Medicaid 1115 Waivers to Support Health-Related Social Needs:

An Overview of Federal Authority, State Strategies, and Options for Colorado to Consider

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Executive Summary

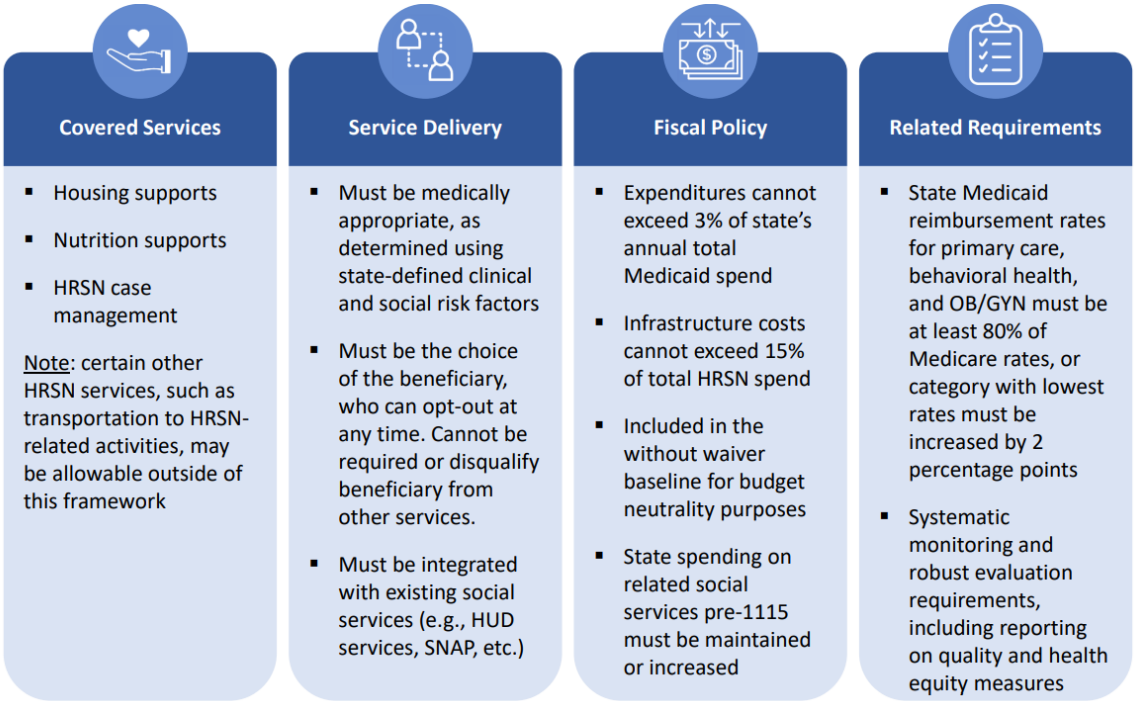
This paper is intended to provide an overview of the evolution of Medicaid-funded health-related social needs (HRSN) services allowed through Centers for Medicare and Medicaid (CMS) recent approval of 1115 Demonstration waiver authorities. The paper discusses the technical provisions, lessons learned from other states, and considerations for Colorado should the state decide to pursue this type of waiver.

Background

The Medicaid program has gradually expanded over time to support non-clinical interventions that can improve member health outcomes and reduce the costs of care, particularly as the evidence base for such interventions has grown larger and stronger. There are a variety of longstanding program authorities that enable state Medicaid programs to provide social supports to specific populations, often connected to long term services and supports for members with developmental disabilities or requiring assistance with activities of daily living. However, the past several years have brought a new emphasis to investing efforts that address HRSNs. Medicaid and healthcare experts increasingly point to the value that those social supports can provide to additional populations, particularly in the context of reducing healthcare disparities.

CMS Framework

In the fall of 2022, CMS approved four landmark 1115 waivers to test approaches to meeting the health-related social needs of Medicaid members. Arkansas, Arizona, Massachusetts, and Oregon all received approval from CMS for waivers that would provide expanded HRSN services to certain subpopulations of Medicaid members. The waiver structure allows for federal matching funds for a variety of housing and nutrition supports for target populations, such as individuals at risk of homelessness. Notably, CMS included the option of up to six months of rental assistance as a potential covered service in these waivers, marking the farthest the federal government has gone in funding housing support via Medicaid.



CMS took a variety of approaches to making this framework accessible to states and indicated that the closer a state's 1115 application hews to the framework, the more straightforward the approval process would be. For example, CMS loosened the budget neutrality requirements on the waiver, making it easier for states to receive sufficient funding for this work. CMS has also indicated a willingness to have Designated State Health Plan programs approved as a mechanism to free up state resources for the state share of the waiver cost. However, CMS has placed caps on HRSN expenditures, as well as requiring robust monitoring and evaluation to complement the loosened restrictions.

Lessons Learned from Other States

As part of the research for this paper, the author spoke with experts in a number of the states that have already been moving on HRSN waivers, including Oregon, Massachusetts, Arizona, and Washington, as well as other experts in waiver development and implementation. While the precise details and advice varied, several common themes emerged.

Implementation frequently takes longer, and costs more than initially anticipated. Early states typically gave themselves 18-24 months from approval for services to begin to flow. However, it is likely that some states will struggle to meet those timeframes and that early uptake of services may be relatively low as processes are refined. At least one state, Massachusetts, has already submitted a waiver amendment to request a higher infrastructure funding level.

Social service providers are often not enrolled Medicaid providers and are not familiar with the Medicaid billing structure. Early and significant technical assistance is prudent to help them become accustomed to Medicaid's reimbursement requirements and processes.

Linking social services provider organizations together can create complex processes and handoffs that – while reducing gaps in the current system – can inadvertently create navigation challenges. Thoughtful processes and systems infrastructure that focuses on member experience can help to increase take-up and subsequent outcomes. It is also important to reduce unnecessary provider administrative burden, as they will also be navigating new systems. In particular, HSRN closed-loop referral systems and data sharing architecture are key pieces of technology to design thoughtfully and build effective processes around.

States are taking different approaches to program design. Some states are having MCOs serve as the conduit for integration, while others have stand-alone entities doing that function. In addition, states target populations and service scope range considerably from relatively narrow to very broad. Several states mentioned the importance of prioritizing certain populations and services up front and gradually expanding over time.

Next Steps for Colorado to Consider

The development and implementation of an 1115 demonstration waiver for health-related social needs is a complex and multi-year endeavor. Colorado has the opportunity to learn from other states that are further along the path and develop a deliberate and strategic approach to building out HRSN services into the Medicaid program.

Execute on HB23-1300, which requires a stakeholder informed study on how to expand continuous eligibility as well as meet the health-related social needs of members via waiver expansion. This study represents an opportunity to begin a thoughtful planning process for a potential waiver application. It

would be particularly prudent to engage social service providers and Medicaid members as key stakeholders, given their investment in the success of the effort. This study is due to the General Assembly no later than Jan 1, 2026. However, given the timeline of 1115 waiver development and approval, the state may wish to consider an earlier submission if resources allow, or dual tracking the report and waiver development process.

Align the direction on HRSN policy with the development and implementation of ACC 3.0. The state is in the process of setting the direction for the next phase of maturity for the Accountable Care Collaborative, which is the overarching structure of Medicaid service delivery in Colorado. Designing the ACC 3.0 structure so that it is compatible with an eventual 1115 waiver requires thinking through what entities will be responsible for and ensuring that there is enough flexibility in the ACC 3.0 to accommodate this approach down the road, without having to significantly reconfigure program structure.

Continue to glean best practices from states in the implementation phase to take advantage of lessons learned and to smooth Colorado's path.

Develop a proposed roadmap and begin conversations with CMS. Informed by the HB23-1300 study and the ACC 3.0 framework, the state could develop a roadmap that outlines the vision that the state hopes to achieve with an 1115 waiver and the path to get there. Because Colorado has a unique Medicaid structure, it would also be prudent to engage in early conversation with CMS about how the standard terms and conditions in the new framework might translate to the Colorado model.

Engage early in capacity building and infrastructure planning. Given the complexity of implementation, it would be to Colorado's advantage to take lessons learned in implementation from other states into account up front in the planning process, ad not wait for waiver approval to begin working through the nuances of how the system would need to evolve to incorporate HRSNs effectively into the Medica model. This can include providing education and technical assistance for social service organizations that may become Medicaid providers for the first time. It also includes developing a thoughtful plan for how the coordination and referral processes and data infrastructure will fit into the current state of Medicaid and what changes may be required.

Conclusion

The new federal framework to supporting health related social needs through Medicaid 1115 demonstration waivers is a major opportunity for states to invest in the upstream social services that have been shown to improve overall health outcomes while reducing health care costs. However, early experiences from leading states suggests that the path is likely to be long, resource intensive, and inherently bumpy. Colorado has the advantage of being able to learn from the experiences of other states in putting together a long-term vision and roadmap, and to begin to take action now to build an integrated and thoughtful approach to improve the health and wellbeing of Coloradans.

Medicaid 1115 Waivers to Support Health-Related Social Needs

Introduction

This paper is intended to provide an overview of the evolution of Medicaid-funded Health-Related Social Needs services allowed through Centers for Medicare and Medicaid (CMS) recent approval of 1115 Demonstration waiver authorities. The paper discusses the technical provisions, lessons learned from other states, and considerations for Colorado should the state decide to pursue this type of waiver.

This paper synthesizes information for Medicaid policy experts while providing an orientation to key Medicaid waiver concepts and considerations for those individuals who may have an interest in 1115 demonstration waivers for health-related social needs but are less grounded in the Medicaid program and policies.

Medicaid Waivers: The Basics

The Federal Medicaid program was established in 1965 as Title XIX of the Social Security Act as a means to provide health coverage to millions of Americans, including eligible low-income adults, children, pregnant individuals, elderly adults, and people with disabilities. The legal framework governing how the Medicaid program works includes eligibility categories, mandatory and optional benefits, and program flexibilities. Over time, Congress enacts new laws that govern the Medicaid program and CMS periodically issues guidance in the form of rules and State Health Official letters.

While Medicaid is a federal program, it is administered by states and American territories. Each state is required to have a State Plan, which outlines how the state governs its Medicaid program in accordance with federal legislation. A State Plan details which optional aspects of the Medicaid program the state has chosen to implement. States may make changes to their State Plan by submitting a State Plan Amendment (SPA) to CMS for approval. Examples of typical SPAs include a rate change or the addition of an optional benefit.

For a full list of required and optional benefits, see Appendix A Table 1. Notably, the housing, nutritional, and other social supports that comprise "Health-Related Social Needs"[1] are not included as mandatory or optional benefits. As such, the SPA structure cannot be used to add or modify their inclusion. Instead, a waiver is required.

The statutory authority for Medicaid waivers dates back to the Omnibus Budget Reconciliation Act of 1981. Waivers allow states to "waive" statutory aspects of the Medicaid program by adding non-covered benefits.

There are a number of different waiver types with different histories and purposes. The waiver type number refers to the section of the Social Security Act (which governs Medicaid) that is being waived. The three main waiver types are 1115 research and demonstration waivers, 1915(b) Freedom of Choice

[1] The term "Health Related Social Needs (HRSN)" is often used interchangeably with the term "Social Determinants of Health (SDOH)". However, there is a key distinction that is important in the context of 1115 waivers. SDOH describe the societal level conditions that impact overall community health. HSRNs are determined at an individual level and must be medically appropriate as determined using clinical and social risk factors to support the overall health of the Medicaid member.

Waivers, and 1915(c) Home and Community Based Services (HCBS) waivers and 1915(i) Medicaid Plan Option for Individuals with Mental Health and Substance Use Disorders.

1115 Demonstration waivers allow states to experiment with different service offerings and eligibility groups. 1915(b) waivers focus on modifications to health care delivery systems. Finally, 1915(c) and 1915(i) HCBS waivers enable states to provide HCBS services as an alternative to institutionalized settings such as nursing homes. A more detailed comparison of the three waiver types is included in Appendix A, figure 2.

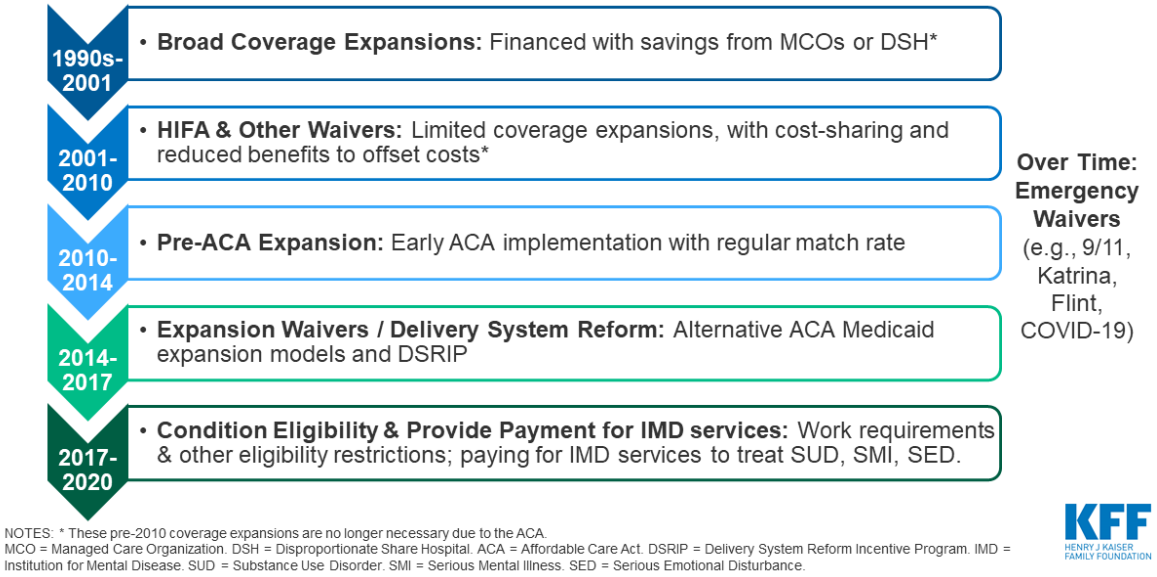
Every state has at least one waiver in place, and the vast majority of states have multiple waivers under each of the waiver types. Colorado currently has fourteen waivers approved by CMS: three 1115s, two 1915(b) waivers, and nine 1915(c) waivers. Waivers enable states to experiment and customize their Medicaid programs to meet the needs of state.

