related social needs.
Who determines housing voucher eligibility?	Department of Local Affairs (DOLA)
I know you have the medically tailored meals through the 1915(c) waiver, how do you do the pantry stocking and medically tailored meals currently? How is that already happening?	Home-delivered meals provided through 1915(c) waivers, for eligible individuals. Transitional settings, expanded to folks leaving hospitals. Pantry stocking has not yet been launched but looking at implementing under Money Follows the Person for individuals leaving long-term hospital stays, medium care facilities.
Who would deliver those meals?	For meals, we have Medicaid providers. This enrollment is required under Medicaid and paid through claims system. Do have providers for home-delivered meals? We are still working on that component.
Who would deliver pre-tenancy and sustaining services?	Regarding pantry stocking, one of the services in pre-tenancy and sustaining services is case management. Initial set up, to help someone get basics to get started with the intention of getting other services ongoing.
Clarification: housing component is just on the eligibility side?	It is a bundle of services, and where an individual is on the housing continuum will determine services that are received. However, all services will be available.
Curious about the housing eligibility — why aren't single parents/guardians with children included in who is eligible? Excited to see foster care graduates in the group though.	Families are eligible. We did receive feedback on nutrition services for children, but children are ineligible since they cannot get the housing vouchers. We will be looking at expanding the nutrition services in the feasibility studies. We elected these target populations for this bundle due to budgetary constraints. We are looking at expanding eligibility in the second round. A single parent could fit into any of the eligible waivers, three vouchers, parent and then the child would be eligible for supports. A

	household receives support that helps them get andstay housed.
Feasibility Study, new amendment or another waiver?	We will have a new, comprehensive waiver once we renew, and the amendments will apply to the renewed waiver.
I think 1115 waivers must be cost neutral. Do you have to demonstrate cost neutrality to CMS, or anyone else?	Yes.
How is the State going to involve Colorado Department of Public Health and Environment (CDPHE) teams?	This program will be happening at the same time as the CHW legislation. There is an opportunity to leverage these professionals to do referrals.
So, the populations who are eligible for housing/nutrition services via 1115, is there anyone who is already receiving Medicaid in these eligible populations?	Yes.
Thank you for all the clarification. I wasn't so concerned about the children receiving the benefit directly versus head of household, as I was making sure families were able to be eligible to receive rent assistance/tenancy support, etc. etc. as shown.	Yes, families are eligible for the housing vouchers
How are you planning on getting information out? RHC could be a support.	Thank you for your suggestion.
ACC 3.0 contracts around nutrition. The RAEs will have to ID the food access within the RAEs. RHC has a touch point.	Thank you for your suggestion.
Populations focusing on SUD in Office of eHealth Innovation (OeHI), any overlap there?	Working with OeHI, thinking about the connections to the Social Health Information Exchange (SHIE) that will enable more of this work to happen more efficiency. Different data, permissions. Starting with housing and expanding to food and nutrition.
Thanks, all this is very helpful. Trying to make sure I can communicate back to some partners as we also were interested in how an 1115 could support rental assistance as a part of economic mobility (and then we found HCPF was doing all this work), so thank you.	Thank you.
CDPHE to debrief with CDPHE colleagues. Do we want to have more meetings with the HEAL team? Make it broader?	Thank you.
I think that this would be a tremendous help to our clients in need. Our team works with clients who all have Medicaid and this would help with there out of pocket costs. It would also help with the company's out of pocket	Thank you, the state appreciates the comment and feedback.

expenses when we have newly admitted client!	
It is important that we get this funding source which will allow us (HPP) to continue to provide housing through our PSH projects.	Thank you, the state appreciates the comment and feedback.
I am writing to support the state of Colorado applying for a 1115 Medicaid waiver to allow state Medicaid funding of housing and substance abuse funding. For the last five years I have volunteered to serve on the Board of Directors of Homeward Pikes Peak and witnessed first hand the need for funding of services that can be provided through this program. Thank you for taking the necessary steps to support my state and community.	Thank you, the state appreciates the comment and feedback.
No! Absolutely not! The cost will be too high. This will act as a magnet to bring more non-workers to our state. As a middle-class citizen of Colorado, I am experiencing lifestyle erosion. My budget is being overwhelmed by inflation, energy cost, insurance cost, and taxes. It is only a matter of a couple years until I will not be able to afford the property tax on my home. Lifestyle erosion is in all aspects of my life.	Thank you, the state appreciates the comment and feedback.
No! Absolutely not! The cost will be too high. This will act as a magnet to bring more non-workers to our state. As a middle-class citizen of Colorado, I am experiencing lifestyle erosion. My budget is being overwhelmed by inflation, energy cost, insurance cost, and taxes. It is only a matter of a couple years until I will not be able to afford the property tax on my home. Lifestyle erosion is in all aspects of my life.	Thank you, the state appreciates the comment and feedback.
I am concerned that the current scope of the waiver amendment is not sufficient to significantly increase access to nutrition services for Health First Colorado members and will not result in the cost-savings the state hopes to realize. I encourage the Department to prioritize Community Based Organizations (CBOs) to act as service providers and deliver these nutrition services. I encourage the Department to allow a group approval process for nutrition service providers, especially CBOs. I encourage the Department to carefully define 'home-delivered meal' and 'medically tailored meal' services to ensure that members are receiving	Thank you, the state appreciates the comment and feedback.

nutritious and culturally relevant food regardless of the nutrition intervention they receive. I want to highlight that medically tailored meals, home delivered meals, and pantry stocking are three separate forms of nutrition services with unique practices, purposes, and client populations.	
June 20, 2024, Public meeting in Denver	
Can you explain how this amendment is connected to substance use disorder? Do folks have to have SUD along with the other requirements in order to receive these housing and nutrition services?	We will be transitioning our waiver into a comprehensive waiver. Currently this is the vehicle we have that will allow us to have an avenue to quickly get this submitted to CMS. We are working closely with our federal partners.
CDPHE, how will you identify the food partners that could provide those services listed? Through a request for proposal?	We have not yet decided how we will identify food partners. But you must be a Medicaid provider. The expectation for standard Medicaid processes (including food and housing services), you will have to enroll through the department's process to become a Medicaid provider. Similar requirements will be required for DOLA (Department of Local Affairs).
Can HCPF provide how they define the differences between home-delivered meals and medically tailored meals, and if they have different populations, they are targeting with each?	There are a lot of things that we will have to determine. We have not yet defined these yet as they are not required under the waiver. We will be looking at the populations we are serving and the services that make the most sense for the eligible populations. We do not have definition currently but will be looking at what exists in the space for us to leverage. Noting that we will want to ensure dollars we invest here in Colorado.
It is important that the investments of these services stay in Colorado, with Colorado-based organizations. Are there ways that HCPF can prioritize that Colorado-based organizations are given priority as service providers for these nutrition services?	Thank you, we will make a note that the dollars we reinvest stay in Colorado.
It seems like there is clinical criteria of behavioral and chronic health conditions — is it Both/And? Eligible population and clinical criteria?	You can have either, or a behavioral health and chronic condition to receive the whole set of services to meet the need.
Is there a clinical criterion for all vouchers? Are there clinical criteria for all vouchers?	Table 1.B has the eligibility criteria for each population. A lot of this is dictated by the voucher program.
We've noticed that children are explicitly excluded from the populations the	Children are not eligible for a housing voucher because the voucher is tied to the eligibility of

