HB23-1300 Feasibility Study

Understanding the Health-Related Social Needs of Health First Colorado and CHP+ Members

JANUARY 9, 2026

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COLORADO
Department of Health Care Policy & Financing

COLORADO HEALTH INSTITUTE

To our community,

At the Colorado Department of Health Care Policy and Financing (HCPF), our mission is to improve health care equity, access, and outcomes for the people we serve, while saving Coloradans money on health care and driving value for Colorado. As Colorado's Medicaid agency, we recognize that our members' health depends on reliable access to health care as well as access to health-related social needs (HRSN). Stable housing and affordable food are an important piece of Coloradans' well-being, and we can play an important role in improving our members' access to HRSN services.

This study, directed by House Bill 23-1300 Continuous Eligibility Medical Coverage in 2023 and authored by the nonpartisan research organization, the Colorado Health Institute, examines the costs and benefits of continuous coverage for Medicaid populations, as well as the need, cost considerations, and evidence for HRSN services related to housing, food and nutrition, extreme weather, and social and community support, and for whom these services are most impactful. The study takes a broad look at services that were prioritized through conversations with service and health care providers, advocates, subject matter experts, Health First Colorado members, and with our peers in other state Medicaid programs. This study will serve as an important future resource to guide HCPF's decision making in expanding HRSN service coverage.

Since the passage of HB23-1300, the state and federal Medicaid financing and policy landscape has shifted significantly. The findings in the study remain important and useful for future exploration; however, these shifts have impacted HCPF's ability to implement new services and expand coverage options. At the time of publishing, Colorado is facing new financial and member coverage constraints due to the federal House Reconciliation bill (H.R. 1) passed in July 2025, which represents the most significant changes to Medicaid programs since the Affordable Care Act expansion in 2010. Much of the impact of H.R. 1 will be felt by the 375,000 Coloradans eligible through expansion who could lose coverage, generating negative downstream impacts on our health system and economy through high uninsured rates, uncompensated care, increased HRSN of members, and worsened health outcomes and a negative impact on our overall economy. On top of these changes, Colorado is facing a significant state budget shortfall and cuts to agency budgets due to unsustainable cost trends over the last few years impacting our ability to pursue expansions to our programs. While HCPF may not be immediately able to implement the services and recommendations outlined in this study, HCPF is committed to our North Star, which is protecting access to Medicaid by mitigating inappropriate coverage loss, as well as finding innovative and cost-effective ways to address the HRSN of Health First Colorado members. Strategic plans are found in our Sustainability Framework. As the study explains, effective implementation of these services requires more than simply choosing to offer them — HCPF will use the coming years to work closely with partners in the housing, food, climate, and social support space to build trust, shared language, and processes for future expansion. Guided by the evidence and data in this study, and our North Star of protecting access to and coverage by Medicaid, HCPF will continue to pave a path forward toward this work.

I want to extend my sincere gratitude to the people who contributed to this report, including the HB23-1300 bill sponsors and legislators who invested in this important work and the individuals and organizations who shared their insights through stakeholder meetings, conversation with HCPF's research team, ongoing participation in one of HCPF's advisory committees, or otherwise. Your voice is a critical piece of the evidence highlighted here, and we appreciate your contribution to this study and in any future work it may inform.

Thank you for your collaborative engagement, and continued commitment to our shared mission.

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Executive Summary

This study focuses on two topics — the feasibility of expanding Medicaid coverage of health-related social needs (HRSN) and the feasibility of extending continuous Medicaid eligibility, referred to as continuous eligibility, for additional children and adults. This study was mandated by House Bill 23-1300 (HB23-1300) Continuous Eligibility Medical Coverage directing the Colorado Department of Health Care Policy and Financing (HCPF) to examine the feasibility of extending continuous medical coverage for additional children and adults and to explore research related to HRSN expansion. HCPF contracted with the Colorado Health Institute (CHI) to collaboratively conduct the analysis, stakeholder engagement, and research to carry out this study.

The findings of this feasibility study will build on and inform ongoing initiatives at HCPF related to continuous eligibility and HRSN services. Implementation of initiatives is dependent on state and federal Medicaid policy, which has significantly changed since the passage of HB23-1300. Colorado is facing new financial and coverage constraints due to changes in guidance from the federal Centers for Medicare and Medicaid Services (CMS) regarding HRSN services and continuous eligibility and the federal House Reconciliation bill (H.R. 1) passed in July 2025. H.R. 1 changes are leading to significant budget reductions and potential loss of coverage for thousands of members. HCPF has published a Sustainability Framework to address these changes and to support our North Star of mitigating inappropriate coverage loss.

These changes will have downstream impacts, including increased HRSN of members and reduced opportunities for continuous eligibility expansions. While these policy changes have historically had federal support, guidance on HRSN in Medicaid services, especially in 1115 waivers, has changed significantly.

While HCPF may be unable to immediately implement recommendations in this report due to policy shifts as well as the state's own budget shortfalls, which reduce agency funding at a state level, ongoing work may include collaboration with partners in the HRSN space to plan for future expansion and to understand how new infrastructure like the Social Health Information Exchange fit in.

Addressing Health-Related Social Needs

This study examined the feasibility to implement HRSN services described in HB23-1300 and categorized into one of four domains:

- **Housing**
- **Food and nutrition**
- **Extreme weather**
- **Social and community support**

These services include those that support children and families, people experiencing homelessness, people impacted by natural disasters, people impacted by interpersonal violence (IPV), and other key populations defined in the legislation or through additional research.

CHI first identified services implemented in other states or communities, reviewed the need for these services in Colorado and evidence for them, identified appropriate and relevant data to estimate the cost of the service, and identified relevant populations to prioritize receiving these services. The following questions should be considered to ultimately determine which HRSN services to expand upon and/or implement:

- **Population Need.** To what extent does the Health First Colorado population need this service?
- **Stakeholder Prioritization.** To what extent do Health First Colorado members, providers, and community partners prioritize this service?
- **Cost.** Is the cost to implement reasonable and something HCPF can afford over the long term?
- **Evidence of Cost Savings or Avoidance.** Is there evidence to indicate implementing this service will lead to future cost savings or avoidance for HCPF?
- **Precedent to Implement.** Has HCPF or another state agency implemented this service and does the infrastructure and mechanism exist to do so?

Based on these factors, the following table summarizes how these criteria are met for each HRSN service domain. The green, yellow, and red boxes indicate whether that criteria is met for each domain holistically with high, medium, or low evidence, prioritization, cost, or precedent.

Service Domain	Population Need	Stakeholder Prioritization	Cost	Evidence of Cost Savings or Avoidance	Precedent to Implement
Housing	Medium	High	High	High	High
Food	High	High	Medium	High	High
Extreme Weather	High	Low	Low	Medium	Low
Social Support	High	Medium	Low	Low	Low

Finally, lessons learned from other states, from existing research, and from pilot interventions within Colorado highlight the following considerations:

- HRSN service implementation can lead to **cost savings** in the long term, but not in the short term.
- HRSN **service uptake** may vary by service; other states have seen greater participation in programs related to food and nutrition than services in other domains. Additionally, service uptake may start slowly but increase greatly over time.
- A **coordinated interagency infrastructure** is needed to effectively deliver HRSN services through Medicaid. This involves coordinated care navigation networks, data sharing agreements, and defined shared language and processes.
- **Trust building** between agencies, key stakeholders in different sectors, and Health First Colorado members is necessary to ensure the right services get to the right people.
- **Food distribution shows promise** and may be a good starting place for Colorado given existing programming, stakeholder prioritization, and available resources to inform and support implementation.