1115 Demonstration Waivers

Section 1115 Demonstration waivers provide broad parameters within which states can test innovative approaches to the Medicaid program. Section 1115 waivers permit states to receive federal matching funds for expenditures that are not otherwise allowable under the Medicaid statute.[2] States have commonly used 1115 waivers to expand Medicaid to additional eligibility groups, to expand benefit offerings and allowable settings, and to implement new restrictions or requirements. The evolution of how 1115 waivers have been used reflects the priorities of the states, the philosophy of the Presidential Administration, and the overall evolution of the healthcare system, as shown in the diagram below from the Kaiser Family Foundation.[i] Section 1115 demonstration waivers are approved at the discretion of the Secretary of Health and Human Services and are therefore inherently political. This provides both opportunity and risk depending on the Presidential agenda and the influence of the state.

[2] It is important to note that states may add benefits and populations outside of the waiver structure. However, those changes must be fully financed by state funding; no federal match is allowable. One recent example of this is California's expansion of Medicaid ("Medi-Cal") coverage for low-income adults under 26 and over 50 regardless of immigration status. https://www.gov.ca.gov/2022/10/19/medi-cal-expansion-provided-286000-undocumented-californians-with-comprehensive-health-care/

Figure 1. Section 1115 Waivers in Medicaid



However, 1115 waivers do not give states carte blanche to ignore Medicaid statute. An 1115 waiver must meet a number of requirements.

1. The waiver must be a demonstration that is fully evaluated and time limited to 3 to 5 years.
2. The waiver must be budget neutral. This is not a legal requirement but has been longstanding federal policy across many administrations.
3. The waiver must be likely to promote the objectives and goals of the Medicaid Program.
4. The waiver must be limited in scope to the extent needed to carry out the experiment.
5. The state must engage a third-party evaluator to assess the efficacy and outcomes of the experiment relative to its objective(s).

The breadth of this flexibility has been subject to judicial review. In 2011, the Ninth Circuit Court of Appeals overturned Arizona's 1115 waiver which made significant changes to copays required of members, saying:

> *[W]e doubt Congress would enact such comprehensive regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute allowing states to evade these requirements with little or no federal agency review. Rather, Congress intended that the Secretary would selectively approve state projects.*[ii]

Given the potential scope of 1115 waivers, states commonly spend 18-24 months developing their waiver application, depending on the complexity of the proposal. Applications are required to have gone through a public comment period, though states typically run significantly more robust stakeholder engagement processes, particularly on major waivers. Negotiations with CMS can last anywhere from months to years, and CMS may approve parts of state waiver applications while other parts remain under review. For example, CMS approved the HSRN portion of Arizona's 1115 waiver application in September of 2022, but as of July 2023, the portion of the application that would add traditional healing as a benefit was still under review.

In theory, if an 1115 waiver is successful in demonstrating the efficacy of an approach via the independent evaluation, while meeting the core objectives of the Medicaid program, that eligibility category, benefit, etc., could be added via legislation to the Medicaid governing statutory authority. Should that happen, states would either be required to implement that provision or would simply submit a SPA to incorporate it into their Medicaid program. In practice, however, relatively few changes have been made to the underlying Medicaid statute since its inception. Therefore, 1115 waivers are more commonly extended and amended as programs evolve. For example, Oregon's first 1115 demonstration waiver that governed Oregon's Medicaid delivery system was approved in the early 1990s and the state has renewed their waiver every five years with the most recent approval in September 2022.

1115 waiver application components

1115 waiver applications vary in length and scope but must contain information on the demonstration and hypotheses being tested in the waiver, as well as the impact to caseload and changes in funding and financial impacts. CMS has provided states with a template for submitting an 1115 waiver application.[iii] The specific components required include:

- A comprehensive program description of the demonstration, including the goals and objectives to be implemented under the demonstration project
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act
- An estimate of the expected increase or decrease in annual enrollment, and in annual aggregate expenditures, including historic enrollment or budgetary data, if applicable
- Current enrollment data, if applicable, and enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration
- Other program features that the demonstration would modify in the state's Medicaid program and/or CHIP
- The specific waiver and expenditure authorities that the state believes to be necessary to authorize the demonstration
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives; a plan for testing the hypotheses in the context of an evaluation; and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators
- Written documentation of the state's compliance with the public notice requirements, with a report of the issues raised by the public during the comment period, which shall be no less than 30 days, and how the state considered those comments when developing the demonstration application

Given these requirements, state waiver applications that make major program changes are often quite long. For example, Oregon's recent 1115 demonstration waiver application totaled 607 pages, and Arizona's application clocked in at 816 pages.

Budget Neutrality

One central tenet of an 1115 waiver is that it is required to be budget neutral relative to the amount of money the federal government would have spent absent the waiver. This requirement is not specified in statute but has been a longstanding CMS policy over the course of changing administrations. The precise calculation has evolved over the years with significant impacts on the overall funding available under the waiver.

Typically, states calculated the hypothetical amount of funding that they would have spent in absence of the waiver, referred to as the "without waiver" or "WOW" projection. The difference in the amount of funding spent in the absence of the waiver and with the waiver constituted the available funding that could support the financing of the waiver itself or be carried over into the future. If a state's spending under the waiver exceeded its WOW projection, CMS would not provide federal funds for the overage and the state would be required to come up with 100% of the funding for the overage.

The result of this practice was that some states were able to "bank" savings from multiple 1115 waivers to use in the future. At one point, California had amassed an 1115 waiver cushion of hundreds of millions of dollars.

In 2018, CMS announced a series of changes to the budget neutrality calculation aimed at addressing some of these criticisms, such as limiting the rollover of banked savings to five years, rather than allowing them to be kept indefinitely. States expressed significant concerns with these new policies, arguing that they were overly restrictive and would do too much too fast and destabilize the underpinnings of 1115 waivers.

As a result, CMS and NAMD led a process with state representatives from 2021 to 2022 to identify middle ground approaches that would address CMS's concerns with waiver savings while continuing to provide states with an incentive structure to invest in promising and innovative approaches to reducing costs and improving outcomes. They landed on a compromise approach, which was rolled out in the summer of 2022.[iv]

1. **"Without waiver" rebasing.** The savings calculation must be rebased every five years, meaning that the calculation of spending in absence of the waiver can't date back decades, for example to the introduction of managed care in certain states. In addition, 20 percent of the re-basing may come from the pre-2018 without waiver baseline with 80 percent coming from actual expenditures. While complicated, the intent was to enable states with a significant historical savings differential to leverage a small portion of it, while providing restraints and easing the budgetary penalty on states without cushions.
2. **"Without waiver" trend rate.** States should use the President's Budget trend rate, as opposed to the individual state's historic Medicaid cost trend. This puts states on an equal footing and doesn't penalize states that had lower historical cost growth.
3. **Savings rollover**. States may rollover ten years of savings, and the oldest savings are used first, which generally reduces the amount of savings that expire, while still putting limits on the overall size of the savings cushion that states can amass.
4. **Savings cap.** Because the new policy provided states with more flexibility to leverage "without waiver" savings, the new policy imposed a cap of fifteen percent of Medicaid expenditure during

the most recent five-year period. This is a high cap, presumably allowing states to continue health savings cushions but with a consistent limitation.

5. **Mid-course corrections**. Previously, states had to submit a formal 1115 amendment to change their projection of budget neutrality. Now, states can update the calculation via a state plan amendment, reducing the review process and the risk that a state will exceed its budget neutrality projection for unforeseen or necessary changes, while still providing CMS with an oversight mechanism.

It should be noted that there are experts in the field who argue that the budget neutrality requirement should be phased out altogether, arguing that it creates significant administrative burden. Additionally, since states are already required to come up with a state share of funding for 1115 waivers, this naturally serves as a limiting factor.

This set of policy changes has significant implications for states such as Colorado that may seek an 1115 waiver or waiver amendment in the future. While standardization provides more structure, these are still complex calculations subject to significant negotiation at the federal level. In addition to CMS, the White House Office of Management and Budget (OMB), is a part of the state waiver approval process and pays particular attention to the fiscal and budgetary calculations and implementation of the waiver.

Recent Federal Policy Evolution on Health-Related Social Needs (HRSN) services in Medicaid

The Medicaid program has gradually expanded over time to support non-clinical interventions that can improve member health outcomes and reduce the costs of care, particularly as the evidence base for such interventions has grown larger and stronger.

The United States spends almost double, per capita, on health care than other wealthy nations do with worse outcomes, as measured by average life expectancy.[v] In contrast, other wealthy countries tend to invest far more in other aspects of social welfare, such as housing and employment supports.

Figure 2. Life Expectancy and Health Care Spending Per Capita, (2021 or most recent year)

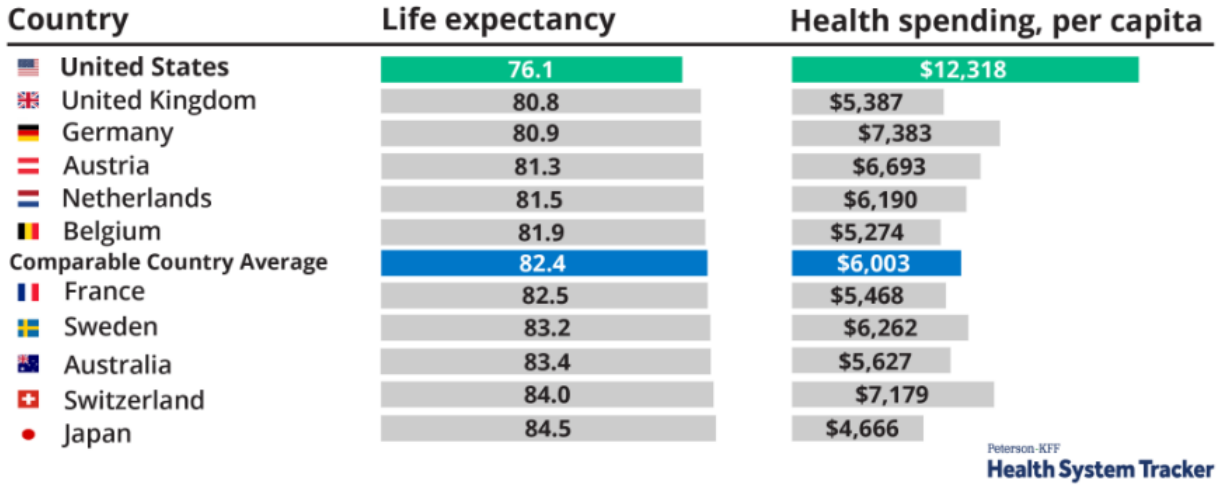
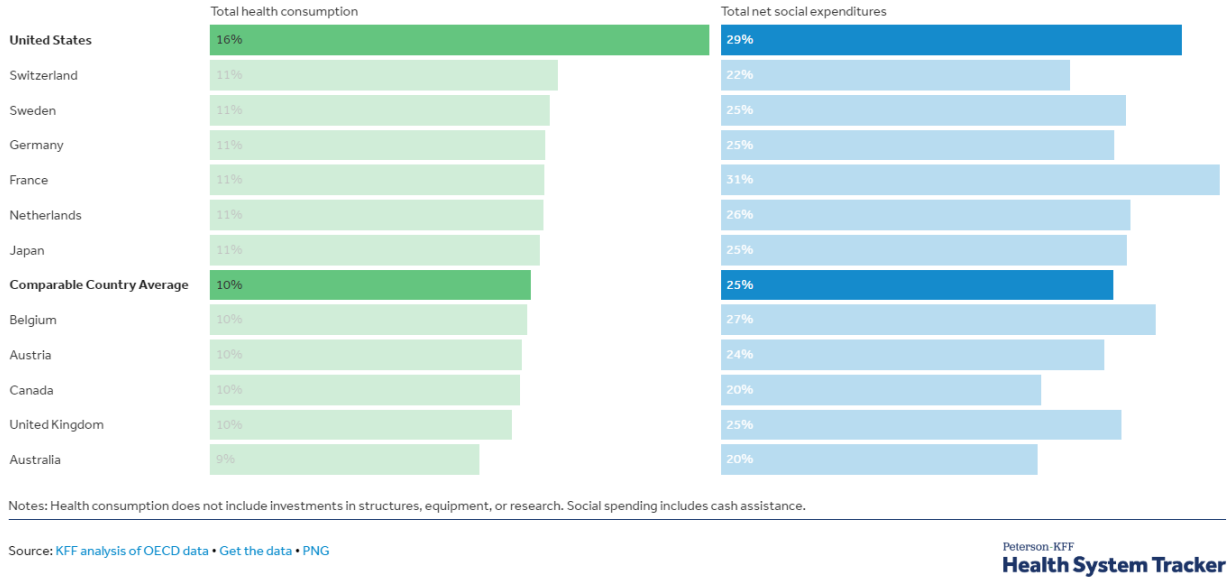


Figure 3. Total health consumption as percent of GDP, 2013; Total social spending (including health and other social services) as percent of GDP, 2013[vi]



This suggests that investing in social spending is a more efficient way to achieve health outcomes than traditional clinical care spending. Additional research has borne this out, particularly around housing supports, leading to the "housing first" model to achieve health outcomes, particularly as related to behavioral health and substance use disorders.[vii]

In January of 2021, CMS released a State Medicaid Director letter that outlined the authorities already available to states to help address these types of social needs. Some of these authorities are more tailored to states that run Medicaid via managed care. Colorado's unique structure of fee-for-service physical health with capitated behavioral health and care coordination complicates how these provisions apply. As a result, the table below provides a very high level overview of the non-1115 authorities and how they do or could apply in Colorado. A more detailed analysis of each of these options would be advisable to understand if and how they could be leverage in coordination with a potential 1115 waiver.