Department has outlined in the draft waiver language. Can you help us to understand this?	the services. We can look at children for our nutrition services in our feasibility services.
It's also important that we maximize the impact that these Medicaid dollars could have on our local food systems, particularly with produce/protein prescriptions and pantry stocking services. Are there ways HCPF can prioritize procurement from local farmers, ranchers or food hubs? What partnerships and support does HCPF need to make these priorities a reality?	We really appreciate you to reinforce us supporting our local system and keep the funding local. I think this is really important to submit as a formal comment so we can keep these in mind when we look at moving forward with services.
hello all, we'd love to offer some comments along the line of the question that Kevin Wilson raised as well. We strongly encourage the Department to include a focus on families with children. We look forward to working on this and share our thoughts today.	For newer programs, we are required to look at specific populations including postpartum individuals and families. We may not be able to prioritize one population over another, but we will explore options to expand coverage in our feasibility studies.
follow-up questions would be what if the child has Medicaid eligibility, but a parent does not — for reasons such as FPL, disability, or a mixed-status family. We would strongly recommend including children as an entry-point to whole-family services. Along these lines, we'd love to know if broader eligibility is possible for nutrition support services. It feels perhaps a bit restrictive to tie everything to housing voucher eligibility.	Thank you for your suggestion.
Anonymous attendee strongly agreed with earlier comments.	Thank you for your comment.
thank you for doing this work! The Children's Campaign is looking forward to supporting these feasibility studies and future amendment waivers.	Thank you for your comment.
June 24, 2024, Public meeting in Fort Collins	
who is eligible for the program? Is it people eligible and waiting for housing and/or people who are already housed with the vouchers?	Both, where a person is in the housing continuum will dictate the services available for them.
do the eligibility requirements apply to nutrition supports or just housing?	The eligibility requirements apply to nutrition and housing supports.
will these slides be available? I don't see them on the website. Thanks!	We will be posting an FAQ on the website. We have the stakeholder meetings from May 2024 on the website with recordings.

• who are the providers identified to perform the personalized nutrition counseling?	We do not have providers identified yet. That will be part of the implementation and operationalization planning.
A down the road question: How hard would it be to expand those the waiver serves and how long it will take? Is HCPF exploring this?	We have feasibility studies required under HB23-100 and HB24-1322. We are exploring additional options for expanding services through these studies. This is looking at different populations and services that we could expand on. In terms of how long, we have our due dates of November of 2024 (HB24-1322) and January of 2026 (HB23-1300) to understand the feasibility of these implementations. There are a lot of variables involved in how we move forward and the timeline.
Will you be taking input from provider groups during these conversations?	Yes, absolutely.
Denver Health will be drafting and sending a comment letter in soon. Appreciate this process!	Thank you very much.
Providers need to be contracted with Medicaid/DOLA, correct? Versus procurement?	Yes, they will need to be a contracted Medicaid provider. There are a number of ways we can implement this, and we are wanting to make this easy for providers, but providers will need to be a Medicaid provider. We are open to receiving feedback from providers.
I'm here from the Colorado Academy of Nutrition and Dietetics. More will come in our comments for the amendment, but we would welcome the opportunity to participate and support the implementation and operationalization planning. How can we best stay connected?	You can sign up for the newsletters via the email: hcp_1115waiver@state.co.us.
Are there ways that HCPF can prioritize that Colorado-based organizations are given priority as service providers for nutrition services?	That is something we love feedback on and provide comments and recommendations on how to prioritize.
Please clarify: Is it people eligible and waiting for housing and/or people who are already housed with the vouchers?	It is both.
what is the role of the Regional Accountable Entity (RAEs) (especially in ACC phase III) in implementing the HRSN 1115 waiver?	The RAEs will continue to support and administer behavioral health needs (substance use, behavioral health, etc.) HCPF is not sure yet. We would like to hear about flexibility you would like to see with

	payments. This will help decide FFS and MC.
In terms of the PSHa population, is this population people who are already prioritized in coordinated entry? Will providers have ability to self-refer potentially eligible folks who might be eligible?	The process for qualifying for PSH, runs through DOLA and their criteria. Through the coordinated entry system, DOLA will still maintain that oversight of how individuals are prioritized. Once an individual is identified as being eligible and part of this population, then the individual will become eligible for subsets of services. The services are matched to where the individual is. This does not change the way the coordinated entry system works
Hello, I'm here on behalf of the Colorado Academy of Nutrition and Dietetics, and I would like to provide a comment/testimony if possible. ● **Medically Tailored Meals Definition and Program Design —** We strongly recommend HCPF implement a model that is inclusive of Registered Dietician Nutritionalists (RDNs) and nutrition assessment and education, such as the Food is Medicine Coalition (FIMC) model. Under these models, beneficiaries approved for medically tailored meals undergo a clinical nutrition assessment with a Registered Dietician. The RDN develops a customized nutrition care plan involving food and nutrition counseling tailored to the individual's specific medical needs. ● We urge HCPF to consider the transition of care for individuals receiving medically tailored meals. Even after stabilization, these individuals might require ongoing nutritional education and intervention, despite no longer meeting the program's eligibility criteria. Upon discharge from a	We are excited about exploring the possibility of an Environmental Scan of “incident to” possibilities for Registered Dieticians. We are aware of the limitations of enrolling Registered Dieticians in Medicaid and are trying to creatively look into options. We are committed to addressing the challenges posed by lack of licensure and will work with other regulatory agencies to examine the options.

medically tailored meals program, participants should be connected to both food insecurity programs and clinical services, such as medical nutrition therapy (MNT), to bridge the gap between nutritional recommendations and their practical situation. • Environmental scan of Registered Dieticians as "incident to" in Medicaid and managed care. Dietitians are not yet licensed in Colorado. Therefore, we recommend that the HCPF conduct an environmental scan and issue guidance allowing licensed practitioners to bill for Registered Dieticians.	
Thank you Cristen! We look forward to collaborating and partnering with you regarding these important services for Coloradans.	Thank you very much.
We'd support Niki's comments regarding coverage of medical nutrition therapy (MNT) and the Food As Medicine (FAM) model. The team at Children's Hospital Colorado certainly agrees that these are important parts of the service mix for the food security component of the 1115 waiver.	Thank you very much.
We're very excited by this work and we're looking forward to seeing these services go-live! You'd mentioned to expect a number of different iterations for the waiver — something the Department previewed during the legislative process. Cristen, in your presentation, you mentioned the current timeline and the immediate filing. Adela mentioned exploring different populations and different services through the course of the feasibility studies. Could you preview for us a bit more about the intersection with the feasibility study and report that the Department will be doing? Is it reasonable to expect an amendment to this amendment after that feasibility study is completed?	Both HB23-1300 and HB24-1322 both have feasibility studies due in November 2024 (1322) and January 2026 (1300) https://Medicaiddirectors.org/resource/how-1115-waivers-work/.