Expanding Continuous Eligibility

Continuous eligibility supports consistent medical coverage and continuity of care by keeping children and adults enrolled in Health First Colorado or Child Health Plan *Plus* (CHP+) regardless of the changes in their eligibility circumstances, such as income, that would otherwise cause them to lose their coverage. This study examines the feasibility of expanding continuous eligibility for specific scenarios as directed by HB23-1300. These scenarios are:

- **Scenario A:** Children ages 3 to 18 remain continuously eligible for 24 months after they are deemed eligible or until they turn 19 years old (Medicaid and CHP+).
- **Scenario B:** Children ages 3 to 5 remain continuously eligible until the child reaches 6 years old (Medicaid and CHP+).
- **Scenario C:** Eligible adults remain continuously eligible without regard to income for 12 months after they are first determined eligible.
- **Scenario D:** Eligible adults remain continuously eligible without regard to income for 24 months after they are first determined eligible.

Eligible adults, as defined in the HB23-1300 legislation, are those in any of the following categories:

- With incomes under 33% of the federal poverty level (or an income less than $5,165 per year for a single adult in 2025)
- Experiencing homelessness
- Who have been in community corrections, are on parole, or have been released from another carceral setting, including local or state jails or federal prison

Findings outlined in the report, including the cost to expand coverage for these groups, suggest prioritizing the following two populations for continuous eligibility expansion:

- **The youngest Health First Colorado members,** starting with ages under 3 up until the child's third birthday
- **Adults leaving state Department of Corrections (DOC) settings**

Continuous eligibility for these two populations was previously authorized by the federal government and then rescinded in 2025. Findings from this study affirm the evidence base and prioritization for reconsidering continuous eligibility expansion for these populations when federal authority permits this to continue.

Resources

Many HRSN services are already available to Health First Colorado members through different programs offered through HCPF. More information on current efforts, as well as updates on future work, are available on HCPF's HRSN webpage.

Background and Study Purpose

House Bill 23-1300 Feasibility Study

This study focuses on two topics — the feasibility of expanding Medicaid coverage of health-related social needs (HRSN) and the feasibility of extending continuous Medicaid eligibility, referred to as continuous eligibility, for additional children and adults. This study was mandated by House Bill 23-1300 (HB23-1300) Continuous Eligibility Medical Coverage directing the Colorado Department of Health Care Policy and Financing (HCPF) to examine the feasibility of extending continuous medical coverage for additional children and adults and to explore research related to HRSN expansion.[1] HCPF contracted with the Colorado Health Institute (CHI) to collaboratively conduct the analysis, stakeholder engagement, and research to carry out this study.

The findings of this feasibility study will build on and inform ongoing initiatives at HCPF related to continuous eligibility and HRSN services, including HCPF's current federal approval to operate the Expanding the Substance Use Disorder Continuum of Care Section 1115 demonstration waiver, referred to as the 1115 waiver.[2] For the purposes of this study, when considering services included in the current 1115 waiver implementation, CHI looked at expanding current HRSN services to additional populations and offering a more generous benefit design.

Regarding the continuous eligibility research covered in this study, CHI focused on populations beyond the ages of 0 to 3 years as outlined in the previously approved 1115 waiver amendment. Recent federal policy changes issued by the Centers for Medicare and Medicaid Services (CMS) in 2025 block implementation of the continuous eligibility components of the 1115 waiver. More detailed information on these changes is described in the Federal and State Policy Changes and Feasibility of Continuous Eligibility sections.

What Are Health-Related Social Needs (HRSN)?

HRSN are non-medical factors that influence a person's health and well-being. These factors include affordable and safe housing, nutritious and available food, consistent utilities, freedom from violence and discrimination, and health care availability, among others. Research has found that these factors can account for up to 55% of health outcomes.[3] State Medicaid agencies can help meet these needs by paying for services such as utilities or home-delivered meals, providing case management to connect members to social service providers, or investing in infrastructure to support the implementation and delivery of HRSN services.

Current federal administration guidelines shifted back to using the term social determinants of health rather than HRSN. The legislation required the term HRSN, so for the purposes of this study, this term will be used to denote these factors that influence a person's health and well-being.

Ongoing HCPF Initiatives to Address HRSN

Introduction

HCPF recognizes that HRSN play an important role in the health and well-being of Health First Colorado members and is exploring pathways to expand services and supports that address HRSN. HCPF's overarching goals in this space include understanding and supporting members' needs; improving short-term and long-term health outcomes; and partnering with the community to strengthen HRSN services offered through Health First Colorado and Child Health Plan *Plus*. By proactively addressing HRSN, payers, such as HCPF can reduce costs in the long term.

HCPF has ongoing and emerging initiatives to address the HRSN of Health First Colorado and CHP+ members, from studying the feasibility of expanding and refining services through this study and past feasibility studies, to reimbursing and paying for certain HRSN services to specific member populations, especially through its waiver programs.[4] A limited set of HRSN services is currently covered via the Medicaid State Plan and federally approved waivers, including the 1115 waiver, 1915(b)(3) non-Medicaid services waiver, 1915(c) home and community-based services (HCBS) waiver, Community First Choice, and Money Follows the Person. These existing services offered to waiver populations include tenancy-sustaining services, targeted case management for transition services, and home modifications. Current HRSN services are listed in Table 1.

Additional background on ongoing HCPF initiatives is described below.

HB24-1322 Feasibility Study

In June 2024, Governor Jared Polis signed House Bill 24-1322 (HB24-1322) into law, directing HCPF to assess the feasibility of seeking federal authorization to provide certain housing and nutrition services for Health First Colorado members. The resulting study, the HB24-1322 feasibility study, was published in December 2024 and the results have been used to inform 1115 waiver applications.[5]

CMS approved Colorado's Expanding the Substance Use Disorder Continuum of Care Section 1115 demonstration waiver (1115 waiver) effective January 1, 2021, through December 31, 2025. This demonstration ran for five years and provided the state with authority to provide high-quality, clinically appropriate treatment to participants with substance use disorders. Certain findings from the HB24-1322 feasibility study were incorporated into the 1115 waiver amendment described below. The

Table 1. Summary of Medicaid HRSN Services and Supports

This table lists HRSN services currently able to be funded through Medicaid. These services vary in the eligible population and when they will be operational. Actual service availability may vary depending on provider network and capacity.

Service Title	Money Follows the Person	State Plan	HCBS	Community First Choice 1915(k)	1915(b)	1115 Waiver
Home-Delivered Meals			●	●		● Future
Home Modification	●		●			
Medically Tailored Meals						● Future
Nutrition Counseling		● (under Physician Services)	●	●		● Future
One-Time Moving Costs				●		● Future
Pantry Stocking	●					● Future
Peer Support Services	●		●		●	
Pre-Tenancy and/or Tenancy Services	●				●	●
Rental Assistance	●			●		●
Short-Term Food Assistance	●					
Supportive Services			●	●	●	●
Targeted Case Management – Transition Coordination	●	●				●
Transition Set-Up			●	●		

amendment was submitted concurrently to the study drafting period.

Remaining items from the HB24-1322 study will be covered in this report. Specifically, this report will include a cost estimate for providing housing and pantry-stocking services to specific populations outlined under HB24-1322.

1115 Substance Use Disorder (SUD) Continuum of Care Waiver

In 2020, CMS approved a Colorado pilot initiative to provide high-quality, clinically appropriate treatment to members with substance use disorders. This initiative, referred to as Expanding the Substance Use Continuum of Care, was approved through a section 1115 demonstration waiver. CMS grants 1115 waivers to provide state Medicaid agencies authority to pilot innovative policies and programs intended to better serve Medicaid populations. HCPF submitted and was approved to implement expanded HRSN benefits for specific populations through an amendment to this 1115 waiver in August 2024. Implementation of the amendment was approved in January 2025.

HRSN Services

The pursuit of this 1115 waiver authority leveraged CMS's growing support for state Medicaid agencies to expand certain housing and nutrition-related services. The housing services covered under the 1115 waiver include case management for housing supports, pre-tenancy navigation services, tenancy-sustaining services, rental assistance, utility assistance, and one-time transition and moving costs. For eligible housing voucher recipients, the nutrition-related services covered under the 1115 waiver include nutrition counseling, home-delivered meals and pantry stocking, and medically tailored meals.