Table 1. HRSN non-1115 Authorities

Authority	HRSN Services	Population Eligible	In Colorado?
1915(b)(3) services	• Housing transition costs • Meal delivery • Home and environmental modifications	Waiver and Managed Care Organization (MCO) enrolled	Yes
1915(c) HCBS waiver	• Case management • Home modifications • Housing and tenancy support • Non-medical transportation • Home delivered meals • Supported employment services • Assistive technologies	Individuals who meet the criteria for an institutional level of care, but can stay in the community with the appropriate supports	Yes

1915(k) Community First Choice	• Supports for activities of daily living • Expenditures for transition costs from institution to community • Expenditures that increase individuals' independence or substitute for human assistance	Individuals who meet the criteria for an institutional level of care	Under consideration via American Rescue Plan Act (ARPA) HCBS project
Managed Care In lieu of Services[3]	• Voluntary on part of managed care plan • Medically appropriate and cost effective substitute for covered services	Managed care enrollees with demonstrated medical need	No current provision of health related social needs services via ILOS
Managed Care Value Added Services	• Voluntary on part of plan • Supportive housing • Home modification • Enhanced care coordination • Transportation	Managed care enrollees	Not typically provided. Done outside of capitation and therefore may be cost prohibitive

The "Core Four" HRSN Framework

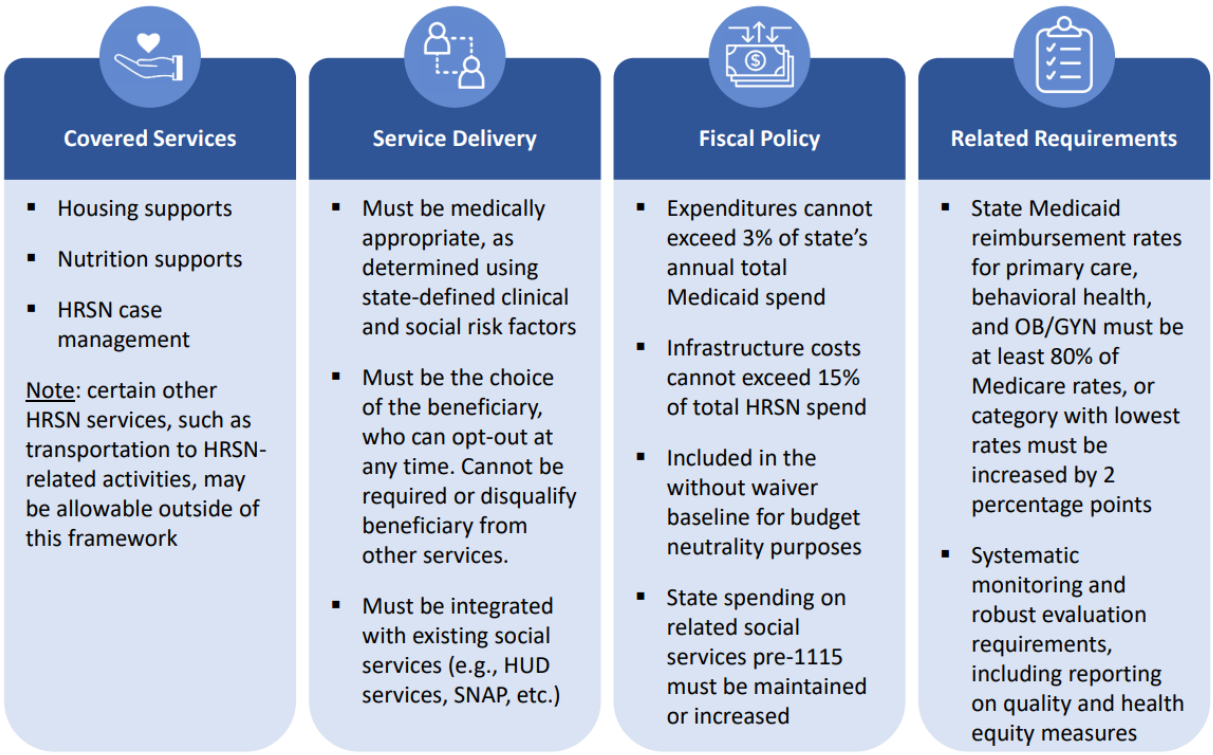
In the fall of 2022, CMS announced the approval of four states' 1115 waivers and with them, a new framework for how Medicaid could support and finance health-related social needs services. Those states, Arkansas, Arizona, Massachusetts, and Oregon, are referred to in this paper as the "Core Four". Overall, the framework expanded allowable services, while also easing the financing restrictions on these services, and providing a standard structure through which states could be confident in receiving federal approval.

It is critical to note that states that are adopting these new services through 1115 approval will receive Medicaid match dollars for the services since they will be considered a Medicaid benefit - that also means that these services become an entitlement such that the members who are part of the target population and qualify for services will be entitled to the service and it will be mandatory for the state to provide it. This was groundbreaking since CMS has never before considered HRSN services a benefit for populations beyond the 1915 HCBS populations. Given this, CMS modeled some aspects to the program on existing 1915 requirements such as requiring a care plan. It is important to note that HRSN services can still be targeted to a particular group under this framework, such individuals at risk of homelessness or justice-involved. This targeting is intended to provide the benefit to the people who most need it while limiting the overall financial implications.

[3] A key difference between ILOS and Value Added is that costs incurred under ILOS may be included in the Medical Loss Ratio calculation for the purposes of capitation, meaning that they do not eat into the plan's administrative costs and profit margin. Value Added services may not be counted as part of the plans MLR, and therefore must be captured under administrative costs. While plans may decide to provide certain value added services that they determine are highly cost effective, and improve member outcomes, the ILOS structure provides more of a fiscal incentive for plans to invest in HRSNs.

Rental supports is a prime example of the policy shift evidenced in the HRSN framework. The longstanding policy of CMS was that Medicaid doesn't pay for housing/room and board outside of inpatient/nursing facilities. As noted in Table 1 above, CMS focused instead on supportive housing services, transition costs, and home modifications. Providing funding for six months of rental assistance represented a significant policy departure. Dan Tsai, administrator of Center for Medicaid and CHP Services within CMS, articulated the logic of this approach on a December 2022 all state call, noting that the evidence base was clear, but that it had taken a lot of work to identify how to structurally approach it and what guardrails should be in place.[viii] On that call, CMS walked states through the 1115 HRSN framework, described below, and encouraged them to collaborate with HRSN-centered entities, such as housing authorities, to develop and submit waiver proposals based off of this framework.

Figure 4. Overview: A Framework for HRSN Services in 1115s



Covered Services

As noted above, a highlight of the new framework was the expansion of CMS's definitions of allowable housing and nutrition supports. Importantly, all support services must be medically appropriate using state-defined clinical and social risk factors for the individual receiving them.

Housing supports are understood to include:

- Pre-tenancy and tenancy support services (e.g. housing application, moving support, and eviction protections)
- Rental assistance or temporary housing for up to six months
- Home modifications

- Supplies to maintain healthy temperatures and clean air (e.g. air conditioners, filtration, and refrigeration) in the case of extreme climate events such as wild fires, extreme heat or cold.
- Housing-focused navigation and/or case management systems
- Housing deposits, application, inspection fees, and other one-time transition and moving costs

Nutrition supports are understood to include:

- Nutrition counseling and education
- Meal delivery up to three meals/day for six months
- Medically tailored food prescriptions
- Cooking supplies (e.g. pots and pans)
- Links to community-based food resources

Service Delivery

The requirement that HRSN services be medically appropriate to an individual sets up two important considerations. First, it anchors the waiver services in the medical model, and places medical providers as key figures in the HSRN services delivery model. The medical appropriateness for HRSN services must be documented in the member's care plan.

Second, it requires states, in collaboration with plans, providers, and stakeholders to develop precise definitions of what constitutes medical appropriateness for the HRSN services that the state intends to cover under the waiver. For example, medical appropriateness for meal delivery services could include some combination of food insecurity, diagnosed diabetes and/or high A1C levels or could include social risk factors such as being pregnant. States need to determine target populations for specific HRSN services based on factors such as the strength of the evidence outcomes, potential state share investment, and the administrative complexity and burden.

The third aspect of service delivery defined under the framework is a requirement for integration with existing social services. This sets up the expectation that, while the medical system must be involved to create a care plan and identify individuals eligible for services, states will not develop a freestanding and siloed model, both to avoid costly duplication of services as well as to take advantage of the experience and expertise of governmental and community-based organizations that work in the HRSN space, such as housing authorities, meal providers, and case management entities.

Fiscal Policy

CMS structured the financing portion of the 1115 framework to make it easier for states to finance HRSNs and meet the budget neutrality requirements of the 1115 waiver authority. The main change was the introduction of "capped hypothetical" expenditures. Simply put, for HRSN expenditures, states don't have to find direct savings but can balance against hypothetical expenditures below a set cap imposed by CMS. In practice, this makes it easier for states to include HRSN services without running afoul of budget neutrality requirements. While states would be on the hook for one hundred percent of HRSN expenditures above the cap, no states to date have expressed concern with the overall HRSN capped amount over the five year waiver period, indicating a general comfort that the level is sufficient.

Figure 5. Budget Neutrality Spending Caps for HRSN Expenditures ($ in millions)[ix]

	Year 1	Year 2	Year 3	Year 4	Year 5
HRSN Services					
AR	-	$8.4	$19.5	$25.8	$31.1
AZ	$96.4	$96.4	$96.4	$96.4	$96.4
MA	$71.9	$124.9	$163.7	$163.7	$163.7
OR	-	$223.0	$227.0	$227.0	$227.0
HRSN Infrastructure					
AR	-	$2.7	$2.0	$3.0	$2.8
AZ	$13.5	$13.5	$13.5	$13.5	$13.5
MA	$4.0	$3.0	$1.0	-	-
OR	$51.0	$53.0	$5.0	$5.0	$5.0

NOTE: These annual aggregate budget neutrality spending caps limit the HRSN service and infrastructure expenditures for which the state can receive federal financial participation. CMS refers to these expenditures as "capped hypothetical expenditures" in the special terms and conditions of each state's waiver.
SOURCE: KFF analysis of AR, AZ, MA, and OR waivers; see Section 1115 waiver tracker • PNG

However, CMS still set spending guardrails on the programs. The three main guardrails are:

- Overall, HRSN spending cannot exceed three percent of a state's total Medicaid expenditures.
- Infrastructure costs cannot exceed fifteen percent of HRSN spending under the waiver.
- State spending on social services pre-waiver must be maintained. This is a component of the maintenance of effort provision in the Special Terms and Conditions. Without it, states could theoretically end other HRSN-related spending and effectively free up the state's budget. The goal is additional investment, not for federal funding to supplant existing state funding.

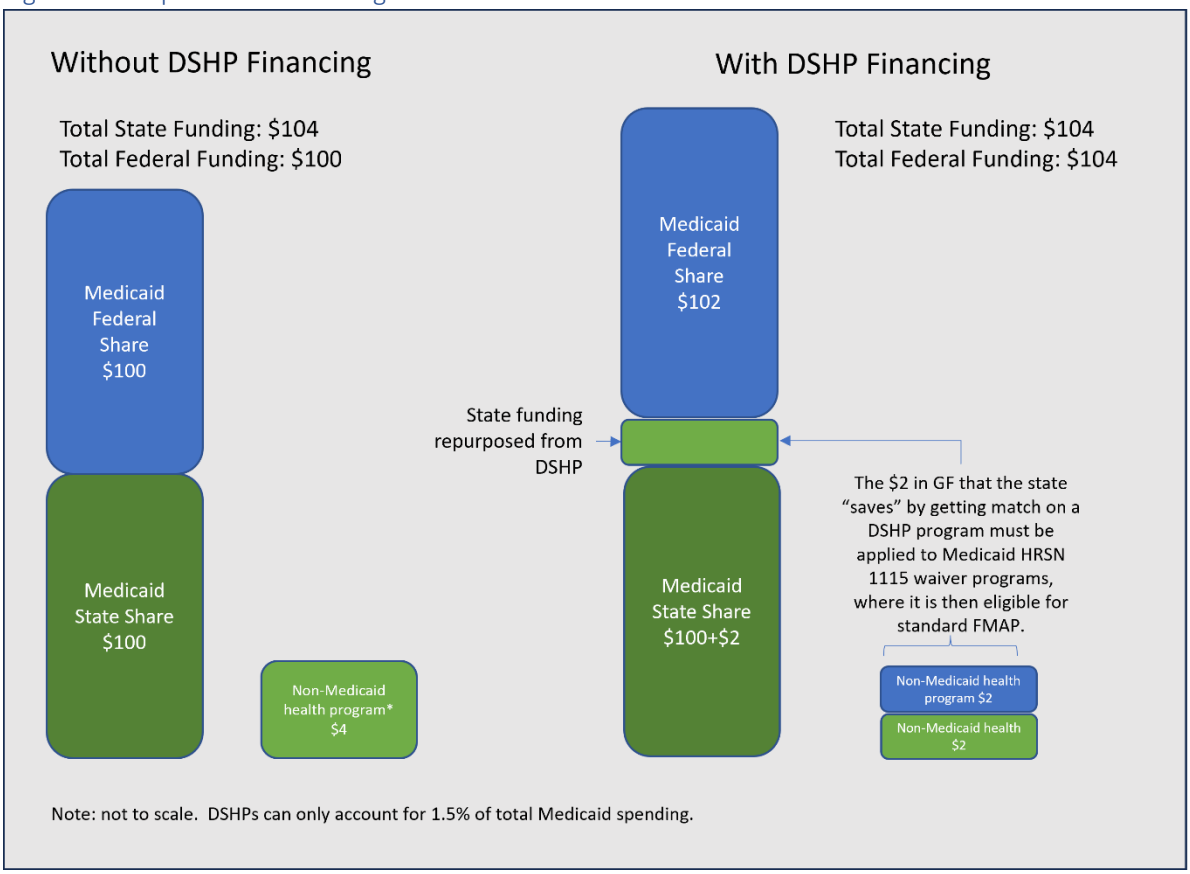
In part because CMS made the budget neutrality and fiscal requirements much less stringent than they might have, CMS also include a set of requirements around reimbursement rates. One longstanding criticism of the Medicaid program is that its payment rates are too low, which limits both access and provider financial stability. This provision required that state Medicaid programs must have reimbursement rates for primary care, OB-GYN, and behavioral health care that are at least 80% of Medicare rates if the state was approved for HRSN services. If states have rates that are too low, they are required to increase those rates by two percentage points no later than the third year of the waiver period.