Cristen asked a question earlier about preference between RAE and FFS systems. We generally support a blended approach between managed care (RAE-supported) and fee-for-service coverage of services. There are strengths to both, and having some aspect covered under the RAEs make good sense, given the focus on these two HRSNs in ACC Phase III.	Thank you very much for your comment.
Please move forward with what you can do correctly keeping timelines and uncertainty in DC in mind. Nutrition support services, we screen a child and learn about a need that family or child has. We don't want to miss an opportunity to get entry into nutrition services. Would love to see a broader definition. Once we start thinking about the different doors we can use. Would like to see a broader population, recognizing the budget and timeline constraints.	Providers have prioritized screening for those needs. We are able to start because of how much work has already been done. What we have in the current waiver is bundle. Eligibility applies for set of services. One thing we were thinking of is the time to implement.
Final comment from the team at Children's Hospital Colorado — summarizing what we just mentioned here in the room. We'd really like to see a broader target population for nutrition services. We recognize the desire to use existing program criteria for population targeting. For the nutrition support services, we would recommend expanding beyond the Department's current definition. To put it directly, we would like to see children who are food-insecure or have a medical need for medically tailored meals to be included as target populations. We'd also recommend that if a screening during a well-child visit shows a need and a gap for the family in terms of housing stability or food security, then we'd like to see that function as a "door" for services.	We will consider expanding target populations in future amendments.
Wonderful to hear CAND will reach out!	Thank you for your comment.

Written Comments

Denver Health Comments Denver Health understands that this initial waiver amendment has a limited scope, but would like to request that these areas of need are addressed in future 1115 waiver amendments:

- **Identification and Referrals to Programs:** Denver Health is requesting to play a stronger role in identifying and referring potentially eligible members for these

benefits through partnerships with Health First Colorado's Regional Accountability Entities (RAEs) and/or homeless resolution partners.

- **Housing Prioritization Needs:** Denver Health wants to be a thought partner in community discussions with the continuum of care about prioritizing individuals for housing resources within the coordinated entry system. Overreliance on the self-report tools in prioritization may result in the under-reporting of vulnerabilities in some groups, in particular those with cognitive impairment or serious mental illness, and among racial and ethnic minoritized communities, given historic consequences of disclosing potentially stigmatized personal histories. Additionally, prioritization tools often do not allow for capturing degrees of clinical risk (e.g., cancer versus high blood pressure). As we know from SWSHE, there is a strong overlap of the unhoused population and the high-cost, complex utilizers that are frequently readmitted to the hospital. To effectively reduce utilization and costs, having a health care utilization criterion, such as that utilized in SWSHE, could be a more objective way to prioritize this housing voucher-eligible patient population versus providers identifying these individuals.

- **Timely Discharge to Post-Acute Care:** It is sometimes very difficult for us to place complex patients within skilled nursing facilities (SNFs) and other long-term post-acute care facilities. Denver Health is requesting that if the focus of this waiver amendment is those transitioning out of nursing facilities or at-risk for institutionalization, that HCPF make easier and more timely post-acute care discharge a priority for acute care hospitals. We will continue to work with the RAEs in this area, but request that better oversight by HCPF is made a priority in this space.

- **Data Considerations:** Better transparency of individuals who have been prioritized for a housing voucher within the coordinated entry process would be helpful for hospitals like ours to ensure Denver Health is able to get this patient population the housing they so desperately need. The operationalization of the state's Social Health Information Exchange (SHIE) is critical to enabling greater transparency of information and data sharing between the housing and health sectors.

- **Broader Scope of Eligibility and Additional Funding Beyond $50 Million:** This would allow for additional housing services to be rendered for the Permanent Supportive Housing (PSH) voucher population on the waitlist and for services to extend to other key populations, such as homeless/at risk individuals who have not yet been prioritized for current voucher programs, but who have complex health needs and/or high utilization of hospital services. We also appreciate HCPF's interest in looking at rate parity to raise this program beyond the $50 million threshold.

- **Reimbursement for Denver Health Housing and Nutrition Programs:** Because funding is always top-of-mind for us, Denver Health would appreciate any funding we can receive through a future 1115 waiver for our housing and nutrition

programs, or at the very least, the ability to receive the federal match funding for these programs.

- **Recuperative Care:** Medical respite is an evidence-based intervention designed specifically to accommodate the post-acute care needs in medically complex homeless populations. We understand that the initial phase of this program has a limited scope, but we would ask that in future iterations special attention be paid to funding for recuperative care services for those on the PSH voucher waitlist that no longer need acute care.

Response: Thank you for these comments and suggestions. They will be considered in the implementation of the program as well as in future amendments. We can look at additional populations and programs in our feasibility study.

Nourish Colorado/Colorado Blueprint to End Hunger/Feeding Colorado/Project Angel Heart

- We are concerned about trends seen in other states where national service providers are outsourced for 1115 waiver nutrition service reimbursements. Our organizations and networks of partners want to see our Medicaid dollars stay in-state. We encourage the Department to consider how it might uphold values of supporting local economies and small businesses by prioritizing Community Based Organizations (CBOs) to act as nutrition service providers. We include some suggestions throughout this comment.

- **We are concerned that the current scope of the waiver amendment is not sufficient to significantly increase access to nutrition services for Health First Colorado members and will not result in the cost-savings the State hopes to realize.** The target populations outlined in the draft amendment are restrictive and limited. As demonstrated by previous home-delivered meal expansions within Colorado's HCBS waiver population, this limited eligibility will result in minimal usage of these nutrition services. We urge the Department to follow the lead of many other states and include chronic disease populations in eligibility for nutrition services.

- **We encourage the Department to prioritize Community Based Organizations (CBOs) to act as service providers and deliver these nutrition services.**

- **We encourage the Department to allow a group approval process for nutrition service providers, especially CBOs.** We ask the Department to consider the role of the Regional Accountable Entities in this model, and if there is an opportunity to leverage the existing and future networks through Accountable Care Collaborative Phase III to assist with group approvals of nutrition service providers.

- **We encourage the Department to carefully define 'home-delivered meal' and 'medically tailored meal' services to ensure that members are receiving nutritious and culturally relevant food regardless of the nutrition intervention they receive.** Project Angel Heart considers medically tailored meals (MTM) to be

meals designed by a Registered Dietitian Nutritionist (RDN) based on a nutritional assessment and provided as part of a person's health care plan. While home-delivered meals are not tied to individuals' specific nutritional needs, we feel strongly that the Department should implement guidelines to ensure that the food being delivered under this service meets general nutrition standards. Other state-funded nutrition programs have seen examples of providers who subcontract their meal provision to fast casual chain restaurants, which provide meals of low nutritional value. We know that this is not the type of nutrition intervention that HCPF intends to support through Medicaid.