The populations eligible for these HRSN services through the current 1115 waiver are narrowly defined.[6] These populations include people who are eligible for:

- Permanent Supportive Housing (PSH) vouchers with a behavioral health need and/or chronic health condition. These vouchers are administered through the Department of Local Affairs (DOLA) for people with a disabling condition who are at risk of homelessness.
- Community Access Team (CAT) rental assistance. This program is administered by DOLA for people at risk of requiring a nursing facility level of care.
- Colorado Fostering Success (CFS) vouchers. This program is jointly administered by DOLA and the Colorado Department of Human Services (CDHS) for young adults ages 18 to 26 and who had prior experience with the foster care or kinship care system.

Continuous Eligibility

An additional amendment to the 1115 waiver —submitted in April 2024 and approved in November 2024 — sought approval for continuous eligibility for children from birth until they turn 3 and 12 months of continuous eligibility for adults ages 19-65 leaving a state Department of Corrections facility. Continuous eligibility provides Health First Colorado or CHP+ coverage regardless of changes in family income or household size.

In July 2025, CMS issued guidance notifying states that it will not approve new state proposals or extend existing approvals for 1115 waivers with continuous eligibility provisions.[7] This new policy blocks Colorado from implementing the continuous eligibility provisions of the 1115 waiver, which were previously approved to take effect in January 2026. This policy change does not impact the current policy of 12 months of continuous eligibility for members 19 and under, which is covered through the Colorado Medicaid State Plan, rather than through federal authority.[8]

Future of the 1115 Waiver

In December 2024, Colorado submitted a request to extend the existing 1115 waiver and proposed renaming the waiver to "Comprehensive Care for Colorado" beginning January 1, 2026. This extension requests no change to the existing SUD waiver authority and includes presumptive eligibility for long-term services and supports. Additionally, Colorado has requested that previously approved programs from past 1115 amendments, including those related to HRSN services, be incorporated into the overall 1115 waiver. At time of writing, this extension has been approved for 90 days through March 31, 2026. Further updates will be provided on HCPF's 1115 waiver webpage.

Federal and State Policy Changes

After the legislation directing this study passed in 2023, several federal policies have changed in a way that impacts future work.

Colorado House Bill 24-1322 (HB24-1322) Medicaid Coverage Housing and Nutrition Services directed HCPF to conduct a feasibility analysis of housing and nutrition services to expand through 1115 waivers, which led to a now approved amendment to the 1115 SUD waiver to provide certain housing and nutrition services.[9]

- In March 2025, CMS rescinded guidance from the Biden administration that outlined and encouraged the use of Medicaid authorities to address HRSN, including a 2023 HRSN framework published by CMS.[10]
- Passage of the 2025 federal budget reconciliation bill, H.R. 1, in July 2025 includes provisions that reduce the ability to implement some of the services described in this study.[11] The evidence base and cost analyses still stand, but this bill will affect potential implementation of services described in this study. Relevant parts of the legislation include the following:
    - States must establish Medicaid work requirements for the Affordable Care Act (ACA) Medicaid expansion population.
    - People eligible under the ACA expansion must have their Medicaid eligibility redetermined every six months versus the traditional 12 months.
    - States must verify members' citizenship before providing services supported by federal funding.
    - Changes to approval for budget neutrality for 1115 waivers. Additional guidance has not yet been provided on this change.

These federal changes will affect Colorado's ability to implement the services described in this study. However, the study's considerations, including the existing evidence base, cost methodology and estimates, and implementation, remain relevant despite these policy changes. Given these federal changes, HCPF has released a Colorado Medicaid Sustainability Framework to maintain focus on the department's North Star of mitigating inappropriate loss of Medicaid coverage from the impacts of federal House Resolution 1.[12]

Study Approach

Research Questions

This report addresses key areas of focus identified through HB23-1300. It also addresses specific items that were not previously evaluated in the HB24-1322 Feasibility Study. Because these two pieces of legislation define key populations of focus differently, they are addressed through separate research questions (RQ).

Health-Related Social Needs

Research questions 1 through 3 focus on items related to expansion of coverage for health-related social needs among the Medicaid population.

HB23-1300

This report defines the key populations as outlined by HB23-1300 and the related HRSN services to be studied. It then evaluates the feasibility of expanding HRSN services for these groups. Key research questions are:

- RQ1) How should key populations and HRSN services be defined?
- RQ2) What is the feasibility of expanding Medicaid and CHP+ services to address the HRSN of key populations?

HB24-1322

This report makes cost estimates for housing services and pantry stocking for key populations as outlined in HB24-1322. It uses key population definitions from the HB24-1322 Feasibility Study where available. The research question is:

- RQ3) What are the population definitions and cost estimates for providing Medicaid coverage of housing and pantry-stocking services to key populations?

Continuous Eligibility

Finally, the report evaluates continuous eligibility expansion for key populations outlined by HB23-1300. The research question for continuous eligibility is:

- RQ4) What is the economic and administrative feasibility of expanding continuous eligibility for Medicaid and CHP+ for key populations?

Research Framework

Key Population Selection

HB23-1300 lists key populations and risk factors for this feasibility study to consider. CHI estimated this population based on existing HCPF or state definitions for these populations and data availability. These populations serve as a starting point to identify the broadest possible need for different HRSN services. More details on key populations and their definitions are provided in the Feasibility of Expanding Health-Related Social Needs Services section.

Prioritized HRSN Population Estimates

To further refine the key populations to be relevant to specific HRSN services, CHI calculated the following population estimates:

- **Social Need Estimates.** Best estimate of the Health First Colorado population experiencing a specific HRSN.
- **Social and Medical Need Estimate.** Best estimate of the Health First Colorado population experiencing a specific HRSN **and** a medical need or risk relevant to the specific service.

Depending on the population and service being considered, the two estimates may be based on the same data source or multiple data sources. Appendix B details the sources of each estimate.

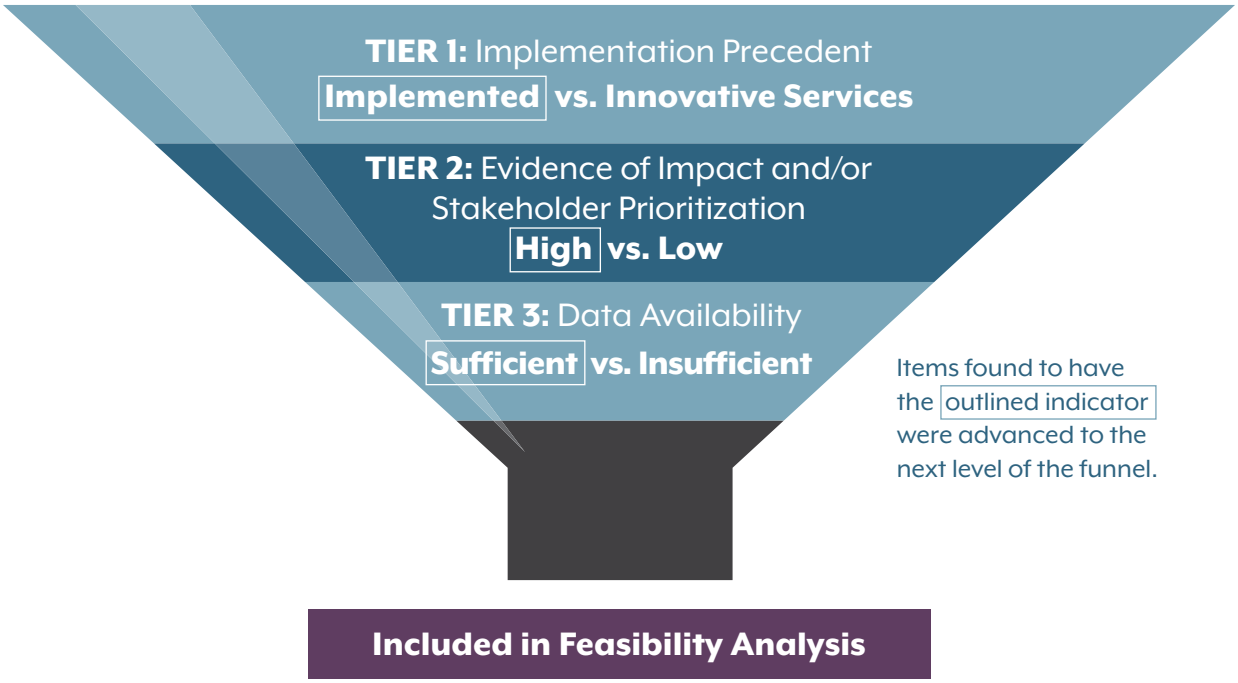
These estimates serve as a ceiling to the total number of Health First Colorado members who might be eligible for a specific service. Insights from other states suggest that uptake of specific HRSN services varies greatly depending on the service.