Designated State Health Programs

Designated State Health Programs, or DSHPs, are a key financing mechanism for some states under the HRSN 1115 waiver structure. The DSHP model allows states to receive 50% federal match on non-Medicaid programs that nonetheless substantially benefit Medicaid recipients, such as a community behavioral health program funded by the Department of Public Health and Environment. By getting

matching funds on non-Medicaid programs, states can free up state funding from these programs to support the Medicaid program and therefore also receive federal match on the freed up state funding put towards the Medicaid program. The diagram below illustrates how DSHP funding flows result in a net increase in federal funding to a state.

Figure 6. Sample DSHP Financing Flow



Historically, DSHPs have been an 1115 funding strategy used by states to free up state funds for investment in the waiver programs. However, they were subject to the criticism that states were using DSHPs not to enhance Medicaid, but simply to shore up state budgets. In 2018, CMS announced that they would begin phasing out DSHPs as a waiver financing mechanism. While DSHP funding wouldn't be stripped from current waivers, it wouldn't be allowed going forward.

CMS changed course in 2022 as part of the HRSN financing framework, but placed new controls on the purpose and amount of DSHP funding that a state could receive. Specifically,

- Federal funding for DSHPs cannot exceed 1.5 percent of the state's total Medicaid spending, which complements the overarching fiscal limitation of the HRSN 1115 framework that specifies that HRSN spending cannot exceed three percent of total Medicaid spend.
- Waiver initiatives cannot be exclusively financed with funds freed up from DSHPs; states must use other sources to fund at least 15 percent of the state's share of costs
- Initiatives financed with funds freed up through DHSPs must be new; they cannot supplant or supplement existing services or programs

CMS requires states to submit a list of state funded programs proposed for DSHP buy out within 90 days of waiver approval. CMS will review and approve the DSHP list, as well as work with states on the funding flows to set up federal Medicaid funding to programs outside the single state Medicaid agency.

Table 2. Oregon Approved DSHP through December 31, 2022

Agency	Program
HCA	Kidney Disease Program (KDP)
ALTSA	Nursing Homes, Community Residential, and Homecare
ALTSA	State Family Caregiver Support
ALTSA	Senior Citizen's Services Act (SCSA)
ALTSA	Office of the Deaf and Hard of Hearing
DDA	Employment & Day and Other Community Services
DDA	Community Residential & Homecare
BHA	Crisis and other non-Medicaid services
BHA	Program of Assertive Community Treatment (PACT)
BHSIA	Offender Re-entry Community Safety Program
BHA	Spokane Acute Care Diversion
BHA	Psychological Evaluations
BHA	Outpatient and Support Services
BHA	Residential Services
BHA	Parent in Reunification
BHA	Problem Gambling Services
DOC	Mental health transition services
DOC	ORCS (Offender Reentry Community Safety)
DOC	Medications for Releasing Offenders
DOC	Community-supervised violator medical treatment
DOH	Tobacco and Marijuana Prevention and Education
DOH	Family Planning Non-Title X
DOH	HIV/AIDS Prevention
Other	Health Professional Loan Repayments (WA Student Achievement Council)

States that use DSHP as a funding mechanism for HRSN expenditures need to be particularly focused on sustainability. CMS has articulated that DSHP for HRSN should be considered a one-time allowable financing mechanism, meaning that is only available as a funding source for one five-year waiver.

In addition to these formal requirements, CMS has also emphasized that states must demonstrate that they have "skin in the game," and that there is a sustainability plan to as to avoid a funding cliff at the end of the waiver period. States have taken a variety of approaches to this piece.

Some states, such as Oregon, that use DSHP as a funding source have front-loaded the DSHP funding source while gradually building up other sources of state share funding to minimize an outyear cliff. For Oregon this means that the governor's budget and general assembly appropriations will need to account for this funding. Transparency with stakeholders – and with state legislators in particular – is a key part of this sustainability planning, particularly if the state share will need to be increased in a year that happens to coincide with an economic downturn, as this will put significant pressure on other parts of the state budget. However, this strategy also reflects an hypothesis that investments in HRSNs will start driving

better outcomes and program cost savings, such as from reduced ED visits, that can be repurposed towards the sustainability of the HRSN benefit.

Core Four Highlights

The waivers approved by CMS in fall of 2022 had many common features, but were each tailored to the structure, needs, and priorities of the individual states. Together, they provide a potential blueprint for other states considering a robust investment in HRSNs for Medicaid.

Table 3. Comparing the Core Four Waivers

What's Standard	What's Common	What's unique
MOE requirements	Type of interventions/services	Implementing entities
Budget Neutrality calculations	Characteristics of target populations	Funding flows
Detailed service delivery protocols	Funding mechanisms, such as DSHP	Timeline for implementation
Cap on spending for services	Focus on infrastructure costs and funding	
Robust evaluation and monitoring requirements		

Massachusetts

Massachusetts' waiver is focused on expanding two current programs, the Flexible Services Program, and the Community Supports Program, to address health related social needs. The state included the full breadth of allowable HRSN services and supports into its waiver, including housing and nutrition supports, case management, and transportation to HRSN services. The target populations for the waiver are justice involved members, pregnant/post-partum members, and members with disabilities. Members with disabilities may already be receiving many of these services, so this waiver is intended to focus on access and quality of the supports for this population. Flexible Services are currently provided via a fee-for-service model, but the waiver includes a glide path for the transition of the HSRN Flexible Services Program into managed care by January 1, 2025.

In total, the waiver has a HRSN services cap of $72 million in the first year that increases to $164 million by the fifth year, potentially totaling up to $687 million over the period of the waiver. If Massachusetts' HRSN expenditures exceeded this amount, the state would either need to renegotiate the waiver or cover 100% of the costs above the cap. However, the general sense is that the caps are sufficiently high as to not create issues in the initial waiver period.

Massachusetts' waiver also includes an $8 million dollar Social Service Organization Integration Fund for the first three years of the waiver that is intended to address many of the hurdles to incorporating HRSN services into a Medicaid structure, including:

- Electronic referral systems
- Shared data platforms
- Electronic health record (EHR) adaptations or bridge structures
- Data analytics and reporting
- Accounting and billing systems

- Workforce development, certification and training
- Outreach and education

Oregon

Oregon's Medicaid program, Oregon Health Plan, is operated via Community Care Organizations (CCOs). CCOs bear a number of resemblances to Colorado's Regional Accountable Entities, described below under "Colorado's Current State", which makes the Oregon approach particularly informative. For example, the CCOs are also based on geographic regions, are required to have Community Advisory Councils with majority member representation, and have been emphasizing transition to value-based payments to providers.[x] Notably, CCOs are responsible for behavioral, physical, and oral health services, which does give them a broader mandate than RAEs, but the overarching similarities remain.

Oregon's waiver focuses on HRSN supports for people experiencing transitions in life circumstances where they may otherwise be prone to falling through the system and experiencing worse outcomes. These target populations include:

- Youth 19-26 with special care needs
- Youth who are transitioning out of foster care homes or aging out of child welfare system involvement
- Members who are identified as homeless or at imminent risk of homelessness
- Adults turning 65 who are transitioning from Medicaid-only coverage to dual Medicaid-Medicare coverage
- Adults and youth who are justice involved and being released from carceral settings

One unique aspect of the Oregon waiver is that it includes extreme weather events as a qualifying eligibility factor, a new approach that may be replicated in other states as part of climate change adaptation strategies.

Oregon includes housing and nutrition supports in its waiver, ranging from six months of rental assistance to medical tailored meal delivery. HSRN supports also include payment for devices that maintain healthy temperatures and clean air. Similar to the other states, Oregon is in the implementation phase, having allowed eighteen months of build time post-approval before services are intended to start flowing.

Oregon received authority for $268 million DSHP federal buy-out for the five years of the demonstration to pay, primarily for HRSN infrastructure and services. The buy-out allows federal matching funds for a state-funded Designated State Health Program that "free up" state funding. The "freed up" state funding will result in $1.2 billion across the demonstration, which includes a state contribution of $88 million during the last year of the demonstration. Therefore, the total federal funds are $1.1 billion for the demonstration. As a condition of using DSHP, Oregon will need to raise its reimbursement rates for primary care services by two percent within the first three years of the waiver period.

Arizona

Arizona's waiver is focused on Medicaid members experiencing homelessness or at risk of homelessness. These members must also have a documented health need, including but not limited to serious mental illness, high-cost, high-needs chronic health conditions, or be enrolled in long term care. Medical appropriateness for HRSN services is based on these clinical and social risk factors as documented in the

individual's medical record and care plan. The services offered to this eligible population are focused on housing supports, including rent or temporary housing for up to six months, tenancy sustaining services, and case management. Arizona will spend up to $96.4 million each year on these housing initiatives and up to $13.5 million dollars each year of the waiver on HRSN infrastructure costs. These expenditures are financed primarily by DSHP. As a condition of using DSHP, Arizona will need to raise its reimbursement rates for primary care services by two percent within the first three years of the waiver period.

Arizona comes to this waiver having had $30 million annually in dedicated state funds to support housing for Medicaid members with serious mental illness, which provided a basis of mutual understanding between Medicaid and housing programs and providers. However, housing service providers had not previously had to be enrolled as Medicaid providers or contract with managed care plans, which is part of the early implementation effort underway in 2023. As a part of this waiver, Arizona is also building out a closed loop referral system so that managed care plans have insight into social services received by the member, as well as determining whether a central entity will be coordinating the administration of the benefit and aggregating claims.

Arkansas

Arkansas is implementing is "Life360Home" concept, which focuses on intensive care coordination to address health-related social needs by connecting members to community supports. The Life360Home has three subcomponents:

- Rural Life360Home focuses on members with serious mental illness and/or substance use diagnoses who live in rural areas
- Maternal Life360Home focuses on members with high-risk pregnancies and provides supports and services for up to two years post-partum.
- Success Life360Home supports young adults ages 19-24 at high risk for long term poverty and poor health outcomes due to involvement with the justice system or the foster care system. This component also supports veterans ages 19-30 who are at a high risk of homelessness.

The Arkansas waiver will make supports available across all three categories of housing, nutrition and case management. Arkansas is also using the waiver to support infrastructure costs for the implementation of HSRNs via the Medicaid program. This includes technology, operations redesign, workforce development, outreach and education.

In addition to the Core Four states whose waiver approval coincided with the release of the HRSN framework, several other states have waivers that invest in HRSNs.

North Carolina. North Carolina's waiver was approved in October of 2018 under the prior Administration. North Carolina is addressing HRSNs through its Healthy Opportunity Pilots, which focus on supporting individuals experiencing housing instability, transportation insecurity, food insecurity, interpersonal violence, and toxic stress. A focus on the last two items makes North Carolina somewhat unique among states. "Network leads" are the entities responsible for building HRSN networks, managing contracts, and overseeing service delivery.

California. California's Medicaid's flagship program is CalAIM, which aims to take a whole person care approach to supporting Medicaid members statewide. CalAIM operates under a combination of 1115 and 1915(b) authority and requires managed care plans to offer enhanced care management and

community supports to high need members, such as those experiencing homelessness and those with a serious mental illness (SMI) or substance use disorder (SUD). California's waiver was approved in 2021.

Washington. Washington's approach leverages Accountable Communities of Health (ACHs), which are regional organizations that work with members to address health related social needs. They are independent from the MCOs that administer the state's managed care plans. HRSN services include nutrition and housing supports, as well as employment services, and are targeted based on the specific needs of the individual.

Frequently Identified Issues

Current and former state Medicaid officials were interviewed for this paper, representing perspectives from Arizona, Massachusetts, Oregon, and Washington, as well as consultants and vendors working in a broad set of states ranging from North Carolina to California.

Based on conversations with the individuals and teams leading the way, their experience can be summarized in three words: **implementation is hard**. States typically gave themselves 18-24 months from approval to services beginning to flow. While this implementation effort is currently underway, it is likely that states may struggle to hit that timeframe, and that initial uptake may be relatively low as the kinks in the system continue to be worked through. There are a number of specific themes and issues that were frequently raised by states. Medicaid programs and social service providers, particularly housing providers, have historically operated in very different and complex settings. They don't naturally speak the same language as the traditional Medicaid providers or understand each other's environments and constraints. There is significant work just on bridge building, relationship building, and mutual education to support effective ongoing implementation.