- We want to highlight that medically tailored meals, home-delivered meals, and pantry stocking are three separate forms of nutrition services with unique practices, purposes, and client populations. While we recognize that the Health Related Social Needs (HRSN) services chart released by Centers for Medicare and Medicaid Services (CMS) conflates "home-delivered meals," "pantry stocking," and "medically tailored meals" into one box with equivalent requirements, we recommend that the Department separates these services with reasoned explanations for why certain populations are eligible for certain services. Pantry stocking, specifically, provides an opportunity for the Department to use values-based procurement strategies to prioritize vendor services from small, local businesses, food hubs, and farms. Especially when procuring unprocessed or lightly processed products including fruits, vegetables, and meats, we encourage the Department to prioritize local procurement.

- We are pleased to see that the Department has requested authority to claim up to the 15% HRSN infrastructure investments allowable through Section 1115 Waivers. In order to support the development and implementation of HRSN services, and create opportunities for future nutrition services waivers, the Department should request the use of the infrastructure investments for:

    i. **Value Chain Coordination and Local Procurement:** Provide technical and operational support to help connect Colorado producers, farmers, ranchers, and CBOs providing food for nutrition services, or those providing the services directly. Partner with Colorado Department of Agriculture and Colorado Department of Public Health and Environment to integrate existing State best practices. We suggest HCPF explore the use of preexisting partnerships and infrastructure in Colorado, such as those developed through planning for the Local Food Purchasing Program and Community Food Access Program.

    ii. **Technology and Data:** CMS guidelines are clear in that nutrition services shall not supplant the support provided by enrollment in federal benefit programs, particularly the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC). The Department should use these infrastructure investments to support long overdue client matching between Medicaid, SNAP, and WIC

participants, creating an opportunity for State agencies (Colorado Department of Human Services, Colorado Department of Public Health and Environment) to reduce enrollment barriers, ensure cross-program enrollment, and maximize proven positive health outcomes from these programs. Any data matching methods should be prioritized for interoperability with other important programs like National School Lunch Programs (Colorado Department of Education), Temporary Assistance for Needy Families (Colorado Department of Human Services), and Commodity Supplemental Food Program (Colorado Department of Human Services).

iii. **Capacity Building and Community Partnership:** Colorado has community-embedded organizations statewide that are dedicated to increasing access to HRSNs. We urge the Department to use infrastructure investments to build capacity of community-based organizations across the state and create the infrastructure and systems needed to prepare organizations to become providers. This can include:

   a. Facilitating community-based workforce (e.g., CHWs) payment through contracts with community-based organizations.

   b. Provide funding and resources to organizations so they can effectively partner with health care organizations.

   c. Creating systems to prepare providers of nutrition services (community-based organizations) to deliver authorized services, receive payment, and reporting of information for managing patient care, monitoring outcomes, and ensuring program integrity or for technical assistance and collaboration with stakeholders.

iv. We suggest the Department review California, Oregon, and Washington's current and submitted waiver proposals for more examples of the use of infrastructure investments. Under Colorado's Food Assistance Provider Grant Program, food banks and pantries across the State are well-equipped to support the pantry-stocking benefit. Create a values-based procurement model for nutrition services reimbursed by Colorado Medicaid.

Response: Thank you for these comments and suggestions. They will be considered in the implementation of the program as well as in future amendments. We can look at additional scope of coverage in our feasibility study.

Colorado Coalition for the Homeless: While we believe that securing this waiver is a crucial step toward improving the wellbeing and housing stability of community members, we have concerns about the amendment request as drafted.

- **The Coalition was one of the many advocates for HB24-1322, which directs HCPF to conduct a feasibility study and pursue an 1115 waiver to allow Medicaid to fund housing supports and nutrition services.** The Coalition is

optimistic that the services under HB24-1322 will result in improved health and stability outcomes among Coloradans experiencing or at-risk of homelessness. Ensuring that FQHCs like CCH can effectively deliver and bill for services and working toward more substantial financial investment for long-term sustainability and scalability of the services are critical components of this effort.

- **The amendment does not address how FQHCs who are currently based on encounter rates based on cost reports will be treated in terms of reimbursement for services.** We suggest providing a per diem payment per client similar to payments under SWSHE as an alternative.
- **The draft amendment request also raises concerns regarding diagnosis codes and provider types.** It will be important to make sure medical necessity rules and covered diagnoses are expanded to enable coding and billing for the nutrition and housing services. For FQHCs, bachelor's level providers and peer specialists should provide the services under the waiver and be able to code and get paid for them.
- **Settings:** The supportive services to individuals in transitional and bridge housing settings, non-congregate shelter, micro-communities, and on the streets is an effective way to assist people experiencing homelessness on the path to housing stability. These settings should be explicitly indicated as prime locations for service delivery.
- **Populations**: We urge HCPF to consider the populations outlined in HB23-1300 (Continuous Eligibility Medical Coverage) that are required to be addressed in the feasibility study, including perinatal care recipients, youth in or transitioning out of foster care, former foster care youth, people with substance use disorders, high-risk infants and children, and low-income individuals impacted by natural disasters. In addition to these populations, we recommend HCPF include those with serious mental illness and youth at risk of juvenile justice involvement.

Response: Thank you for these comments and suggestions. FQHC reimbursement will be considered in the implementation of the program. We will look at additional scope of coverage in our feasibility study as well as in future amendments.

Children's Hospital Colorado Our comments here focus both on the target populations and the service mix proposed in this draft waiver, understanding that Colorado Medicaid may indeed pursue a stepwise expansion. While we are encouraged by the Department's forward-looking statements, we emphatically recommend that the Department make the most of the historic opportunity created by these legislative reforms. We echo the comments of many others in the community of advocates and respectfully request that the Department work to ensure this waiver amendment captures a sufficiently broad set of Medicaid members who are experiencing significant unmet need for these services. We strongly recommend that the Department ensure that children and families who are experiencing housing instability and nutrition insecurity are among its target populations, and that the housing services covered include medical legal partnerships.

- **Importance of Including Children in Targeted Populations**. The target populations proposed explicitly exclude children under 18. While additional populations may be added into the waiver through future amendments, we believe that the limited scope of the current proposal will not make enough of an impact on population health to achieve the long-term cost savings needed for sustainability and scalability. If the program does not serve kids and families, state and federal dollars simply won't go as far. **We strongly recommend that the Department add children, youth, and families as eligible populations.** We also encourage the Department partner with stakeholders on ways to construct its waiver such that both adults and children can be points of eligibility for whole-family services. We believe that these options should be included in the Department's feasibility study planned for this summer. And we would appreciate additional details from the Department about its plans to expand services to these critical populations.

- Debate over the enabling legislation included a much broader population and set of services. Many stakeholders were expecting this draft to align more closely with the development of the enabling legislation. **We therefore encourage the Department to engage stakeholders early in discussions around budgetary considerations. If offering services to the populations most in need, or if offering the full suite of services, will require additional budgetary authority, we encourage the Department to communicate this early and seek that relevant budgetary and/or legislative authority in partnership with stakeholders.**

- **Ensuring Housing Services Include Medical Legal Partnerships**. We also seek clarity about whether the pre-tenancy or tenancy sustaining services defined in the draft waiver will include medical legal partnership's services to improve housing stability. Medical-legal partnerships integrate lawyers into health care settings to help clinicians, case managers, and social workers address structural problems at the root of many housing-related health inequities. Research shows that 47% of low-income and 52% of moderate-income households have at least one unmet legal need. Medical legal partnerships mitigate social and environmental risks that can impact the health and well-being of children and families. People with access to legal partnerships are more likely to achieve adequate, affordable, and stable housing.