Full population estimates are available in Appendix B.

HRSN Services Identified for Analysis

CHI developed a prioritization framework to identify HRSN services for analysis and inclusion in the study, as described in Figure 1. A full feasibility analysis — which includes an evaluation of health impacts, relevant populations for eligibility, cost, and implementation considerations — was only

Figure 1. Feasibility Analysis Selection Funnel



conducted for services that have been implemented by Colorado or other state Medicaid programs, have a sufficient evidence base or high stakeholder prioritization, and have data available. HRSN services that did not meet these criteria may still be important to consider in the future, but they were not assessed in this study.

A full list of the services considered and more detail about this approach is available in Appendix C.

Continuous Eligibility Analysis

To estimate multi-year continuous eligibility costs, CHI reviewed existing approaches and methodologies used by other states to estimate these costs. Based on alignment with previous approaches used by HCPF and the practicality to conduct, CHI adapted a methodology developed and published in the Providing Multi-Year Continuous Enrollment to Medicaid and CHIP Populations: State Toolkit by State Health and Value Strategies.[13] Additional details are available in Appendix D.

Stakeholder Engagement

- External stakeholders served a critical role in informing, and ultimately prioritizing, the findings of this study. Stakeholders were engaged in the following ways:
  - Four large public meetings with Spanish and American Sign Language (ASL) interpretation — three of these meetings were held during the workday and one was held in the evening. Summaries of findings from these meetings are available on the HCPF website.[14]
  - Key informant interviews with state Medicaid agencies in Massachusetts, North Carolina, New York, and Illinois. These state Medicaid agencies were selected because they have existing 1115 waivers that included coverage of relevant HRSN services.
  - Participation in existing meetings including the HCPF Member Experience Advisory Committee and the Program Improvement Advisory Committee Provider and Community Experience Subcommittee.

  One-on-one meetings with advocates and subject matter experts in interpersonal violence, food and nutrition, and housing.

The HB23-1300 legislation mandated engaging with specific stakeholder groups. A full list of stakeholders engaged in these efforts is available in Appendix E.

Feasibility of Expanding Health-Related Social Needs Services

Key Population and HRSN Service Definitions

This feasibility study evaluates the possibility of expanding specific services for different target populations. The populations and services listed below serve as a starting point for further analysis.

Key Populations

HB23-1300 lists key populations for this feasibility study to consider. These populations are:

- Perinatal recipients, including those who are pregnant or up to 12 months postpartum
- Youth, 0-18, transitioning in and out of foster care
- Youth, 0-18, who are former foster care youth
- People with substance use disorders
- High-risk infants and children, which for this study is the estimated number of youth with an adverse childhood experiences (ACEs) score of 4 and above
- People earning low incomes, who for this study are defined as any Medicaid member, impacted by natural disasters such as wildfires, floods, or extreme temperatures
- People at risk of or experiencing interpersonal violence, which can include intimate partner violence or community-based gun violence
- People who are experiencing homelessness or at risk of homelessness
- People transitioning out of an emergency shelter, non-congregate shelter, or micro-community

The following populations listed in HB23-1300 are already eligible for HRSN services such as home modifications, peer mentorship, pre-tenancy, and food assistance through the Money Follows the Person (MFP) grant program, and will not be further examined in this study:

- People transitioning out of institutional care or a congregate setting
- People at risk of institutionalization

MFP is a federal grant program, through September 2027, that creates a path to community living for people living in Medicaid long-term care facilities. HCPF is currently implementing an MFP demonstration to expand services and supports available to people who wish to live in the community.

These populations serve as a starting point to identify who would benefit the most from different HRSN services. To estimate these populations, CHI used the best available data from HCPF administrative records, data from other state agencies, as well as data from national and state surveys to create broad estimates for these groups. Appendix A and Table 15 detail population size estimates and the relevant data sources used to construct the estimates. Information in Appendix B and Tables 16-19 further refines population estimates by calculating the number of Medicaid members in populations prioritized by stakeholders who have a social need (housing, food, etc.). All estimates used in this study should be considered approximate and an overestimate of the population that would receive benefits implemented in the future.

Prioritized HRSN Service Populations

To further refine these estimates for specific populations, CHI used the methods previously described in the Study Approach section. Like the estimates derived for the broader key populations, these estimates are approximations and, in most cases, are overestimates. Actual service uptake is likely to be lower than these estimates suggest. Future implementation should consider ways to screen eligible populations within these population estimates.

Services with sufficient evidence and/or stakeholder prioritization, and for which there is sufficient data to assess feasibility, are described below. Services as identified in HB23-1300 and through stakeholder engagement, are categorized into one of four domains: housing, food and nutrition, extreme weather needs, and social and community supports. Some services may address multiple domains or needs and are noted as such.

Housing Services

Need and Evidence Base

About one in seven Health First Colorado members (13.3%) experience housing instability, defined as worry about not having stable housing in the next two months, according to the 2025 Colorado Health Access Survey (CHAS).[15] Data from the CHAS also find that housing instability is correlated with poor mental and general health.[16] Based on data captured through the Colorado Homeless Management Information System, an estimated 53,000 Health First Colorado members in 45,000 households sought housing or services related to homelessness in 2024.[17] Of these households, 17% were family households (households with at least one adult 25 years of age or older and one youth under 18) or youth households (households where all members are 24 years of age or younger). Evidence suggests that a lack of stable housing can result in negative health outcomes — such as emergency department visits — and worsen existing conditions, while access to stable housing can mitigate these negative impacts.[18, 19]

Prioritized Services

CHI focused this research on services that support a member's safety, health, and well-being by ensuring they have a stable home in which to manage their physical, emotional, and mental health. These include both supportive services, housing assistance, and services that combine supportive services with housing assistance (i.e. permanent supportive housing).

The spectrum of housing-related services is diverse and ranges from preventing homelessness before it happens to intensive intervention with on-site case management. Additionally, while some services, such as permanent supportive housing, may be provided to individual members, many others are provided at the household level and would benefit everyone in a household, even if they are not Health First Colorado members.

Prioritized Housing Services

Supportive Services

- Pre-tenancy navigation and tenancy-sustaining services
- One-time transition and moving costs
- Utility assistance

Housing Assistance

- Transitional housing
- Short-term housing intervention with clinical services (medical respite)
- Rental assistance
- Permanent supportive housing

While services that improve housing quality are important and were raised by stakeholders in discussion of both housing and extreme weather-related services, they did not rise to the level of prioritization for this study. Additionally, many of these services, such as radon testing, are provided by other entities, such as municipalities or the Colorado Department of Public Health and Environment (CDPHE).[20] Other services, such as improving window insulation or other weatherizing options, vary significantly in delivery and cost. These services are documented in Appendix C.

Supportive Services

The services described below help people find and retain housing, but do not directly pay for a place to live. These services may be used on their own or can be coupled with lodging costs. Supportive housing interventions have a demonstrated impact on a person's ability to retain stable housing.