- Social service providers are often not enrolled Medicaid providers and are not familiar with the Medicaid billing structure. Getting these providers onto the Medicaid system involves having them enroll as providers and meet those requirements. In particular, social service providers are accustomed to invoicing against grants or other funding blocks and receive their funding before providing individual services. They are not used to the Medicaid coding and claims system, both in terms of knowing how to bill and having the technical systems to enable billing. Additionally, Medicaid financing will mean that payments are made after providing services.
- States are taking different approaches to the integration of social service organizations with the Medicaid program. Some states are relying on MCOs to be the conduit for integration. Others are exploring having a stand-alone entity(s) serve as the point of integration, either for management of the entire HRSN delivery model, or simply serving as a claim integrator to simplify and increase the program integrity of the billing process. In that case, a procurement would be needed, which would likely require 6 months or more during the implementation phase.
- HRSN data sharing architecture and closed loop referral systems are key pieces of technology. Some states are considering a single statewide system for HRSN data records that would link to the EHR systems used by providers.
- Linking all of these social service provider organizations and systems together can create a complex process and series of handoffs that – while reducing gaps in the current system – can create even more difficult systems for members to access and successfully navigate. This makes

effective case management and navigator services particularly critical as the new integrated system stabilizes over time.

- Consistent with the implementation issues identified above, effective implementation requires close coordination across different organizational divisions of Medicaid programs and in some states across different agencies. Policy and benefit design teams must work closely with the provider enrollment and operations team, the procurement and finance teams, etc. Close internal collaboration and communication is key. Additionally, states may have new full-time equivalent (FTE) authorized to support implementation, and complex hiring processes and delays can further impede effective timely implementation.

Colorado will have to contend with many of these same issues, but the precise form of the challenges will need to account for Colorado's unique structure and determine if and how to weave together other HRSN-related efforts that are in development or ongoing, as described below. However, Colorado also has several considerable strengths on which to draw in this effort. This includes an engaged stakeholder community and state legislators, a number of current grant and pilot programs supporting health-related social needs, and a history of innovation. In addition, Colorado has the benefit of learning from the early states that are implementing these waivers, while still itself being early enough in the process to set its own course.

Colorado's Current State

Like all states, Colorado has a number of unique entities that are an integral part of how Medicaid services are delivered in the state. Most states have the vast majority of their Medicaid populations enrolled in Managed Care plans that cover the scope of physical and behavioral health needs of the members. Some services may be carved out of managed care, such as pharmacy services, based on the policy imperatives of the state.

However, Colorado is unique in that it operates in a hybrid managed care and fee-for-service model. Physical health care services, both primary and specialty care, are administered on a fee-for-service basis. Behavioral health care is administered via managed care. Regional Accountable Entities (RAEs) are care coordination organizations that operate under managed care contracts with the Department of Health Care Policy and Financing (HCPF) and receive a capitated payment and contract with behavioral health providers to serve members. RAEs also receive a per member per month (PMPM) payment for care coordination and contract with primary care services to collaborate in the execution of care coordination across physical and behavioral health care. RAEs also receive pay-for-performance incentive payments from a performance pool of funding.

This overall approach to the provision of services is known as the Accountable care Collaborative (ACC). The diagram below shows the organizing structure of the Colorado Medicaid program, and the following table explains the payment types in additional detail.

Figure 7. HCPF and RAE Structure.

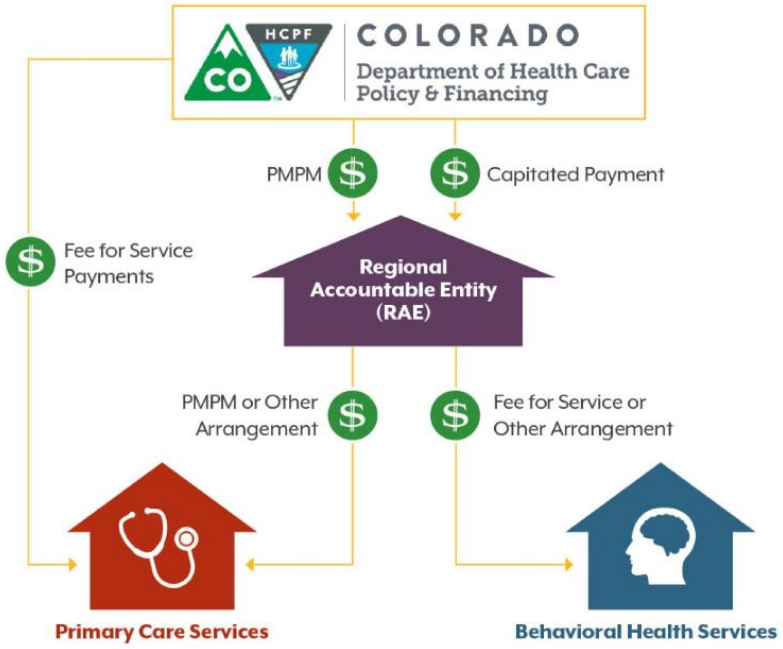


Table 4: The Four Key Types of Medicaid Payment in Colorado[xi]

Concept	Definition	How It's Used in the ACC
Fee-for-Service	Reimbursement from the state to a provider for each service rendered, based on a predetermined fee schedule.	Payments to primary care and specialty care providers for physical health care services.
Capitation	A per capita amount of money paid by the state to a managed care organization to cover health benefits for each member in its geographic region. Capitation rates are adjusted based on the health needs and demographic characteristics of members in that region.	Payment to RAEs for provision of behavioral health services.
Per Member Per Month (PMPM) Payments	Monthly administrative payments from HCPF to RAEs — and then from RAEs to primary care providers — to enable RAEs and providers to offer specific support, like care coordination, to members who need it.	Payments to RAEs for ensuring member access to care coordination. RAEs offer a PMPM or other value-based payment to primary care providers for offering a medical home for members. RAEs may also use the PMPM to pay other types of providers in the "health neighborhood," such as dentists, specialty care providers or local public health agencies.
Pay-for-Performance	Financial sticks and carrots to encourage improvements in the quality of care provided to Health First Colorado members.	Incentives or other value-based payments to reward RAEs or providers for meeting, exceeding or making progress toward established goals. These programs take many different shapes in Phase Two.

Colorado is in the process of the next re-procurement and evolution of the Accountable Care Collaborative, or ACC 3.0. The stated goals of ACC 3.0 are:

- Improve the quality of care and access to care
- Improve the member experience
- Promote health equity and close disparities
- Manage costs to protect member coverage and benefits, as well as provider rates

Planning for ACC 3.0 has been underway since 2021, with the following anticipated timeline.

- Summer 2023: Release concept papers
- November 2023: Draft the RAE request for proposal (RFP)
- April 2024: Issue the RAE RFP
- September 2024: Vendor awards
- July 2025: Go live

Stakeholder meetings in the Spring of 2023 focused on the geographic alignment of the RAEs and the Behavioral Health Administrative Service Organizations (BHASOs). BHASOs will be a new entity in Colorado administered by the recently established Behavioral Health Agency, a cabinet-level state agency that sits within the Colorado Department of Human Services and is charged with improving behavioral health access, quality, and cost in the state.

Existing Waivers in Colorado

Colorado currently has thirteen approved waivers.[xii] Of these waivers, two are operated under 1115 authority, two are operated under 1915(b) authority, and nine are operated under 1915(c) authority.

1115 Waivers

Colorado currently has had two 1115 demonstration waivers approved by CMS, one focused on adult prenatal coverage and premium assistance in the CHP+ program, the other focused on expanding the substance use disorder continuum of care.[xiii] While these waivers are not directly related to HRSNs, they demonstrate a knowledge of the 1115 waiver process and standard components that would be part of an HRSN 1115 waiver development process. However, Colorado does not have experience developing and negotiating a complex 1115 waiver that encompasses the entire delivery system or Medicaid program.

In addition, the Colorado General Assembly passed HB23-1300[xiv] in the 2023 legislative session requiring Colorado to submit a 1115 waiver requesting approval of continuous eligibility for children ages 0-3 years old, and for 12 continuous months for individuals being released from incarceration. In addition, HCPF must establish a stakeholder informed study on how to expand continuous eligibility as well as meet the health-related social needs of members via waiver expansion.

1915(b)(3) and 1915(c) Waivers

HRSN services are currently provided mainly under Section 1915(b)(3) waiver authority and Section 1915(c) authority. The state is using its 1915(b)(3) authority to use the most effective medical care and provide additional services. Services provided under 1915(b)(3) authority include intensive case management for adults who are at risk of hospitalization, incarceration and/or homelessness due to multiple needs and impaired level of functioning. Much like an 1115 HRSN waiver, in order to receive

services, a member must have a current plan of care documenting the allowable non-medical services being provided.

The waivers under section 1915(c) authority are focused on home and community-based services for members who would otherwise qualify for an institutional level of care. Health-related social needs services authorized under these waivers include home delivered meals, non-medical transportation, transition services, remote supports, and home modifications.

Notably, none of these waivers currently include direct rental assistance for up to six months, which was a key change in policy by CMS under the new 1115 structure. However, they do provide a foundation to build upon for additional target populations and expanded services.

Money Follows the Person

Money Follow the Person (MFP)[xv] is a five-year grant program that facilitates the transition of members from nursing or other long-term care (LTC) facilities to the community using home and community based (HCBS) services and supports. After a year in the program, enrollees transition to the appropriate HCBS waiver to receive ongoing support. Services provided under this program include transition coordination and set-up, home meal delivery, life skills training, and peer mentorship.

Statewide Supportive Housing Effort

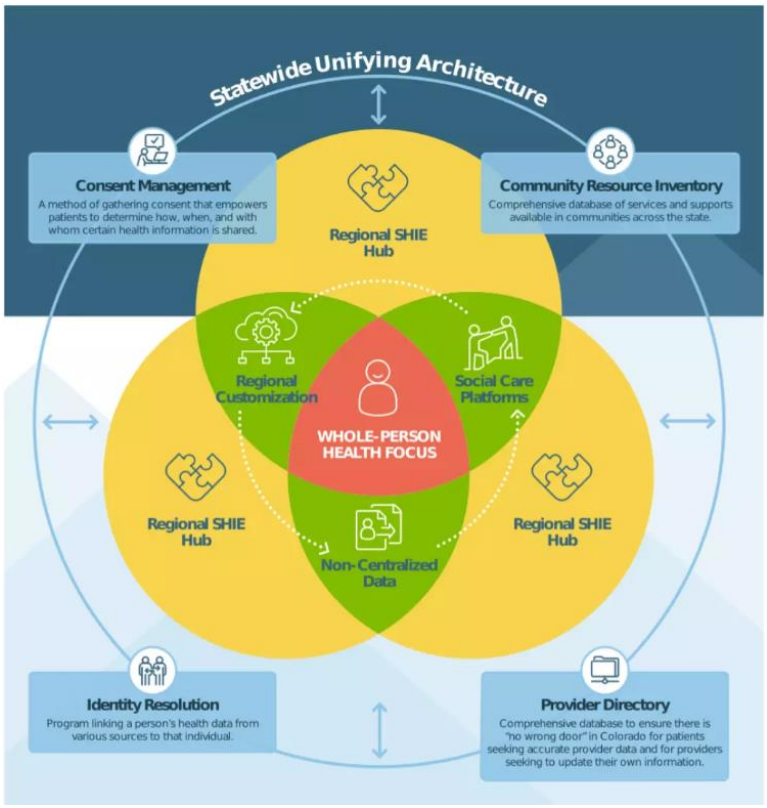
The American Rescue Plan included a temporary 10% increase in the federal medical assistance percentage (FMAP) for HCBS services, with the requirement that the extra funds be put towards strengthening and transforming the HCBS system. This amounted to over $500 million in additional funding for the State to invest in the HCBS system. HCPF is currently in the process of implementing over sixty projects to address services, systems, and workforce issues across the spectrum of HCBS programs. They are also standing up a number of pilot programs, including the Statewide Supportive Housing Effort.[xvi] As articulated by HCPF, the aim of the project is as follows:

> "The Department will implement a pilot program to provide supportive housing services for at least 500 Medicaid members. Participating members will receive housing vouchers from the Colorado Department of Local Affairs (DOLA). This initiative is modeled on the evidence-based social impact bond project in Denver. It focuses on individuals who have serious mental illness and have a history of homelessness and emergency care. The Department has also been awarded a technical assistance program by the National Academy for State Health Policy (NASHP) about how to best integrate services across state agencies to expand housing options to their shared clients who are unhoused.
>
> With the support of the NASHP technical assistance grant, the Department will conduct an analysis of funding mechanisms and payment models. The Department will then develop recommendations on how to improve support models of care for individuals with extensive history of complex social and behavioral health needs.
>
> For providers, this will create options for them to expand their business models, increasing their solvency and the populations they are able to serve. It will build provider capacity, including housing service providers, and sustainability in rural areas where traditional care models are becoming more difficult to provide due to changing economic and population needs."

Social Health Information Exchange

Colorado has an Office of eHealth Innovation (OeHI) that has been central to the Colorado effort in the last decade to adopt electronic health records and establish interoperability and health information exchanges. Now OeHI is also looking at the role of HRSNs in the health network and has laid out a vision for a social health information exchange.[xvii] This vision sets a direction for a statewide unifying architecture that will allow for the secure exchange of social health information. It is not intended to be a single vendor system, but rather a networked model of linking systems, where social health information exchange is built upon the regional health information exchanges that already exist for medical information. OeHI is currently in the Invitation to Negotiate Process of selecting vendors to support this architecture network.

Figure 8. OeHI Social Health Information Exchange Diagram[xviii]



Considerations and Decision Points for Colorado

Given the broad range of activities already taking place that are or could be connected to an HRSN waiver, as well as the many opportunities and challenges that an HRSN 1115 wavier affords, Colorado will have a number of factors to weigh and decision points in the coming months and years as its programs evolve. The sections below outline a number of different decision points and considerations for Colorado, both the state and its stakeholders, as they weigh a path forward on health-related social needs. Many of the insights and considerations included in this section are pulled from interviews with officials in states that are moving forward with HSRN 1115s, as well as subject matter experts.