Response: Under the program as proposed, families are eligible. We did receive feedback on providing nutrition services for children, but children are ineligible since they cannot get the housing vouchers. We will be looking at expanding the nutrition services in the feasibility studies. We elected these target populations for this bundle due to budgetary constraints. We are looking at expanding eligibility in the second round and will seek additional funding as required. At this time, Medical Legal partnerships are not included under the demonstration.

Mom's Meals Supports Colorado's efforts to ensure that the most vulnerable people in Colorado gain access to housing, nutrition education, and nourishing food.

- **Supervision of the Meal Plan by a Registered Dietitian.** Mom's Meals recommends nutritional counseling as an additional option, rather than requiring it to receive meals. While Mom's Meals understands the importance of nutrition counseling, we urge Colorado to consider nutritional counseling as part of the Nutrition Service package and not a prerequisite to receive medically tailored meals, home-delivered meals, or pantry stocking. Although nutrition education from a Registered Dietitian is helpful in assisting with chronic condition management, immediate access to proper nutrition can help initiate program engagement and positive health outcomes. As all of Mom's Meals are already designed by a Registered Dietitian, speaking with one prior to receiving meals is not necessary. It usually only adds complexity and unnecessary costs. Dialogue with a registered dietitian can be introduced once a member has already engaged in the program and the member notices the initial value of dietary improvement. This approach leads to more openness and readiness for conversations about changing their habits. It also leads to better engagement and improved outcomes.

- **Reducing potential barriers to program eligibility.** As a home-delivered meal provider, we understand that documenting medical necessity may be a requirement for a member to gain access to certain services. We have witnessed first-hand that requiring a physician's signature can result in a lower rate of utilization relative to programs that do not require physician involvement. This requirement can also add significant complexity and added cost to the program. Additionally, requiring copies of medical documentation as part of the referral process can be particularly burdensome for members who have had inconsistent or unreliable access to care. The State could determine medical necessity through claims or medical records, which would also result in less burden and added efficiencies if the MCOs uses a centralized team that can complete this review. An additional strategy to help identify medical necessity could include incorporating member-reported chronic condition diagnoses, which could be documented as part of the referral process.

- **Ensuring equitable access to program services.** Mom's Meals has seen that unhoused populations have the most need for nutrition support; however, some may not be eligible for nutrition supports due to storage or delivery concerns. Mom's Meals is fully prepared to offer shelf-stable meals as a temporary solution for members without stable housing and urges HCPF to reconsider offering Nutrition Services to the individuals eligible for Permanent Supportive Housing population.

- **Reducing Operational Complexity.** Some states employ a hub model whereby an organization separate from the Managed Care Organizations (MCOs) administering the Medicaid benefits functions as a centralized hub for contracting with service

providers, including home-delivered meal (HDM) providers. The hub model contrasts with the direct contracting model used by other states in which MCOs directly contract with service providers to deliver HDM benefits. Members have easier access to, and increased uptake in, HDM services by beneficiaries in the direct contracting model. The direct contracting model allows for more efficient communication between service providers and the MCO about operational questions, which enhances care continuity, member experience, and transparency. Hence, we believe that contracting directly with MCOs will improve results relative to the intended program outcomes. Mom's Meals recognizes that some HDM providers may need capacity-building support to enable MCO billing and other capabilities; however, many Section 1115 waivers allow for funding expanded MCO capacity. Building this capacity is in the best long-term interest of the service providers seeking to serve the health care industry over the long-term.

- **Reducing Program Implementation Complexity.** Introducing a new platform or requiring implementation of an additional platform for referral submission can add complexity and additional cost to processes that may already be established and working efficiently. Mom's Meals knows that allowing referrals for HDM services to flow directly to MCOs using existing pathways removes administrative burden, facilitates more seamless access to benefits, and uses funds more efficiently.

Response: Thank you for these comments and suggestions. We will consider these suggestions in the implementation of the program.

Colorado Access We firmly believe that securing this waiver offers a moment of great change and opportunity for Medicaid — having a safe, stable home and consistent access to nutritious food is fundamental to a person's health and wellbeing.

- Colorado Access enthusiastically supports the provision of housing and nutrition services for Medicaid members eligible for permanent supportive housing (PSH) vouchers and experiencing a behavioral health need and/or chronic condition; members eligible for Colorado Fostering Success (CFS) vouchers; and members eligible for Community Access Team (CAT) vouchers. Overall, we believe the new benefits will improve the health status of Medicaid members and contribute to better population health.

- We do not believe the waiver request is sufficient for long-term investment and transformation of the Medicaid system or to create meaningful change in how housing and nutrition services are covered and delivered. We look forward to future expansions of the eligible populations served through these new covered services so that more individuals can benefit from the improved health outcomes that result from the stability of consistent housing and access to food. Compared to other states pursuing HRSN waivers, Colorado aims to serve a much smaller portion of our Medicaid population. The limited populations served through Colorado's waiver amendment are insufficient for long-term sustainability and

scalability of the services. Future iterations of Colorado's HRSN waiver should build toward serving significantly more people with a robust set of services.

- The RAEs are ideal partners for implementing these new services, and we stand ready to assist the State with administering the HRSN waiver. We seek clarity on several pieces, including the specific role that RAEs will play. As part of our preparation and proposal for ACC Phase III, COA is already expanding our work with CBOs to meet member needs but will require additional guidance from the Department about financing and contractual requirements for the HRSN waiver. We seek clarity on the following questions as further implementation plans are laid out for the waiver:

    i. What are the expectations for the RAEs regarding care coordination and care management for members eligible for new HRSN services?

    ii. What types of entities are expected to provide housing and nutrition services? If they need to enroll as Medicaid providers, how will these entities be credentialed?

    iii. Will contracts with housing and nutrition service providers be held by the RAEs or by the State?

    iv. We note that the current processes for establishing new provider types and credentialing requirements, such as those for doulas and community health workers, require a year or multi-year process. How will this impact the timeline for onboarding new providers for housing and nutrition services?

    v. We are concerned that the size of the eligible population may be insufficient to justify service providers investing resources and efforts around enrolling, credentialing, and contracting with Medicaid, assuming this becomes a requirement by the State. What support and resources will be available to service providers before implementation to help them meet these requirements?

    vi. How will data sharing be managed to ensure that RAEs are aware of voucher eligibility and that information is effectively shared among RAEs, HRSN providers, and the Department? Will the Department invest in or require the use of a closed-loop referral system?

    vii. What is the difference between home-delivered meals and medically tailored meals and how does the definition of each affect eligible populations?

    viii. Access to nutritious food is especially important for children's long-term health and development. As drafted, the waiver is primarily focused on the adult Medicaid population, but the households served are likely to have additional family members living with them. Does the Department plan to make the nutrition services available for everyone in the household, including children?