Housing insecurity is associated with high rates of potentially avoidable hospital admissions; research shows housing and supportive housing services are associated with reduced emergency and inpatient hospital admissions.[21] In the stakeholder engagement conversations conducted by CHI, stakeholders prioritized supportive services for people who are transitioning from one setting to another, including youth transitioning out of foster care, people leaving incarceration, and people leaving emergency shelters.

- **Pre-tenancy navigation and tenancy sustaining services.** Pre-tenancy refers to services that help people search and apply for housing, ensure units are safe and ready for move-in, and arrange move-in, as described in Colorado's 1115 waiver amendment.[22] Stakeholder interviews with peer-state Medicaid agencies suggest that forthcoming evaluations of pre-tenancy services will show promising results — indicating they are helpful and cost effective. Tenancy sustaining services, as described in Colorado's 1115 waiver amendment, include tenant rights education and eviction prevention.[23]
- **Targeted case management for housing supports** refers to coordination and planning services provided with, or on behalf of, a member. The member does not need to be physically present for this service to be performed if it is done on the client's behalf. These services are limited to service planning, advocacy, and linkage to other appropriate medical services related to identified member needs, monitoring, and care coordination.

Housing Assistance

The following housing assistance services help people regain or keep housing if they have lost it or are at risk of losing it. Similar to supportive housing services, stakeholders prioritized these services for youth and families of youth transitioning out of foster care, people leaving incarceration, and people leaving emergency shelters.

- **One-time transition and moving costs, including first-month's rent.** As described in the 1115 SUD Amendment Approval, these services include security deposits, first-month's rent, utility activation, and other one-time expenses such as the purchase of goods and furniture.[24] This service may be used in both cases of temporary or permanent housing provision.
- **Utility assistance.** Energy insecurity affects a person's ability to meet basic health needs, including the ability to cook and store healthy foods, charge important medical devices, and maintain safe temperatures within their home.[25] While utility assistance has limited evidence for its impacts, it may free up cash for other needs in low-income households. Evidence suggests that income supports may have greater health benefits compared to other social interventions.[26]
- **Transitional housing.** Transitional housing refers to temporary housing for households in need of support between an emergency shelter and permanent housing. Transitional housing is intended for individuals and families with a specific barrier to safe housing, like those whose living situation has been impacted by extreme weather or those impacted by interpersonal violence.[27]
- **Short-term housing intervention with clinical services** or **medical respite care** is acute and post-acute care for unhoused people who require a safe, short-term, residential care environment in which to recover from a medical event.[28] Housing services experts noted that clinical support is not necessary in certain situations, such as for people on oxygen who could benefit from a stable place to use, maintain, and store their medical equipment. Most respite models do include some level of clinical services, but as infrastructure grows, non-clinical respite care should be considered as a lower-cost option for a broader, less-acute population. These types of settings can include hotel or motel stays and may be coupled with other supportive services.

The following housing assistance services provide longer-term housing support and solutions to people facing the most barriers to stable housing, with the goal of keeping housed members in their homes. Stakeholders prioritized these services for different populations, including families with young children and people who have experienced chronic homelessness.

- **Rental assistance.** Evidence suggests that providing housing vouchers can lead to improved health and well-being outcomes. Data suggest that young children stand to gain the most from these programs through improved health outcomes, as well as improved educational attainment, employment, and income in their adulthood.[29] Colorado currently has authority

to cover rental assistance for up to six months, including utility costs, for certain eligible populations through Colorado's 1115 waiver amendment. This service is also described in the HB24-1322 Feasibility Study.[30]

- **Permanent Supportive Housing.** Permanent Supportive Housing (PSH) combines supportive services with housing assistance. It refers to a non-time limited housing model that provides quality, safe, affordable, and community-based housing in addition to access to other intensive supportive services. Robust evidence suggests that PSH improves housing stability and health care utilization. Results from Colorado's Statewide Supportive Housing Expansion pilot suggest these services build connections to health care through increased primary care and specialist visits, mental health outpatient care, and use of prescription medication.[31] The HB24-1322 Feasibility Study summarizes key findings on the impacts of PSH on reducing emergency department visits, as well as increasing access to other health care services such as outpatient behavioral health and prescription-filling.[32] PSH was evaluated in the HB24-1322 Feasibility Study. This study expands upon the previous study by evaluating cost for additional prioritized populations.

Prioritized Housing Services Populations

Table 2 provides estimates for populations prioritized for housing services through stakeholder engagement and research. Some of these populations may already be covered through other programs and benefits, while others have been identified through HB23-1300, best practices cited in research, or through stakeholder engagement (e.g. people experiencing interpersonal violence). The estimates in the first half of the table demonstrate the number of Medicaid members who need housing services. Below those, a second set of estimates are refined by considering possible prioritization that takes into account both housing and medical needs. For example, people experiencing homelessness are further refined by specific medical conditions that would make that population a priority for certain services such as respite care. Other populations, such as adults experiencing interpersonal violence, are not further parsed by a specific medical condition.

About Population Estimates for HRSN Services

Population estimates in this study are intended to quantify the total number of Medicaid enrollees who are experiencing a relevant HRSN. Unless otherwise noted, these estimates should be considered the ceiling of the number of members who experience a specific HRSN. These estimates provide context on the magnitude of Medicaid members who may need a service but do not incorporate expected utilization or supply and capacity limitations. For example, available housing supply in Colorado may limit the total number of Medicaid members who can access some of these services if implemented. These estimates are based on the best available data; however significant data gaps exist as HRSN screening is not routine for all Medicaid members. Some estimates are extrapolated based on available data about medical need or risk. If a service and population are prioritized for implementation, further consideration of appropriate screening tools and mechanisms is needed to further refine the population eligible for a service. Additionally, any future service expansion would include an authorization process to ensure appropriate utilization. More information about the estimates can be found in Appendix B.

These estimates are modeled on a combination of administrative data and survey data. These populations are not independent from each other, and people may appear in multiple rows or population categories. A full table of data sources used to estimate these population sizes is available in Appendix B.

Potential Service Costs

Table 3 displays the unit cost of prioritized housing services. A portion of the cost of implementing these services would be funded through both federal and state entities, however cost sharing is not explored in this study. Unit costs use relevant available codes from Colorado Medicaid where possible. If Colorado does not have a relevant billing code for the service, a similar billing code from another state is applied.

Table 2. Prioritized Population Estimates for Housing Services

Estimate of Colorado Medicaid members who are in each key population in a given year. People may appear in multiple rows. Data is based on the most recent year available for each population. See Appendix B, Table 16 for detailed information on sources and definitions used for these estimates.

Social Need		
Medicaid Population	**Medicaid Estimate**	**Prioritized Service Types**
People experiencing housing insecurity	145,000	Supportive Services, Housing Assistance
Adults experiencing housing insecurity with a child under 18 in the household	50,000	Supportive Services, Housing Assistance
Youth transitioning out of foster care	2,000	Supportive Services, Housing Assistance
People leaving incarceration	4,000	Supportive Services, Housing Assistance
People leaving emergency shelters	24,000	Supportive Services, Housing Assistance
Adults experiencing interpersonal violence	60,000	Housing Assistance
People experiencing homelessness	53,000	Housing Assistance
People who are chronically homeless	16,000	Housing Assistance
Social and Medical Need		
Medicaid Population	**Medicaid Estimate**	**Prioritized Service Types**
People experiencing housing insecurity who have a chronic condition	65,000	Supportive Services, Housing Assistance
Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household	26,000	Supportive Services, Housing Assistance
People leaving incarceration with a behavioral health condition	3,000	Supportive Services, Housing Assistance
People leaving emergency shelters with a disabling condition	12,000	Supportive Services, Housing Assistance
People experiencing homelessness with a disabling condition	26,000	Supportive Services, Housing Assistance
People experiencing chronic homelessness with a disabling condition	9,000	Housing Assistance
People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year	2,000	Housing Assistance