Timing

Ultimately, in Colorado, the state government, the legislature, and its many stakeholders will need to make a calculation about whether it wants to apply for a program-wide 1115 waiver and if so, how quickly. Moving at a slower, more measured pace allows time for thoughtful planning and learning from other states, but moving more quickly would enable members in the target populations to receive these important services through a waiver funding structure sooner rather than later, though "sooner" is likely to still be several years down the road. There is a long sequence of steps to developing and negotiating a waiver, including:

1. Submit legislative request for authority for an 1115 waiver
2. Receive General Assembly approval to develop and submit a waiver application
3. Conduct stakeholder engagement
4. Draft application
5. Post draft for public comment
6. Review and address public comment
7. Submit waiver application
8. Receive determination of completeness from CMS
9. Negotiate wavier substance and special terms and conditions with CMS
10. Receive approval

This timing is also subject to CMS's capacity to review waivers. While speaking at the August 2023 National Academy for State Health Policy Conference, CMS officials referenced having "over forty" waivers currently in their queue for review and negotiation. Additionally, a change in Administration could result in a policy shift that disrupts this approach and ultimately requires Colorado to rethink its approach.

Alternative Authorities

Given the long runway for 1115s, an interim approach could be for the state to continue developing out its current programs and potentially pursue an "in lieu of services" (ILOS) MCO contract amendment that would expand the offerings and eligible populations and serve as a glide path to an eventual decision about an 1115.

ILOS can only be administered via capitated managed care models. Because managed care contracts are only in place in Colorado for behavioral health via the MCOs, the value proposition for an ILOS would need to be that it produces savings on the behavioral health side. Additionally, a detailed legal, regulatory, and contractual review would be needed to determine exactly how ILOS could be leveraged in Colorado. For example, there is a legal definition of a Managed Care Entity (MCE) which is, as stated in 42 CFR 457.10, an entity that enters into a contract to provide services in a managed care delivery system including, but not limited to, managed care organizations, prepaid health plans, and primary care case managers.[xix]

The RAE authorities and contracts would need to be reviewed to understand whether they are categorized as an MCE or as an MCO, which is a subset of MCEs. If RAEs are MCEs but not MCOs, then an additional analysis would be necessary to determine the extent to which ILOS authorities are available to MCEs that are not MCOs, since ILOS is traditionally understood as an MCO-specific flexibility.

Discussions with CMS may also be prudent to come to consensus on the extent to which ILOS can be leveraged under the Colorado Medicaid model.

In terms of the substance of what can be provided under ILOS, one classic example of ILOS is air conditioners. If a plan member has chronic conditions that are exacerbated by heat, it may be demonstrably less expensive and drive better outcomes for the plan to provide the member with an air conditioning unit than to have to pay for the higher cost and worse outcomes of continued emergency room visits.

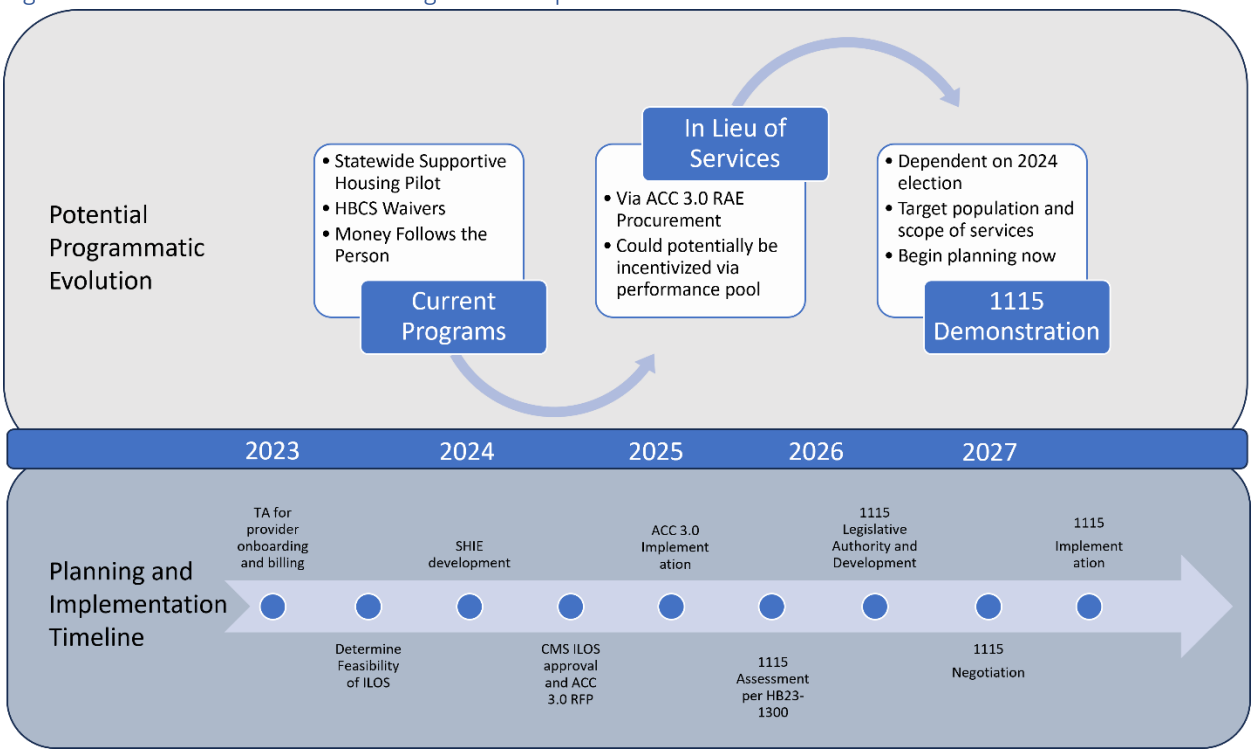
To use ILOS for behavioral health, the state would need proof of concept for non-covered HRSN services that would produce an equal or greater reduction in behavioral health expenditures. One next step in exploring this concept would be a literature review of the evidence base for non-clinical interventions that improve behavioral health outcomes.

There are several downsides to the ILOS approach as compared to the 1115 approach. First, it doesn't provide a funding mechanism for infrastructure and implementation costs. Some of this downside could be potentially mitigated through the use of Implementation Advance Planning Document (IAPD) funding, for which the federal government covers 90 percent of the expenses associated with design, development and implementation of specific Medicaid IT systems. [xx] Second, by running under a managed care cost avoidance framework, HRSN services would primarily be provided to members who were already connected to and receiving significant services and might miss members who are minimally connected to care but could benefit from HRSN interventions. Third, a plan-based approach means that data will presumably be housed in different systems and potentially be challenging to aggregate and analyze on a statewide basis. Third, ILOS are not required but optional, meaning that an MCO can opt not to offer them, which can limit program reach and effectiveness.

However, there are significant upsides as well. The approval process is also considerably less onerous, given that CMS can provide approval via their review of the Medicaid managed care contracts and an amendment to a 1915(b) waiver. ILOS authorities are also a part of underlying Medicaid regulation and less subject to change based on the political leadership of CMS, because of the amount of time, effort, and public comment that goes into rulemaking. Notably, it makes use of the managed care infrastructure already in place. It also helps community-based organizations become more engaged with the Medicaid program, including being contracted as service providers who are able to submit claims for payment via the RAEs.

Given these factors, one question for Colorado to consider is whether ILOS could serve as an imperfect bridge between the current ARPA-financed approaches and an eventual 1115 waiver application. The roadmap below is one example of how an approach like this could play out.

Figure 9. Potential ILOS to 1115 Bridge Roadmap



Target Populations

As noted above, the target population for the 1115 HRSN waiver is considered one of the primary "demonstration tests" of the waiver, along with scope of services. As such, it is one of the most important decisions the state will make in its waiver application. Colorado will need to consider which populations make the most sense to be eligible for HRSN services.

The state will need to propose how medical appropriateness is defined in the context of these services. For example, Colorado could consider that a combination of medical and HRSN risk factors are required for eligibility, or it could identify the degree of severity of a social risk factor would have to have to likely result in a negative health outcome. One approach taken by other states is to consider a social risk factor in conjunction with a behavioral health need. This type of approach could be a good fit for Colorado to administer via the Regional Accountable Entity structure, given that behavioral health care is already in a managed care structure. A number of states have 1115 waivers that include SDOH or HRSN provisions even though they pre-date the 2022 waiver approvals and their expanded service offerings. However, the range of populations served by these programs offers insights into which populations other states are prioritizing for HRSN services.

Table 5. Populations currently included in other states' 1115 waivers with SDOH/HRSN provisions

Population	States with HRSN eligibility
Members who are homeless or at risk of homelessness	AZ, CA, FL, HA, IL, MD, MA, NC, OR, RI, UT, VT, VA, WA
Justice-involved members	AR, MA, NJ, OR, UT, VT, VA
Children aging out of foster care	AR, NC, VA, OR

Individuals with SMI or SUD	AR, CA, IL, OR, WA
Pregnant or post-partum individuals	AR, MA, NJ, NM, NC, OR

Colorado could also consider target populations outside of those proposed by other states. For example, one potential population or circumstance mentioned in interviews was Medicaid members with an acute diagnosis that renders them temporarily unable to work while receiving treatment. Six months of rental assistance and meal delivery could allow the member to focus on recovery and prevent a health event from becoming an inciting cause of homelessness. This could also cover instances where a child has an acute illness that requires a caregiver to temporarily stop working to provide care. Another option raised was medically tailored meals for post-partum birthing individuals, particularly if they are breast-feeding or high risk.

There are doubtless other innovative ways of identifying Medicaid populations with a health-related need for housing, nutrition, or other allowable social supports. However, Colorado should be cognizant that any population that has not previously been approved by CMS in other states would likely require more protracted negotiations and be subject to a potential modification.

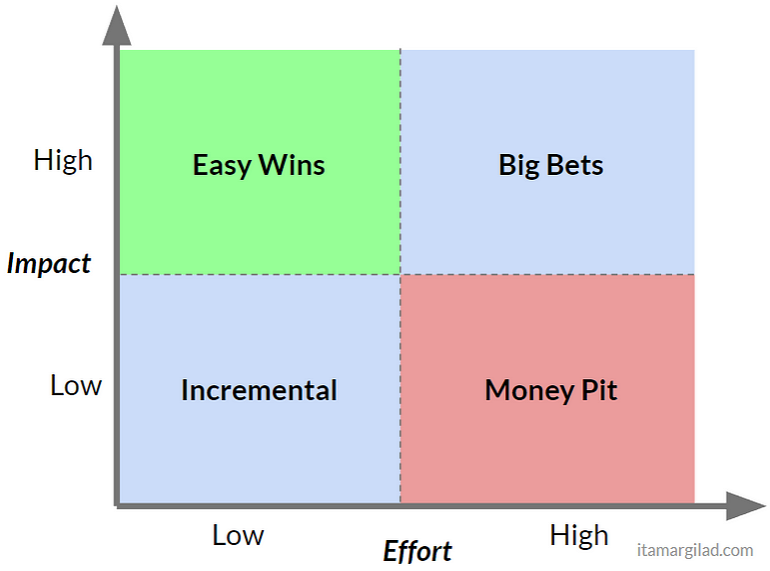
Scope of Covered Services

When asked what they might have done differently if they'd had perfect foresight, one Medicaid program leader noted that it would have been helpful to prioritize the types of HRSN services up front as part of the waiver application development process.

Assess what are the most critical services for the target population, looking at the evidence base while listening to stakeholders, and most importantly, the members who would fall into the target populations themselves.

Colorado will likely need to wrestle with the impact/effort tradeoff. More meaningful services may also require more effort to implement. For example, it may be easier for meal delivery providers to bill under Medicaid than housing support agencies that provide a range of services, but housing supports may be more meaningful to the target population. Alternately, it may be that current housing pilots result in housing services providers successfully navigating the challenges of Medicaid claiming ahead of an 1115 implementation. Colorado will need to map this out to determine which services to target and whether to implement a phased approach to rolling on HRSN services.

Figure 10. Impact/Effort Matrix Template



State Share Funding Mechanism(s) and Fiscal Considerations

Designated State Health Program (DSHP) Funding Authority

As described previously, many states have leveraged DSHP funding authority as a means of financing HRSNs. Other than the work involved to identify them and set up the funding flows, DSHP funds are extra federal dollars for states to invest in programs and services like HRSNs. DSHP funds help states to overcome a major hurdle of state general fund investment and may be a highly strategic approach to financing the early years of the waiver.

However, DSHP funding does come with a number of downside risks. First, there needs to be broad agreement on the part of the agencies that operate the proposed DSHP programs as well as the state legislature that the savings from the federal match for DSHP programs will be put towards the Medicaid program and matched. This requires a multi-year commitment on the part of the state legislatures, who may be tempted to use savings on the DSHP side for purposes other than investing in Medicaid HRSNs as agreed to in the waiver, particularly in an economic downturn. This repurposing of the DSHP financing mechanism to shore up other state budget gaps is one of the reasons why DSHPs were targeted to phaseout in 2017. This is also a reason for states to consider front-loading their DSHP funding in the early years of the waiver.

The second main risk to DSHP funding is the potential of disapproval or phaseout. While states have submitted their lists of proposed DSHP programs, CMS has not provided program-by-program approval of all DSHPs yet, nor has the new matching funding begun to flow. This could put states in a precarious position of having to reduce scope or find additional state share funding in order to implement the waiver if they don't receive approval for all DSHP programs. For example, some states included county-level health programs in their list of proposed DSHPs to CMS. CMS could determine that all DSHPs need to be state-level programs, as the name suggests.

Even more problematic would be a new federal administration taking a different approach to the allowability of DSHP funding and eliminating it altogether. If a state is developing a waiver proposal against the backdrop of a potential change in administration, it may want to consider having alternative

feasible funding strategies ready as a backup plan. It's also possible that the current administration could consider reversing course on DSHPs down the road, particularly if they feel that DSHPs are being defined too broadly or not for their intended purpose.