- Recommendations for future iterations. We strongly encourage the Department to seek budgetary authority during next year's legislative session to expand the eligible populations and ensure the waiver achieves the promise of transformation that we all share. In doing so, we also encourage the Department to consider the populations outlined in HB23-1300 that are required to be addressed in the feasibility study, including the needs of perinatal recipients, youth in or transitioning out of foster care, people with substance use disorders, high-risk infants and children, and the needs of low-income individuals impacted by natural disasters. In addition to these populations, we recommend the Department be inclusive of those with serious mental illness, youth at risk of juvenile justice involvement, and generally apply a whole-family approach to ensure that both adults and children can be points of eligibility.

Response: Under the program as proposed, families are eligible. We did receive feedback on providing nutrition services for children, but children are ineligible since they cannot get the housing vouchers. We will be looking at expanding the nutrition services in the feasibility studies. We elected these target populations for this bundle due to budgetary constraints. We are looking at expanding eligibility in the second round and will seek additional funding as required. Thank you for these questions and suggestions. We will consider these suggestions in the operationalization of the program and as we seek to answer administrative questions in program guidance after demonstration approval.

Unite Us Unite Us writes in enthusiastic support of Colorado's 1115 Waiver Amendment application. Our comments below reflect our support and include recommendations stemming from the lessons that we've learned on the ground supporting similar transformative reforms in other states.

- Unite Us applauds and strongly supports HCPF's inclusion of HRSN-specific infrastructure expenditures for technology and connecting Medicaid enrollees effectively and efficiently to HRSN services.

- **Unite Us recommends that HCPF include statewide closed-loop referral technology (CLRT) as an HRSN infrastructure expense** to drive health-equity at scale through tech-enabled community care coordination and HRSN implementation**.** Shared CLRT can act as the technology infrastructure to support all pilot initiatives, improve coordination and communication across sectors and between community providers, help facilitate payments for HRSN services, and provide the appropriate data tracking to evaluate results. A shared CLRT will help to drive health-equity at scale through tech-enabled community care coordination and HRSN implementation**.** Shared closed loop referral technology **reduces workflow disruptions** for community-based providers and **ensures standard data collection** for evaluation purposes. Requiring the CLRT to utilize an electronic master person index **enables cross-sector care teams** to monitor services and limit service and screening duplication using a **single client record**.

- Proactively outlining standard expectations for provider **certification/enrollment** and service **eligibility**, **enrollment** and **utilization** promotes swifter and more equitable access and member engagement with services.

- A **common fee schedule, coding** and **service standards**, can expedite implementation while controlling for wide variability in cost and quality across plans and providers.

- Efforts to increase **participation of community providers** of all sizes are strengthened by the provision of **capacity building** funds, ongoing **technical, contracting and quality support**, and **streamlined payment tracking** that limits how much CBOs need to shoulder coding and claims processes.

- States can **maximize federal financing** and **promote effective system interoperability** across their delivery system by integrating standard social care technology capabilities and modules, like member notifications, closed loop referrals and social care payment tracking, into your **Medicaid Enterprise Systems (MES)**.

- Unite Us highlights uniquely innovative strategies deployed in our partner states to implement HRSN benefits. **North Carolina:** North Carolina's Healthy Opportunities policies exemplify the most robust state-led strategy for advancing the whole-person health of Medicaid beneficiaries through one statewide referral and screening platform, closed-loop referrals, and value-based payments to providers (NCCARE360, powered by Unite Us). **Massachusetts**: MassHealth's new 1115 demonstration includes a HRSN initiative that requires MassHealth and its partners to develop **a networked infrastructure** to systematically identify and address members' HRSN to improve health outcomes. Delivery of HRSN services will occur through managed care and FFS care systems. This networked infrastructure can be implemented through a closed-loop referral technology. **Oregon**: Oregon encourages its CCOs to offer health-related services, which include "flexible services" (cost-effective services offered voluntarily to individuals as an adjunct to covered benefits) and "community benefit initiatives" (community-level interventions focused on improving population health and health care quality). In addition, Oregon is requesting federal investments to support capacity-building among community investment collaboratives and for statewide infrastructure to support the community investment collaboratives and cross-sector communication for fee-for-service populations. **Illinois**: The Unite Illinois network leverages Unite Us CLRT to deliver the core capabilities and benefits to current network partners.

- To ensure success in coordinating HRSNs and executing pilot goals for Coloradans, **HCPF should leverage a single CLRT enabled with payment tracking capabilities.** Standard enterprise billing systems are typically not built to support CBOs and may be difficult for them to use due to certification requirements and unfamiliar billing processes that require navigating codes and claim submissions. In order to enable community organizations to effectively participate in HRSN billing arrangements,

all partners need an easy-to-use solution to generate service-level invoices and manage reimbursements. Payment's functionality allows CBOs to easily invoice and be paid for the important services they provide, without unduly burdening them with administrative requirements and expenses.

Response: Thank you for these comments and suggestions. We will consider these suggestions in the implementation of the program.

Colorado Academy of Nutrition and Dietetics The Colorado Academy believes the proposed waiver will significantly improve the health and well-being of individuals with chronic diseases facing housing or food insecurity. We commend the Department of Health Care Policy & Financing (HCPF) for addressing food insecurity through initiatives like medically tailored meals, especially for those with chronic diseases.

- **Participant Eligibility**. We appreciate that HCPF has included cirrhosis, chronic obstructive pulmonary disease, diabetes, epilepsy, heart failure, hepatitis, HIV/aids, and hypertension under its eligible chronic conditions category. However, we request a more inclusive approach by expanding the list to include additional disease states. We suggest following the examples set by other states, which also recognize conditions such as chronic kidney disease, end stage renal disease, cancer, and stroke.

- **Medically Tailored Meals Definition and Program Design.** We strongly recommend HCPF implement a model that is inclusive of RDNs and nutrition assessment and education, such as the Food is Medicine Coalition (FIMC) model. Under these models, beneficiaries approved for medically tailored meals undergo a 60 to 90-minute clinical nutrition assessment with an RDN. The RDN develops a customized nutrition care plan involving food and nutrition counseling tailored to the individual's specific medical needs.

- Providing access to therapeutic diets. Home-delivered meals that are specifically tailored by an RDN to meet individual needs and the variances in nutritional requirements posed by various chronic diseases and conditions is an essential part of medical treatment in a successful food as medicine (FAM) program.

- We urge HCPF to consider the transition of care for individuals receiving medically tailored meals. Even after stabilization, these individuals might require ongoing nutritional education and intervention, despite no longer meeting the program's eligibility criteria. Upon discharge from a medically tailored meals program, participants should be connected to both food insecurity programs and clinical services, such as medical nutrition therapy (MNT), to bridge the gap between nutritional recommendations and their practical situation.

- **Medical Nutrition Therapy Benefit Design**: The proposed nutrition services in the waiver include "nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement,

including, for example, guidance on selecting healthy food and meal preparation for up to six months." We recommend allowing individuals to receive MNT beyond the proposed six months or more than once per month when medically necessary. Typical MNT services include an initial assessment and intervention followed by reassessment and continued intervention as determined by medical necessity. Failing to consider the severity of medical conditions and relying on arbitrary visit limits can disrupt patient centered care, potentially leading to setbacks and hindering overall health outcomes.