About Cost Estimates

This study supplies the unit cost of HRSN services, and broad population estimates, but does not model the actual total cost of service implementation. Modeling total costs includes considerations for actual service eligibility requirements and screening, utilization estimates, and potential supply and provider capacity limitations (e.g. availability of housing). Instead, this study provides the current unit cost of HRSN services, relevant population estimates for each service, and considerations around implementation costs and utilization from other states. Depending on future policy decisions around implementation priority and future service and service provider capacity, these population estimates can be further narrowed to better represent the true total cost of implementation for the relevant time and context. For future implementation, implementation cost should be considered in conjunction with potential cost savings to assess for budget neutrality. Specifically for services implemented through an 1115 waiver, state budget neutrality must be demonstrated over the five year period in which the waiver is active. Historically, CMS has only approved 1115 waivers if the project is determined to be budget neutral over the five-year implementation period of the demonstration. This means there would be no net increase in costs to the federal government when the demonstration is implemented, as well as neutral to the state's General Fund budget as well.[33]

Table 3. Unit Costs and Prioritized Populations of Housing Services

Service	Service Type	Cost	Prioritized Population with a Social and/or Medical Need
Pre-tenancy navigation services and tenancy-sustaining services	Supportive Service	Up to $552.94 per month depending on member need Source: HCPF Supportive Housing Services webpage	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • Adults experiencing interpersonal violence
Targeted Case Management for Housing Supports	Supportive Service	Up to $106.32 per month depending on member need Source: HCPF Supportive Housing Services webpage	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • Adults experiencing interpersonal violence
Utility Assistance	Housing Assistance	Dependent on member housing type and size, the utilities and appliances in a member's home, and utility costs per region e.g. Medicaid would cover $389 per month in utility assistance for a member living in a two-bedroom apartment in Denver Source: Colorado Division of Local Affairs Payment Standards, Utility Allowances, and Income Limits	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • Adults experiencing interpersonal violence
One-time transition and moving costs, including first-month's rent	Housing Assistance	Dependent on member's county of residence e.g. Medicaid would cover $1,100 in one-time transition and moving costs other than rent for a member moving to Denver County and the additional cost of one month's rent described under rental assistance. Source: Colorado Medicaid Code T2038	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year • Adults experiencing interpersonal violence

Table 3 Continued.

Service	Service Type	Cost	Prioritized Population with a Social and/or Medical Need
Transitional Housing	Housing Assistance	$96.26 per day Source: Arizona Medicaid Code H0043	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year • Adults experiencing interpersonal violence
Short-term housing intervention with clinical services, or medical respite care	Housing Assistance	Dependent on member county of residence e.g. In Denver County, Medicaid will cover $2,147 toward the cost of short-term housing Source: Colorado Medicaid Code T2032	• People experiencing housing insecurity who have a chronic condition • Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household • People leaving incarceration with a behavioral health condition • People leaving emergency shelters with a disabling condition • People experiencing homelessness with a disabling condition • People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year
Rental Assistance	Housing Assistance	Dependent on member county of residence. e.g. Medicaid would cover $2,147 a month in rental assistance for a member living in a single-bedroom apartment in Denver County Source: Colorado Medicaid Code T2032	• People experiencing chronic homelessness with a disabling condition • People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year
Permanent Supportive Housing	Housing Assistance	Covered HRSN services for permanent supportive housing includes: targeted case management for housing supports, pre-tenancy and housing transition navigation services, one-time transition and moving costs, and rent/temporary housing up to six months, including utility costs. e.g. Medicaid could cover $552.94 per month for pre-tenancy/tenancy support and $2,147 a month in rental assistance for a member living in a single-room apartment in Denver County. Source: HCPF Supportive Housing Services webpage	• People experiencing chronic homelessness with a disabling condition • People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year

CASE STUDY: **North Carolina**

Examples from HRSN services in other states provide insight into the potential costs in the first years of implementation. In 2022, North Carolina implemented a suite of housing services through its Health Opportunities Pilot (HOP) along with a broad suite of HRSN services, including food, transportation, interpersonal safety, and cross-domain services.[34] The housing services included housing navigation, support, and sustaining services; essential utility set up; move-in support; and home remediation, safety and quality inspection, or accessibility and safety. In the first 20 months of operation, the HOP delivered about 22,000 housing services to about 6,000 Medicaid members, costing roughly $12 million. North Carolina's Medicaid program currently has roughly 2.6 times more members than Colorado's.[35] Initial evaluation findings show that North Carolina's HOP was successful at reducing housing needs of participating members.[36] While North Carolina's Medicaid program differs from Colorado's in many important ways (benefit offerings, payment, and administration), the HOP pilot can serve as an example for housing-related HRSN service implementation for Colorado.

Impact on Cost and Possible Savings

Research and evidence are clear that lack of stable housing has negative impacts on health, driving up medical spending. Inversely, certain housing interventions, such as PSH, are supported by robust evidence that shows these services reduce hospitalizations, hospital bed days, ambulance trips, detox visits, and their associated costs. In one analysis, the average cost reduction for these medical services was estimated to be $35,000 per person per year.[37]

Implementation Considerations

The Division of Housing in the Department of Local Affairs (DOLA) has a long history of funding high-quality supportive housing and related services. Its 2024 report illustrates key findings from the past decade of implementing various services across the state. For example, most households receiving supportive housing (94%) consistently maintain permanent housing after one year.[38] By implementing services through the 1115 waiver, HCPF and DOLA laid the groundwork for collaboration. The HB24-1322 Feasibility Study names specific provider types and service settings that continue to be critical partners in implementation, including case management agencies, transition coordination agencies, supportive housing providers, homeless service agencies, and individual providers for resources like peer services, skill building, and home modifications.

Colorado's tightening rental market is a key barrier to providing housing services. The DOLA report highlights the increasing delay between when someone begins accessing housing services and move-in.[39] The Colorado Homeless Management Information System (COHMIS) 2024 State of Homelessness Report also notes that a low supply of affordable housing is a barrier to addressing homelessness.[40] These infrastructure challenges will continue to be a key driver of both service demand as well as the implementation costs and the ability to meet demand.

Many current housing initiatives, such as those described through DOLA, are intended for people with acute medical and social needs. While this population should remain a priority, stakeholders also noted the importance of housing services for families, particularly families of young children. These situations may require access to additional types of housing units that accommodate larger household size. In some cases, these families may benefit from shorter-term supports, such as one-time moving costs or pre-tenancy supports, rather than higher intensity interventions like PSH.

Additionally, many stakeholders emphasized and prioritized the importance of both short-term housing with and without clinical intervention, or respite service, and end-of-life accommodations for the unhoused population. A number of respite, also known as recuperative care, sites already exist in Colorado and can be further expanded upon to accommodate people experiencing different levels of acuity who do not need medical respite, but could still benefit from non-clinical respite care. Lessons learned from existing pilots can inform future respite service expansion.[41] While hospice services are currently covered by Health First Colorado, in many cases, people experiencing homelessness would prefer to receive these services outside a traditional clinical or shelter setting.[42] While these types of settings are not common in Colorado, local organizations, such as Rocky Mountain Refuge, can serve as a model to scale up. As these settings become more widely available, they should be considered for future HRSN coverage.