Sustainability Funding Strategy

CMS has also emphasized the importance of states having sustainability plans for their 1115 waivers. Sustainability planning can be complicated because state budgets are approved on an annual basis, and legislators don't have an easy means by which to bind future legislators to financial commitments. This could be particularly acute if the waiver is implemented during a strong economy and a fiscal cliff for the waiver hits at the same time that an economic downturn is putting pressure on the state budget. [4]

In addition, if there is an 18-24 month waiver implementation period followed by slow initial uptake, it is possible that the overall program costs could accelerate just as the waiver is ending. While the waiver could be amended and extended, DSHP funding would presumably not be available as a state share source, potentially exacerbating a funding cliff.

Ultimately, the legislature that signs off on an 1115 waiver proposal is doing so with the tacit understanding of the outyear commitment they are making, and with the knowledge that stakeholders, advocates, members, and providers will hold them accountable for that commitment. A Governor can help by articulating a long-term vision for the state's Medicaid program and the direction of health policy efforts generally.

Sustainability planning becomes particularly important if the state share for HRSNs is primarily financed via DSHPs, because CMS has specified that they are a one-time funding source. As such, states need to anticipate a funding cliff at the end of the five-year waiver, or a gradual phase out over the course of the waiver by front-loading DSHP funds.

Provider Rates

It is also possible that Colorado would need to raise reimbursement rates as a condition of an HRSN 1115 waiver. According to the Kaiser Family Foundation's comparison chart, Colorado Medicaid's primary care rates were at 84% of Medicare rates in 2019, but obstetric rates were only at 69% percent of Medicare rate, well below the 80% threshold.[xxi] Assuming this is hasn't changed substantially in the intervening years, Colorado would need to increase OB/GYN rates by a minimum of two percent in the first three years of the waiver. Further research is needed into the third rate category, behavioral health, given the capitated payment model.

Member Experience Considerations

One common piece of feedback from Medicaid members is that the program is difficult to navigate. The member experience can be fraught with complex eligibility requirements, long call wait times, provider shortages, and handoffs between different entities. In addition, excessive administrative burdens may make it difficult for many Medicaid members to access services.

One advantage to the new HSRN 1115 structure is that it helps to address gaps in the system, such as providing a rental benefit while people may be awaiting a housing voucher. However, the underlying

[4] One technical note on this is that the state would need to review its budget laws and regulations to determine whether HRSN services, which fall into a new category as a capped hypothetical benefit, would be included in aggregate caseload projections or as an individual line item(s).

social safety net still is a patchwork of different programs, agencies, and regulations. With so many stakeholders involved in the 1115 structure, the benefits of these waivers risk being inhibited by confusing handoffs and navigation challenges.

Fortunately, Colorado has a structure for incorporating members input and lived experience into policy design, program outreach, and operations via the Membership Experience Advisory Council, as well as the state's many strong member advocacy organizations. These groups could collaborate in the early planning stages to map the member journey from the point of initial care and/or screening to the ultimate delivery of HRSN services, assessing considerations such as:

- How many different handoffs are there?
- What paperwork is required of the member?
- Is there one central point of contact or navigator for the member? Is that person in a role and from a background that will engender trust and credibility?

Ultimately, a program is only as good as its uptake and outcomes. If members are unable to navigate the program, they will not be able to reap the substantial benefits. A program that puts member experience front and center is critical to fully achieving the promise of integrating health related social needs into the fabric of Medicaid.

The Role of the Philanthropic Community

The effective design and implementation of an 1115 waiver for health-related social needs is a major health system undertaking with the potential to both improve outcomes and reduce disparities. There are a variety of ways in which the Colorado philanthropic community could consider engaging, include the three ideas below.

Community Planning Grants

Community engagement is a required and critical part of the waiver development process. In particular, community input is critical to identifying which HRSN services and target populations should be prioritized. Additionally, community engagement can help to improve the eventual member experience, as well as building trust and channels of communication for the inevitable ups and downs of the implementation. The role of philanthropies could include convening groups, funding and facilitating forums throughout the state in collaboration with HCPF to get community ideas, input and feedback throughout various stages of the waiver development process.

Technical Assistance and Infrastructure Grants

A central implementation challenge is the new requirements and change management necessary to help social service organizations learn how to effectively operate as Medicaid providers. Philanthropies could find direct technical assistance to these entities, as well as funding the development of best practices, guides, trainings, and other resources to help these organizations learn the Medicaid environment and what will be required of them. In addition, depending on how the program is structured, providers (especially social service providers) could have infrastructure costs for new systems. While these infrastructure expenses could presumably be funded out of an approved waiver, there may be portions of these costs that philanthropies could provide seed funding for, so that the state potentially can operate on a more expedited implementation timeline.

State Share Funding

One question that arose over the course of this analysis is whether there is a place for the philanthropic community to directly support the state share funding requirements. While other states did not identify this as an approach that they were familiar with, there is a history of the Colorado philanthropic community directly supporting state initiatives, such as long-acting reversible contraception services and primary care technical support for the State Innovation Model. Additionally, the philanthropy community is likely to take an interest in this effort, given the prominent role they have taken in health equity and addressing social determinants of health. Accordingly, the state could consider engaging with CMS on this question, both at a high level as well as the specifics of how the funding flows would need to be structured to enable federal match.

In particular, early philanthropy implementation and infrastructure support could help to set the effort up for success, while outyear support for the waiver services could help to inform sustainability planning. This funding mechanism could be complex and potentially complicate and extend waiver negotiations, it would also be a powerful testament to community-wide support for the effort.

Potential Next Steps

The development and implementation of an 1115 demonstration waiver for health-related social needs is a complex and multi-year endeavor. Colorado has the opportunity to learn from other states that are further along the path and develop a deliberate and strategic approach to building out HRSN services into the Medicaid program.

Execute on HB23-1300, which requires a stakeholder informed study on how to expand continuous eligibility as well as meet the health-related social needs of members via waiver expansion. This study represents an opportunity to begin a thoughtful planning process for a potential waiver application. It would be particularly prudent to engage social service providers and Medicaid members as key stakeholders, given their investment in the success of the effort.

One frequent observation by interviewees was that Medicaid providers and community-based social services providers speak different languages. Getting an early start on communicating across programs and services will help to proactively identify problems and design mutually agreeable solutions.

This study is due to the General Assembly no later than Jan 1, 2026. However, given the timeline of 1115 waiver development and approval, the state may wish to consider an earlier submission if resources allow, or dual tracking the report and waiver development process.

Align the direction on HRSN policy with the development and implementation of ACC 3.0. The state is in the process of setting the direction for the next phase of maturity for the Accountable Care Collaborative, which is the overarching structure of Medicaid service delivery in Colorado. Designing the ACC 3.0 structure so that it is compatible with an eventual 1115 waiver requires thinking through what entities will be responsible for and ensuring that there is enough flexibility in the ACC 3.0 to accommodate this approach down the road, without having to significantly reconfigure program structure.

For example, it would be helpful to have a preliminary idea of what role the regional Accountable Entities may play in the HRSN structure. Will they be operating shared or unique referral systems? Will they be responsible for contracting with social service providers? Or will they otherwise act as an

intermediary between the state and the social service providers? What other structural adaptations might the ACC 3.0 contracts need to account for, or at least allow for in the future? Spending time thinking through these questions as art of the ACC 3.0 development process will likely save time and potentially avoid challenges as setbacks when it comes time to implement a waiver.

Continue to glean best practices from states in the implementation phase to take advantage of lessons learned and help to smooth Colorado's path. Leverage national organizations, conferences, research and issue briefs, and informal connections with other states to stay up to date on what challenges and innovations other states are working through. The collaborative dialogue that exists across state Medicaid programs can be a major asset to Colorado in its planning and implementation of a waiver.

Develop a proposed roadmap, financial strategy, and begin conversations with CMS. Informed by the HB23-1300 study and the ACC 3.0 framework, the state could develop a roadmap that outlines the vision that the state hopes to achieve with an 1115 waiver and the path to get there. This could also include an outline of the funding strategy, such as whether to fund a portion of the state share with DSHP dollars. Because Colorado has a unique Medicaid structure, it would also be prudent to engage in early conversation with CMS about how the standard terms and conditions in the new framework might translate to the Colorado model.

Engage early in capacity building and infrastructure planning. Given the complexity of implementation, it would be to Colorado's advantage to take lessons learned in implementation from other states into account up front in the planning process, and not wait for waiver approval to begin working through the nuances of how the system would need to evolve to incorporate HRSNs effectively into the Medica model. This can include providing education and technical assistance for social service organizations that may become Medicaid providers for the first time.

It also includes developing a thoughtful plan for how the coordination and referral processes and data infrastructure will fit into the current state of Medicaid and what changes may be required. For example, OeHI can be brought into the conversation to understand how the Social Health Information Exchange can and should be connected to other provider systems. Gaining an early understanding of where there are challenges or concerns, particularly when considering what will be asked of the SHI Exchange as these services expand and mature.

Conclusion

The new federal framework to supporting health related social needs through Medicaid 1115 demonstration waivers is a major opportunity for states to invest in the upstream social services that have been shown to improve overall health outcomes while reducing health care costs. However, early experiences from leading states suggests that the path is likely to be long, resource intensive, and inherently bumpy. Colorado has the advantage of being able to learn from the experiences of other states in putting together a long-term vision and roadmap, and to begin to take action now to build an integrated and thoughtful approach to improve the health and wellbeing of Coloradans.

Appendix A: Supplemental Tables and Figures

Appendix Table 1. Medicaid Required vs Optional Benefits.[xxii]

Required Benefits	Optional Benefits
• Inpatient hospital services • Outpatient hospital services • EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services • Nursing Facility Services • Home health services • Physician services • Rural health clinic services • Federally qualified health center services • Laboratory and X-ray services • Family planning services • Nurse Midwife services • Certified Pediatric and Family Nurse Practitioner services • Freestanding Birth Center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription Drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing and language disorder services • Respiratory care services • Other diagnostic, screening, preventive and rehabilitative services • Podiatry services • Optometry services • Dental Services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal Care • Hospice • Case management • Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) • Services in an intermediate care facility for Individuals with Intellectual Disability • State Plan Home and Community Based Services- 1915(i) • Self-Directed Personal Assistance Services- 1915(j) • Community First Choice Option- 1915(k) • TB Related Services • Inpatient psychiatric services for individuals under age 21 • Other services approved by the Secretary* • Health Homes for Enrollees with Chronic Conditions – Section 1945

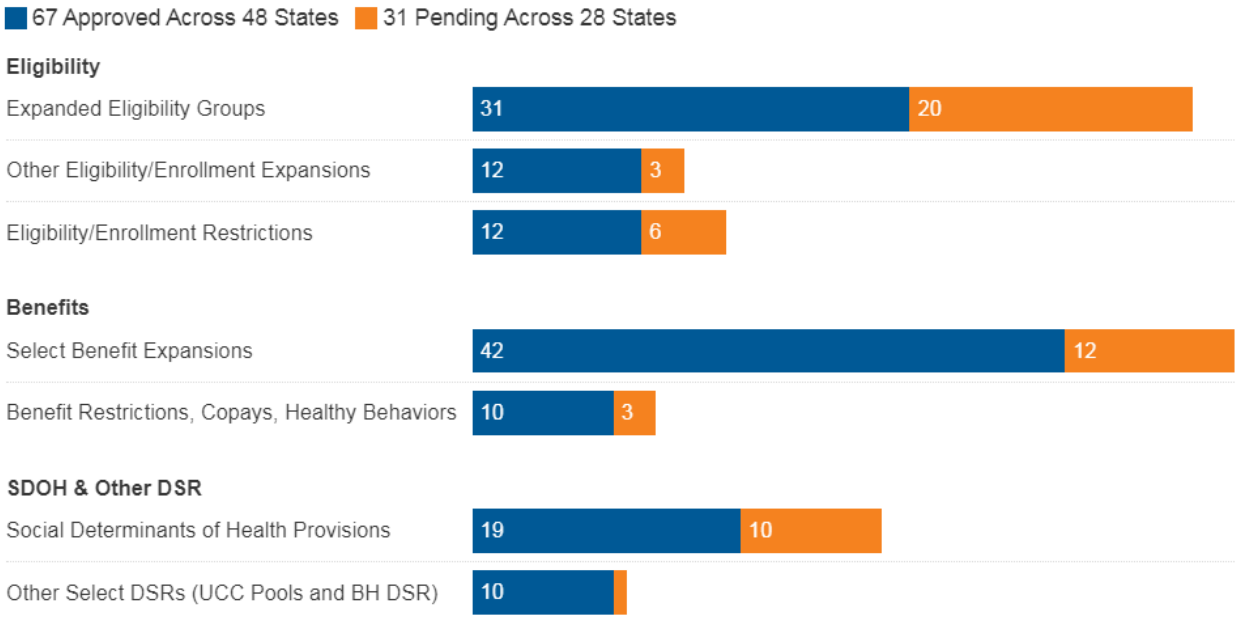
Appendix Table 2. Summary of Waiver Types[xxiii]

Waiver Type	Issues Addressed
1115	Section 1115 of the Social Security Act gives broad authority to the Secretary to authorize “any experimental, pilot or demonstration project likely to assist in promoting the objectives” of the programs. Under Section

	1115 research and demonstration authority, the Secretary may waive certain provisions of the Medicaid (and CHIP) statutes related to state program design. Such projects are generally broad in scope, operate statewide, and affect a large portion of the Medicaid population within a state. Although the specifics of each initiative vary, states have used Medicaid funds under Section 1115 authority to purchase premiums for exchange coverage, achieve savings through enrollment and eligibility restrictions or premium and cost sharing increases, expand the use of managed care, and restructure service delivery and payment systems.
1915(b)	The Medicaid statute generally guarantees beneficiaries freedom of choice of providers, but Section 1915(b) waivers permit states to implement service delivery models (e.g., those involving managed care plans) that restrict choice of providers other than in emergency circumstances. States can also use Section 1915(b) to waive statewideness requirements (e.g., to provide managed care in a limited geographic area) and comparability requirements (e.g., to provide enhanced benefits to managed care enrollees). Section 1915(b) waivers are generally approved for an initial two years with two-year renewal periods.
1915(c) Home and Community-Based Services (HBCS)	Section 1915(c) waivers authorize states to provide HCBS as an alternative to institutional care in nursing homes, intermediate care facilities for individuals with intellectual disabilities, and hospitals. The statute identifies services that may be considered HCBS, including case management, homemaker/home health aide, personal care, adult day programs, habilitation, and respite care services. Under HCBS waivers, states can provide targeted sets of services to specific populations including, for example, seniors, people with physical or developmental disabilities, and individuals with specific conditions such as HIV/AIDS or traumatic brain injuries. States are permitted to impose caps on waiver program enrollment and average costs per person to ensure that they do not exceed the waiver's cost-neutrality limit.