- **Network Adequacy:** To benefit patients, it is crucial for dietitians to be recognized as "providers." However, since dietitians are not yet licensed in Colorado, it remains uncertain if they can enroll as providers. Therefore, we recommend that the HCPF collaborate with RDNs to explore all possibilities. This exploration should determine if there is a pathway for RDNs to enroll as Medicaid providers and bill directly for their services under the Section 1115 waiver. We acknowledge that direct provider status may not be feasible until dietitian licensure is achieved.

- **Environmental Scan:** Regardless of whether RDNs may be deemed direct "providers" under this waiver, we recommend HCPF conduct an environmental scan to assess the workforce availability of RDNs within Medicaid and Managed Care networks, particularly in underserved areas. Evaluating network adequacy is crucial for program success. This assessment should utilize claims data analysis for codes 97802 and 97803, supplemented by a provider survey conducted in collaboration with the Colorado Academy to gather comprehensive workforce availability information both currently and in the future.

- **Payment Methodology**: Failing to account for the clinical time involved in these service results in uncompensated care, which undermines program sustainability and impacts the participants they serve. Regardless of whether payment is through a bundled, population health model, or fee-for-service model, programs must establish payment methodologies that properly value the clinical service component of medically tailored meal programs. We appreciate and support HCPF's outlined payment methodology in the waiver, maintaining fee-for-service reimbursement rates as per the Colorado Medicaid Fee schedule. We recommend that medically tailored meal agencies bill separately for the RDN's time and the meal component, using 97802/97803 for MNT services and S5170 for meals. This separation facilitates accurate data collection and analysis, offering insights into how each component contributes to overall health outcomes and enabling targeted improvements.

Response: We are excited about exploring the possibility of an Environmental Scan of "incident to" possibilities for Registered Dieticians. We are aware of the limitations of enrolling Registered Dieticians in Medicaid and are trying to creatively look into options. We are committed to addressing the challenges posed by lack of licensure and will work

with other regulatory agencies to examine the options. We will consider all of these recommendations in program operational design.

Healthier Colorado We are excited by this opportunity to provide holistic housing and nutrition services to Health First members. Healthier Colorado recognizes that this waiver request is an important step forward in filling the gaps that exist in our state for housing and food security. However, it falls short of truly realizing the goals detailed in HB23-1300 and HB24-1322. We look forward to reviewing the feasibility study required by these bills when it is published in late 2024, and we would encourage HCPF to conduct extensive stakeholdering across the State to inform future iterations of an 1115 waiver request, ensuring our Medicaid members can benefit from the most innovative, expansive, and comprehensive housing and nutrition services available, while saving money on health care for all Coloradans.

- While Healthier Colorado enthusiastically supports these efforts, we also want to share our concerns that this draft 1115 waiver amendment is too narrowly focused on a small, targeted population and therefore will be unable to meet the vast needs of our state's Medicaid population, during a time where COVID-19 relief dollars are expiring and inflation and cost of living are at an all-time high. **We would like to recommend that the targeted populations for this waiver request include pregnant and postpartum individuals and children.**

- Healthier Colorado appreciates the focus on supporting individuals experiencing homelessness. However, by limiting the targeted population to only individuals eligible for these voucher programs, children have been completely excluded from receiving benefits from the housing and nutrition supports sought through this waiver. Further, when pregnant people experience homelessness, infants are more likely to be in fair or poor health and more likely to have been hospitalized since birth compared to children who did not experience prenatal homelessness. The exclusion of people in the perinatal time period, young children, and families is in conflict with the goals of the demonstration waiver, which is to achieve healthcare savings through prevention. Investments in children and families that can ultimately prevent homelessness and the poor health outcomes associated with it will undoubtedly provide the largest financial return on investment in the long run.

- Healthier Colorado would also recommend expanding nutrition services to individuals with chronic conditions who could benefit from medically tailored meals.

- We recognize that the amendment request does not provide detailed information on how the waiver would be implemented should it be approved. **Healthier Colorado recommends conducting meaningful stakeholder outreach while the waiver amendment request is being considered by the Centers for Medicare & Medicaid Services (CMS) to inform implementation and ensure that Colorado continues to build the infrastructure needed to efficiently and effectively expand our health related social needs services.** Implementation topics to consider include, but are not limited to:

i. Provider eligibility and increased provider participation in Medicaid

ii. Payment methodology that is sufficient and sustainable

iii. Data collection and sharing for evaluation

iv. Role of the Regional Accountable Entities

Response: Under the program as proposed, families are eligible. We did receive feedback on providing nutrition services for children, but children are ineligible since they cannot get the housing vouchers. We will be looking at expanding the nutrition services in the feasibility studies. We elected these target populations for this bundle due to budgetary constraints. We are looking at expanding eligibility in the second round and will seek additional funding as required.

Colorado Children's Campaign: We are thrilled by the Department's work toward this waiver submission as a first step to connect food and housing insecurity with health outcomes and are eager to support the Department in the implementation and expansion of this work. However, we are concerned with the lack of inclusion of children and pregnant and postpartum people in the waiver amendment. We respectfully request the amendment be updated to include these crucial populations. At the Children's Campaign, we know how profoundly the health and healthy development of kids are impacted when their families face challenges like unstable housing or food insecurity, and we strongly encourage the Department to include a focus on families with children and pregnant and postpartum individuals as a priority in this waiver and beyond.

- We request the inclusion of child and family-specific populations and investments including family-focused housing vouchers, safe sleep costs associated with housing, and basic needs investments, such as infant diapers. Examples can be found in Oregon, Tennessee, and Delaware's approved waiver proposals.

- We request the Department identify clinical criteria to govern the inclusion children in health related social needs service expansions, such as low birthweight, malnutrition, and developmental delays or impairment because of insufficient nutrition or housing instability.

- We request the inclusion of having a high-risk pregnancy as a clinical criterion for the provision of health-related social needs housing and nutrition services. Many other states are including this criterion in their proposals, which is significant given the high rates of maternal mortality and disproportionate negative impacts on Black and Indigenous birthing people in Colorado.

- We are pleased to see that the Department has requested authority to claim up to the 15% health related social needs infrastructure investments allowable through Section 1115 Waivers and suggest the Department review California, Oregon, and Washington's waiver proposals for more examples of the use of infrastructure investments.

- During the March 11, 2024, stakeholder event on expanding health related social needs services in Colorado, a poll was taken asking: What populations should HCPF

prioritize understanding the HRSN of? Attendees ranked “individuals experiencing housing insecurity first, followed by “high-risk infants and children” out of the eight opinions in the poll. We encourage the Department to keep in mind the voices of the many stakeholders and advocates who marked this population as an essential focus of this opportunity during this meeting and throughout the legislative process.

- The upcoming feasibility studies regarding further expansion of health related social needs services should focus on the populations outlined in HB23-1300 that are required to be addressed in the feasibility study, including the needs of pregnant and postpartum individuals and high-risk infants and children.

Response: Under the program as proposed, families are eligible. We did receive feedback on providing nutrition services for children, but children are ineligible since they cannot get the housing vouchers. We will be looking at expanding the nutrition services in the feasibility studies. We elected these target populations for this bundle due to budgetary constraints. We are looking at expanding eligibility in the second round and will seek additional funding as required.