Food and Nutrition Services

Need and Evidence Base

Nearly a quarter of Health First Colorado members (21.5%) experience food insecurity, defined as a person eating less than they thought they should due to affordability issues, according to the 2025 CHAS.[43] Food insecurity was more common in rural farming and ranching communities in the state, as well as among Coloradans who identified as nonbinary or another gender, Coloradans who speak a language other than English, and Hispanic or Latino Coloradans.[44] The survey also found that food insecure Health First Colorado members were twice as likely to report fair or poor general health as Health First Colorado members who were food secure, and 1.6 times as likely to report poor mental health.[45] Food insecure adults are at higher risk for chronic diseases.[46] Children experiencing food insecurity may be at risk for several negative health outcomes, including poor mental health.[47] CDPHE's 2025-2029 State Health Improvement Plan includes strategies to improve access to healthy nutrition for adults and children through education, policies, practice, and environmental changes.[48]

Prioritized Services

CHI's research focused on food and nutrition services that support members' health and well-being by ensuring they have access to nutritious food. HCPF has conducted extensive past stakeholder engagement on nutritional supports as part of the 1115 waiver and previous feasibility studies. As a result, CHI considered possible expansions of nutrition services covered through the existing 1115 waiver (such as nutrition counseling and education, medically tailored meals, pantry stocking, or home-delivered meals) in alignment with the parameters set by HB23-1300. Additionally, the Colorado Department of Human Services (CDHS) operates a number of critical food assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) for low-income families; Everyday Eats, a food support program for qualifying Coloradans ages 60+; home-delivered meals; and congregate meals for older adults in partnership with local Area Agencies on Aging.[49] CHI considered additional services that could be prioritized for these populations beyond those currently offered to provide more robust food and nutrition support, and considered additional populations, such as adults impacted by interpersonal violence.

Prioritized Food and Nutrition Services

- Home delivered meals
- Pantry stocking
- Medically tailored meals
- Produce prescription programs
- Nutrition counseling and instruction

Stakeholders offered suggestions and considerations for implementation of these services, mostly focusing on the individual eligible for services. In the community, meals are often consumed in a communal way whether at home or in a recreational setting, and stakeholders pointed out that offering food services to just one member of the household fragments the benefits of family meals.[50] Opportunities regarding communal meals are described in the Social and Community Support section of this study.

Services reviewed in this study are categorized as direct food provision or educational services. Populations that are prioritized for services include food-insecure members (i.e. people who currently eat less than they thought they should because they could not afford food) with diet-sensitive medical conditions which include Type 2 diabetes, HIV/AIDS, heart failure, chronic liver disease, cancer, end stage renal disease, hemodialysis, Chronic Obstructive Pulmonary Disease [COPD], hypertension, or hyperlipidemia). This report also prioritizes households with children with diet-sensitive medical needs and people transitioning out of institutional or congregate living situations.

Food Provision and Delivery

Food is Medicine is an approach to provide consistent, nutritious foods to households to improve health outcomes.[51] Many food advocates in Colorado and other states have developed resources to incorporate a Food is Medicine approach into health care and other settings. For example, the Aspen Institute's 2024 Food is Medicine Action Plan includes affordable and accessible food provision as a critical component of a Food is Medicine approach.[52] Evidence indicates that providing nutritious food can support both

primary prevention as well as treatment and management of specific health conditions. The services below consider both clinical needs, as supported by this research, and social needs.

- **Home-delivered meals** are fully prepared, ready-to-eat, meals delivered directly to a member's home address. These are standardized meals that are not typically connected to an individual's health conditions and specific nutrition needs. These meals are shown to improve health outcomes and reduce readmission rates, emergency department visits, and inpatient hospitalizations. Home-delivered meals are particularly effective for people who are unable to physically go to a grocery store due to access or ability, such as older adults or disabled adults.[53]
- **Pantry stocking** allows a member to purchase an assortment of foods to cover initial pantry stocking at move in. In Colorado's 1115 waiver application, eligible individuals may access either pantry stocking or the home-delivered meals benefit, though pantry stocking is often categorized with home-delivered meals in research studies. One-time moving costs, described in the Housing Services section, also include pantry stocking.
- **Medically tailored meals** are fully prepared meals designed by registered dietician nutritionists (RDNs) to address an individual's medical diagnosis, symptoms, allergies, and medication side effects. Data suggest that medically tailored meals may improve health outcomes and reduce readmission rates, emergency department visits, and inpatient hospitalizations.[54]
- **Produce prescription programs** can vary in definition based on the food a program might have access to but typically source products from commercial food retailers and farmers markets, which serve as access points to these programs. These programs may increase self-reported health status and other biomarkers associated with improved health, such as blood pressure and body mass index.

Food and Nutrition Education and Counseling

- **Nutrition counseling and instruction** includes any combination of educational strategies designed to motivate or facilitate voluntary adoption of food choices or nutrition behaviors that improve health and well-being. These services may also include meal preparation guidance. Evidence suggests nutrition counseling can benefit pregnant people as well as those with diabetes or other chronic diseases.[55, 56, 57]

Stakeholders also noted the importance of case management and connections to food and nutrition resources as a high-impact service, particularly with federal changes to SNAP and SNAP-Ed programs which are managed at a state level by other agencies. Regional Accountable Entities (RAEs), organizations that help arrange care for Health First Colorado members, are responsible for connecting members to relevant agencies and organizations and may support enrollment in food programs. Future value-based or medical home payments could incentivize referrals to nutrition benefits or services as part of a model to support primary care providers and RAEs in strengthening these connections for members. Coordinating closely with other state agencies, case management organizations, or community-based organizations may streamline case management, system enhancements, and service awareness of Food is Medicine-aligned supports.

Prioritized Food and Nutrition Services Populations

Table 4 provides estimates for populations prioritized for food and nutrition services through stakeholder engagement and research. Some of these populations may already be covered through other programs and benefits, while others have been identified through the HB23-1300, best practices cited in research, or through stakeholder engagement.

Potential Service Costs

Table 5 displays the unit cost of prioritized food service. A portion of the cost of implementing these services would be funded through both federal and state entities, however cost sharing is not explored in this study. Unit costs use relevant available codes from Colorado Medicaid where possible. If Colorado does not have a relevant billing code for the service, a similar billing code from another state is applied.

Table 4. Prioritized Population Estimates for Food Services

Estimate of Colorado Medicaid members who are in each key population in a given year. Data is based on the most recent year available for each population. See Appendix B, Table 17 for detailed information on sources for these estimates.

Social Need		
Medicaid Population	**Medicaid Estimate**	**Prioritized Services**
People experiencing food insecurity	248,000	All food services
Children experiencing food insecurity	38,000	All food services
Older adults (65+) experiencing food insecurity	12,000	Home-delivered meals, nutritional counseling and education
People with disabilities experiencing food insecurity	111,000	All food services
Youth transitioning out of foster care	2,000	All food services
People leaving incarceration	4,000	All food services
Adults experiencing interpersonal violence	60,000	All food services
Social and Medical Need		
Population	**Medicaid Estimate**	**Prioritized Services**
Adults experiencing food insecurity with a diet-sensitive condition	75,000	All food services
Youth ages 0-20 experiencing food insecurity with a diet-sensitive condition	2,000	All food services
Older adults (65+) experiencing food insecurity with a diet-sensitive condition	5,000	All food services

CASE STUDY: **Massachusetts**

In 2020, Massachusetts' Medicaid program launched a pilot program to address food and housing insecurity under its 1115 waiver, called the Flexible Services Program. The program provided food services including medically tailored meals; home-delivered meals; food boxes or groceries; produce prescriptions, food vouchers, or gift cards; kitchen supplies; connection to community food pantries or federal nutrition program application assistance; and nutrition education. From 2020 through Q1 of 2023, the program provided over 82,000 services to almost 30,000 unique members — with food services accounting for the majority of services delivered.[58] From 2020 through Q1 of 2023, the Flexible Services Program demonstrated a 23% reduction in hospitalization and a 13% reduction in emergency department visits. In 2021, Massachusetts spent $22.6 million on its Flexible Services supports; this doubled to $52.4 million in 2022. Massachusetts' Medicaid program enrollment is roughly 1.7 times larger than Colorado's.[59]