Appendix Figure 1: Nearly All States Have At least One 1115 Demonstration Waiver in Place[xxiv]

Approved and Pending Section 1115 Waivers as of June 5, 2023



Appendix Table 3. North Carolina HRSN Payment Rates

Service	Unit of service	Rate or cap
Housing		
Inspection for housing safety and quality	Cost-based reimbursement up to a cap	$250 per inspection
Housing move-in support	Cost-based reimbursement up to a cap	One to five or more bedrooms: $900–1,250
Interpersonal violence (IPV)/toxic stress		
IPV case management services	Per member per month	$209.37
Home visiting services	One home visit	$63.43
Food		
Evidence-based group nutrition class	One class	$21.60
Healthy food box (delivered)	One food box	Small box: $90.04
		Large box: $141.06
Transportation		
Reimbursement for health-related public transportation	Cost-based reimbursement up to a cap	$102 per month
Reimbursement for health-related private transportation	Cost-based reimbursement up to a cap	$203 per month

Table: Center for American Progress • Source: North Carolina Department of Health and Human Services, "Healthy Opportunities Lead Pilot Entity Request for Proposal (RFP)" (Raleigh, NC: 2019), available at https://files.nc.gov/ncdhhs/medicaid/20191223-HO-LPE-RFP-Addendum-7-Revisions-to-the-RFP-TO-POST.pdf.

Appendix B: Potential DSHP Programs

If Colorado determines that 1) it wants to pursue an 1115 waiver for HRSNs, and 2) it wants to have DSHP serve as a source of funding, the state will need to undertake a thorough review process to identify and fully vet programs that meet the DSHP requirements and propose those to CMS. This process would involve a detailed review of state spending against the DSHP criteria, and would take collaboration and coordination across many state agencies. In addition, Colorado could also consider whether it wants to put forward potential city and county DSHP programs, which may be more complicated and subject to additional federal scrutiny, but could also broaden the available funds.

The programs included below are pulled from the long bill and represent potential DSHP sources that could be investigated further to determine appropriateness. Programs were included if they: did not have a federal funding source, were primarily funded by general revenue, and appeared to be health-related programs that would benefit Medicaid members, but were not actually Medicaid programs. This list is intended to be illustrative but not comprehensive or conclusive. The tables below are taken from the Joint Budget Committee's FY 2023-24 Figure Setting process which, while not final, present the clearest set of tables showing funding sources at the program level.[xxv]

JBC Staff Figure Setting - FY 2023-24
Staff Working Document - Does Not Represent Committee Decision

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
CDPHE – Office of Health Equity					
Health Disparities Grants	3,145,173	3,126,664	10,975,917	10,975,917	11,014,813
General Fund	0	1,117,964	4,700,000	4,700,000	4,700,000
Cash Funds	858,257	0	3,616,743	3,616,743	3,655,639
Reappropriated Funds	2,286,916	2,008,700	2,659,174	2,659,174	2,659,174
Federal Funds	0	0	0	0	0
CDPHE – Office of Public Health Practice, Planning, and Local Partnership					
Distributions to Local Public Health Agencies	9,006,380	9,231,540	19,416,172	19,698,658	19,698,658 *
General Fund	6,832,223	7,376,182	17,523,706	7,749,418	7,749,418
Cash Funds	1,810,105	1,855,358	1,892,466	11,949,240	11,949,240
Reappropriated Funds	364,052	0	0	0	0
Federal Funds	0	0	0	0	0
CDPHE – Office of HIV, Viral Hepatitis, and STIs					
Viral Hepatitis Program Costs	0	436,754	200,000	200,000	200,000
FTE	0.0	0.0	0.0	0.0	0.0
General Fund	0	198,176	200,000	200,000	200,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	238,578	0	0	0

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
CDPHE – Prevention Services Division					
Child Fatality Prevention	524,424	582,694	589,646	599,707	599,707
FTE	2.9	2.9	2.9	2.9	2.9
General Fund	524,424	582,694	589,646	599,707	599,707
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
School-based Health Centers	7,298,912	6,417,295	6,519,267	5,030,571	5,030,571
FTE	2.4	2.4	2.8	2.4	2.8
General Fund	5,007,431	4,985,804	5,019,267	5,030,571	5,030,571
Cash Funds	378,301	0	1,500,000	(0)	(0)
Reappropriated Funds	0	0	0	0	0
Federal Funds	1,913,180	1,431,491	0	0	0
Comprehensive Sexual Education	444,588	875,848	988,891	994,263	994,263
FTE	1.3	1.3	1.3	1.3	1.3
General Fund	444,588	875,848	988,891	994,263	994,263
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Suicide Prevention	3,425,079	5,226,750	1,312,469	1,321,260	1,321,260
FTE	2.9	2.9	2.9	2.9	2.9
General Fund	901,037	1,221,889	1,312,469	1,321,260	1,321,260
Cash Funds	136,015	279,885	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	2,388,027	3,724,976	0	0	0
Mental Health First Aid	460,000	460,000	210,000	210,000	210,000
General Fund	210,000	460,000	210,000	210,000	210,000
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	250,000	0	0	0	0
Community Crime Victims Grant Program	1,484,072	880,570	881,078	882,349	882,349
General Fund	1,081,665	880,570	881,078	882,349	882,349
Cash Funds	402,407	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
CARE Network	559,299	819,739	912,651	913,819	913,819
FTE	0.4	0.4	0.4	0.4	0.4
General Fund	559,299	819,739	912,651	913,819	913,819
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Department of Early Childhood					
Child Care Services and Substance Use Disorder Treatment Pilot Program	0	0	500,000	500,000	500,000
General Fund	0	0	500,000	500,000	500,000

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Department of Human Services – Behavioral Health Authority and Office of Behavioral Health					
ACT Programs and Other Alternatives to the MHIs	15,721,007	17,139,032	17,481,813	18,006,267	18,006,267
General Fund	15,721,007	17,139,032	17,481,813	18,006,267	18,006,267
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Veteran Suicide Prevention Pilot Program	0	1,400,000	2,953,200	3,028,800	3,028,800
General Fund	0	1,400,000	2,953,200	3,028,800	3,028,800
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Housing Assistance for Individuals with a Substance use Disorder	0	3,093,595	4,000,000	4,005,779	4,005,779
FTE	0.0	0.0	1.0	1.0	1.0
General Fund	0	3,093,595	4,000,000	4,005,779	4,005,779
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Crisis Response System - Telephone Hotline	3,503,226	3,605,807	4,012,250	3,798,208	3,788,175
General Fund	3,503,226	3,590,807	3,662,625	3,438,094	3,428,061
Cash Funds	0	15,000	349,625	360,114	360,114
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Community Transition Services	6,460,012	7,414,874	7,563,171	7,790,066	7,790,066
General Fund	6,460,012	7,414,874	7,563,171	7,790,066	7,790,066
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Temporary Youth Mental Health Services Program	0	5,515,752	6,000,000 1.0	6,000,000 1.0	6,000,000 1.0
General Fund	0	5,515,752	0	6,000,000	6,000,000
Cash Funds	0	0	6,000,000	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Recovery Support Services Grant program	0	1,356,271	1,600,000	1,606,430	1,606,430
FTE	0.0	0.0	1.0	1.0	1.0
General Fund	0	1,356,271	1,600,000	1,606,430	1,606,430
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Department of Human Services – Office of Economic Security					
Transitional Jobs Programs	2,564,445	2,524,102	2,572,588	2,678,387	2,849,911
FTE	2.0	2.0	2.0	2.0	2.0
General Fund	2,564,445	2,524,102	2,572,588	2,678,387	2,849,911
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

Home Care Allowance	0	8,059,514	8,720,437	8,720,437	8,720,437
General Fund	0	8,059,514	8,218,473	8,218,473	8,218,473
Cash Funds	0	0	501,964	501,964	501,964
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

	FY 2020-21 Actual	FY 2021-22 Actual	FY 2022-23 Appropriation	FY 2023-24 Request	FY 2023-24 Recommendation
Aid to the Needy Disabled Programs	9,471,248	8,431,306	13,394,238	13,394,238	13,394,238
General Fund	8,931,721	8,431,306	7,654,065	7,654,065	7,654,065
Cash Funds	539,527	0	5,740,173	5,740,173	5,740,173
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Colorado Diaper Distribution Program	0	2,000,000	2,000,000	2,002,005	2,002,005
FTE	0.0	1.9	2.0	2.0	2.0
General Fund	0	2,000,000	2,000,000	2,002,005	2,002,005
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0

Department of Human Services – Office of Children, Youth, and Families

Public Awareness Campaign for Child Welfare	1,004,037	973,211	1,014,397	1,014,397	1,014,397
FTE	1.0	1.0	1.0	1.0	1.0
General Fund	1,004,037	973,211	1,014,397	1,014,397	1,014,397
Cash Funds	0	0	0	0	0
Reappropriated Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Tony Grampsas Youth Services Program	9,155,126	9,889,296	11,867,673	11,902,072	12,092,536
FTE	3.0	3.0	3.0	3.0	3.0
General Fund	1,467,475	1,717,475	3,219,206	3,220,663	3,220,663
Cash Funds	7,190,652	7,701,467	8,148,639	8,180,643	8,371,107
Reappropriated Funds	496,999	470,354	499,828	500,766	500,766
Federal Funds	0	0	0	0	0

Appendix C. Sample Timelines

One main decision point that Colorado would have to consider is the overall complexity and timing of undertaking an 1115 HRSN program. As noted previously, it's not uncommon for states to spend 12+ months developing a waiver application. Prior to formally undertaking the development process, the Colorado General Assembly would need to pass legislation giving the Department of Health Care Policy and Financing the state authority to seek an 1115 waiver. Given this, an accelerated timeframe could be as follows:

- **Fall 2023**: Informal and exploratory conversations, internal prep for planning process, development of legislative proposal
- **Spring 2024:** Legislative session focused on passage of legislation authorizing 1115 waiver application. Negotiation with legislature over any key waiver components that would be required to be included, such as specific target populations and funding needs to include the state's share
- **Summer 2024**: Formal planning and stakeholder engagement
- **Fall/Winter 2024**: Draft waiver application
- **Winter 2024/2025**: Public Comment Period
- **Spring 2025**: Finalization and Submission
- **Summer/Fall 2025**: CMS review and negotiation
- **Winter 2025**: Approval and implementation launch

Because CMS has encouraged states to submit 1115 waiver requests to support HRSN using the 2022 framework as a reference, a waiver application that hews closely to this framework would presumably require less negotiation and could receive approval in a shorter timeframe. However, Colorado has a uniquely structured Medicaid program, and may require more adjustments to the CMS HSRN framework to successfully adapt the approach in the state.

Additionally, as shown in the timeframe above, it's a virtual certainty that a waiver would not complete the submission, review, and approval process before the end of the first term of the current administration. Even if submission could be accelerated, there are a number of states with major waivers already "in the queue" at CMS, and more to follow in the coming months, making it unlikely that CMS could work through the full approval process even if they were highly motivated to move quickly.

If there is a change in administration, there is the potential that CMS would rescind this framework and no longer approve these types of 1115 demonstration grants. CMS also may rescind the use of DSHP as was observed in the prior administration. This makes for a potentially high-risk effort, where a significant amount of work could be undertaken with no guarantee of a result.

Moreover, the previously referenced legislation, HB23-1300, requires the report on the expansion of waiver authorities to address health related social needs to be submitted by January 1, 2026. It would be understandable if the General Assembly was reluctant to grant authority for a waiver prior to reviewing that report. That would move the timing out by roughly two years, meaning that a waiver application would not be with CMS until 2027.

Another approach could potentially be for the General Assembly to provide authority for an HRSN 1115 waiver application, but without specified timing, or specified for submission by 2026 if the framework is

still in effect. This would allow for a "wait-and-see" approach to uncertainty around the 2024 Presidential election, but wouldn't require HCPF to wait until the 2025 session to receive authority, which would push submission into 2026 if not beyond.

Endnotes

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[iv] State Health and Value Strategies. "Recent updates to Section 1115 Waiver Budget Neutrality Policy: Overview and Implications for States." Prepared by Manatt Health. December 2022. https://www.shvs.org/wp-content/uploads/2022/12/SHVS_Recent-Updates-to-Section-1115-Waiver-Budget-Neutrality-Policy.pdf

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[xvi] https://hcpf.colorado.gov/arpa/project-directory/improve-access-for-underserved-populations#3.07

[xvii] https://oehi.colorado.gov/SHIE

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[xix] https://www.law.cornell.edu/definitions/uscode.php?width=840&height=800&iframe=true&def_id=42-USC-154841297-707478113&term_occur=999&term_src=title:42:chapter:7:subchapter:XIX:section:1396u%E2%80%932

[xx] SHO21-001. "Opportunities in Medicaid and CHIP to address social determinants of health. Page 33. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf

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