Attachment 6: Tribal Consultation

Colorado certifies that it conducted tribal consultation in accordance with the state's approved tribal consultation State Plan Amendment. The State solicited feedback from both tribes by sending emails to the tribal representatives with a summary of the Demonstration, plus a copy of the public notice, and waiver amendment application (as well as a link to the HCPF website with the relevant documents). This process follows the State's approved tribal consultation State Plan Amendment. During the 60-day tribal consultation period, the State received 3 comments and/or questions. The State attended 2024 Formal Tribal Consultation meetings on July 15, 2024 to discuss the proposed amendment.

Tribal Consultation: Programmatic Action Log #565

Log Date: 6/10/2024

	TRIBAL CONSULTATION – PROGRAMMATIC ACTION LOG						Estimated Effective Date:			
	COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING						END OF PHE	New additions or updates to the Log		
							Estimated Submission Date	Item was on previous Log; Project is ongoing; there may be future updates		
							1-Feb-23	Item was on previous Log; Item is basically completed		
Log #	**Log Date**	**Major Program (Medicaid, CHP+, etc)**	**Action Type (SPA, waiver, other)**	**Category (Eligibility, benefits, rates, etc)**	**Programmatic Action Title**	**Brief Description**	**Important Dates and Timelines**	**Clearly Foreseeable Tribal Implications**	**Actionable or Non-Actionable Item – Why**	**Feedback? Other Implications?**
565	6/10/2024	Colorado Medi	1115 HRSN Waiver Amendment	Covered Benefits	Health Related Social Needs	The Department of Health Care Policy and Financing (Department) intends to submit an amendment to its 1115 Waiver to the Centers for Medicare and Medicaid Services (CMS) to allow for the provision of Health Related Social Needs (HRSN) services to certain eligibile populations. Such services include housing and nutrition supports.	**Estimated Effective Date:** January 1, 2025 **Estimated Submission Date:** September 1, 2024	The Department does not foresee any negative tribal implications as a result of this 1115 Waiver amendment.	Any comments or questions are welcome. Posted on HCPF website: https://hcpf.colorado.gov/1115sudwaiver.	

COLORADO
Department of Health Care Policy & Financing

AGENDA

2024 Formal Tribal Consultation

Colorado Department of Health Care Policy and Financing

Ute Mountain Ute Indian Tribe

Monday, July 15, 2024

Ute Mountain Casino

Conference Room 3

8:00 - 11:30am

Ute Mountain Ute Indian Tribe Morning Session:

Invocation by Ute Mountain Ute Indian Tribe by Chairman Heart – 5 minutes

Opening Remarks by Kim Bimestefer, Executive Director – 5 minutes

Listening Session facilitated by Director Bimestefer – 20 minutes

Information Session:

- Updates – 5 minutes
    - 2019 Consultation Action Log Check and State Plan Updates
- Public Health Emergency (PHE) Unwind: What Happened & Risks - 20 minutes
- Federal Medicaid Pass Through Funding - 25 minutes
- 1115 Waiver - CO HRSN Amendment Draft 6.10.24 & Behavioral Health Supports - 20 minutes
- Formal Tribal Consultation Agreement - 10 minutes
- Open Forum, Ute Mountain Ute Indian Tribe to bring any items to discuss – 20 minutes

Questions & Answers – Ute Mountain Ute Indian Tribe & HCPF – 15 minutes

Review Action Items Captured - 8 minutes

Closing Remarks and Comments from Ute Mountain Ute Indian Tribe – 5 minutes

Follow Up from Listening Session and Closing Remarks by Director Bimestefer – 2 minutes

COLORADO
Department of Health Care Policy & Financing

AGENDA

2024 Formal Tribal Consultation

Colorado Department of Health Care Policy and Financing

Southern Ute Indian Tribe

Monday, July 15, 2024

Sky Ute Casino

Bonny Kent Conference Room

1:00 - 4:30pm

Southern Ute Indian Tribe Afternoon Session:

Invocation by Southern Ute Indian Tribe by Chairman Baker – 5 minutes

Opening Remarks by Kim Bimestefer, Executive Director – 5 minutes

Listening Session facilitated by Director Bimestefer – 20 minutes

Information Session:

- Updates – 5 minutes
    - 2022 Consultation Action Log Check and State Plan Updates
- Public Health Emergency (PHE) Unwind: What Happened & Risks - 20 minutes
- Federal Medicaid Pass Through Funding - 25 minutes
- 1115 Waiver - CO HRSN Amendment Draft 6.10.24 & Behavioral Health Supports - 20 minutes

- Formal Tribal Consultation Agreement - 10 minutes
- Open Forum, Southern Ute Indian Tribe to bring any items to discuss – 20 minutes

Questions & Answers – Southern Ute Indian Tribe & HCPF – 15 minutes

Review Action Items Captured - 8 minutes

Closing Remarks and Comments from Southern Ute Indian Tribe – 5 minutes

Follow Up from Listening Session and Closing Remarks by Director Bimestefer – 2 minutes

Attachment 7: Tribal Consultation Comments

Comments/Questions	State Response
1115 waiver is very beneficial - Housing. They've been trying to work on adult services, but trouble with funding. Facilities - They were funded for an after care facility - Partnering with SUIT, but would like to build something at UMUT and received 2Mil from Sen. Hickenlooper. Multiple generations in household and homes are small and old. Need Upgrades to fix the homes.	Thank you, the state appreciates the feedback.
Care and share program for food - looking into building a grocery store and additional avenues to support food sovereignty. Diabetes program. They need more equipment for programs. Veterans apply for programs through VA but VA hospitals are far away.	Thank you, the state appreciates the comment and feedback.
The waiver will be beneficial for expediting things. Will there be Tribal set asides of funding?	There is not currently any federal option to have any set-aside funding, since the funding is connected to reimbursement to providers for services. However, the state would like to further discuss the potential to look at how we could work with our federally recognized tribal partners on if there are any creative solutions in this space.
Rehabilitation and transitional housing - UMUT housing program has a waiting list of 200+ people. It's already challenging to get housing support so disable individuals or those re-entering the community have a more challenging time. Support on transitional housing is needed.	Thank you, the state appreciates the comment and feedback.
Multigenerational housing - Since councilman Jacket is living in a multigenerational home, many others are as well. As someone who is not under poverty level his household does not give them support.	Thank you, the state appreciates the comment and feedback.
Pinion Project is a very good program that supports the Tribe. They have a good partnership. While they offer support to community members they also need to work with directly with the Tribes.	Thank you, the state appreciates the comment and feedback.

The healthcare system is not siloed from these issues. Working more with the Tribes on the Social Influencers of health will aid the Tribe in supporting the homeless population.	Thank you, the state appreciates the comment and feedback.
This is really important for Tribal members for the implementation plan for 1115 waiver enroll and after having a baby - add an enrollment member to implementation plan for individuals after having a baby	Thank you, the state will continue to engage during implementation planning.
Tribal services departments could benefit from this information	Thank you.