Impact on Cost and Savings

Broadly, the Food is Medicine approach has the potential to reduce hospital admissions and decrease treatment costs for chronic conditions. Studies suggest that if implemented nationally, this approach could avert 1.6 million hospitalizations and save $13.6 billion in health care costs in the first year, including $5.7 billion for Medicaid patients.[60] Other state Medicaid agencies that offered nutrition programs saw a reduction in health care spending resulting from reduced hospitalizations and emergency department visits. Data from Massachusetts found that adults enrolled for more than 90 days lowered their health care costs by $2,502 per member over the entire study period. A cost reduction was not found among children, though these outcomes may not be realized during the study period.[61] In North Carolina, HRSN services were associated with a reduction in spending over time, estimated at $85 per member per month.[62]

Table 5. Unit Costs and Prioritized Populations of Food Services

Service	Service Type	Cost	Prioritized Population with a Social and/or Medical Need
Home-delivered meals	Food Provision and Delivery	$12.58 per meal, capped at $4,579.00 e.g. Medicaid would cover $1,132.20 to provide a member with three home-delivered meals a day for 30 days. Source: Colorado Medicaid Code S5170 U1	• Adults experiencing food insecurity with a diet-sensitive condition • Children experiencing food insecurity with a diet-sensitive condition • Older adults (65+) experiencing food insecurity with a diet-sensitive condition • Adults experiencing interpersonal violence
Pantry stocking	Food Provision and Delivery	Up to $500 per person for 30 days of food Source: Colorado Medicaid Code S5170 U2	• Adults experiencing food insecurity with a diet-sensitive condition • Children experiencing food insecurity with a diet-sensitive condition • Older adults (65+) experiencing food insecurity with a diet-sensitive condition • Adults experiencing interpersonal violence
Medically tailored meals	Food Provision and Delivery	$20.50 per meal, capped at $7,380.00 e.g. Medicaid would cover $1,845.00 to provide a member with three medically tailored meals a day for 30 days. Source: Colorado Medicaid Code S5170 U3	• Adults experiencing food insecurity with a diet-sensitive condition • Children experiencing food insecurity with a diet-sensitive condition • Older adults (65+) experiencing food insecurity with a diet-sensitive condition
Produce prescription programs	Food Provision and Delivery	Up to $83.33 per month Source: Washington Medicaid	• Adults experiencing food insecurity with a diet-sensitive condition • Children experiencing food insecurity with a diet-sensitive condition • Older adults (65+) experiencing food insecurity with a diet-sensitive condition
Nutrition counseling and instruction	Food and Nutrition Education and Counseling	$14.14-$32.97 per 15-30 minutes depending on the member Source: Colorado Medicaid Codes S9452, 97802-97804, G0447	• Adults experiencing food insecurity with a diet-sensitive condition • Children experiencing food insecurity with a diet-sensitive condition • Older adults (65+) experiencing food insecurity with a diet-sensitive condition

Implementation Considerations

Community stakeholders shared considerations for implementing these services. First, where possible, HCPF should use vendors who prioritize sourcing local and fresh produce and meats to address nutrition and climate sustainability concerns. Second, stakeholders also recommended that food vouchers, such as those provided for the pantry-stocking benefit, include vouchers that can be redeemed at local farmers markets and grocers in addition to prepaid cards for national supermarket chains. Third, stakeholders raised the importance of culturally responsive food options and education. Data from the 2025 CHAS found that Hispanic and Latino Coloradans experience food insecurity at rates more than double that of non-Hispanic/Latino white communities.[63] These findings further emphasize the value of culturally relevant foods, communication, and related resources. Resources from the Provecho Collective can help support a community-centered approach that prioritizes local and culturally relevant partnerships to address food insecurity.[64]

Finally, at the time of writing, many resources exist to support states in implementing Food is Medicine interventions through Medicaid, including Food is Medicine: A State Medicaid Policy Toolkit.[65] These frameworks, along with learnings from pilot programs in Colorado and other states, can help support implementation through different policy levers and mechanisms.

Extreme Weather

Need and Evidence Base

The HB23-1300 legislation requests consideration for the needs of low-income individuals impacted by natural disasters. This study examines relevant services for Medicaid members at risk of extreme weather events, which refers to both natural disasters, such as wildfires and floods, as well as extreme temperatures, such as heat waves and cold snaps.

Broadly, the vast majority of Medicaid members in Colorado live in a region at risk for some form of extreme weather. Based on existing resources developed by the U.S. Census Bureau, approximately 1 million Medicaid members live in one of the 31 Colorado counties that experience extreme heat and Federal Emergency Management Agency (FEMA) analysis estimates that 1 million Medicaid members live in one of 14 Colorado counties at risk of extreme cold weather (see Appendix B).

More specifically, half of adult Health First Colorado members (50.1%) say the changing climate has affected their health or their family's health, according to the 2025 CHAS.[66] Of this group, 29.0% report impacts on respiratory health and breathing, 10.8% report a worsening chronic illness, 9.9% report heat-related impacts like heat illness, stress, or stroke. CDPHE's State Health Improvement Plan includes strategies to address extreme heat, including improving access to in-home solutions.[67]

The State Health Improvement Plan also includes strategies for dealing with wildfire smoke, including in-home solutions such as air purifiers. While there is precedent for state Medicaid programs to cover the cost of in-home air filters, stakeholders did not set this as a priority for this study.[68] Stakeholders noted efforts by other government entities and local programs to address wildfire smoke. High-quality air conditioning units, which are examined in this study, may have the added benefit of mitigating the health effects of wildfire smoke, though the evidence is limited.[69]

Prioritized Extreme Weather Services

- Air conditioning
- Heating
- Mini fridges
- Utility assistance
- Portable power supply

Prioritized Services

For this study, CHI focused on services that help maintain or improve a member's health during an extreme weather event. Stakeholders prioritized services or products that help maintain safety and comfort during extreme temperatures, as well as services or items that help maintain access to medication and other basic needs during a power outage.

Extreme Temperature Mitigation

Heat is associated with increased mortality and morbidity, adverse pregnancy outcomes, and poor mental health.[70] Both excessive heat and cold have been found to increase medical costs, as well as lower economic productivity, resulting in compounded economic costs.[71] Populations prioritized for these services include people who live in parts of the state that are more severely impacted by extreme temperatures and who have medical conditions that may be worsened by extreme temperatures.

- **Air Conditioning.** Access to air conditioning plays a role in reducing heat-related mortality.[72] Pregnant people, youth with asthma, or adults with chronic health conditions are at highest risk for heat-related impacts.[73] Research suggests that some drug classes may make people more susceptible to heat.[74] While people taking these medications are not included in this study, they might be considered in the future.
- **Heating.** Cold weather can exacerbate certain medical conditions such as cardiovascular disease and asthma. Older adults are more susceptible to health impacts from cold weather.[75] Additionally, without safe heating sources, some people may choose to use

unsafe options such as ovens, stoves, or fuel-burning appliances, which may worsen air quality and put the household at risk of fire or carbon monoxide poisoning.[76] Heating options are important for both people who may experience a loss of heat during an emergency and for those without shelter. For unhoused people, stakeholders emphasized the need for tent-safe heating devices to avoid the risk of tent fires.[77] Reducing these hazards can reduce the risk of related injuries or deaths.

- **Mini Fridges.** Refrigeration units are intended to help people with a health condition store temperature-sensitive medication in variable temperature climates. Certain medications, like insulin, may not be as effective unless they are kept within the manufacturers' recommended temperature range. Data shows that insulin storage in home refrigeration may be inconsistent since home refrigerators may vary in quality or in the temperature in which they are kept due to daily use and wear and tear. This may pose a risk to insulin quality.[78]
- **Utility Assistance.** Financial assistance can offset the cost of running utilities like air conditioners or heaters which are needed for protection against hazardous temperatures. This service may be offered in conjunction with provision of air conditioning or heating to encourage use and appropriate temperature maintenance. The Colorado Low-income Energy Assistance Program (LEAP), run through CDHS, is a federally funded program that helps low-income Coloradans pay a portion of their winter home heating costs.[79] While most Medicaid members would likely be eligible for this program, this study proposes expanding utility assistance to also cover cooling costs and to more robustly cover the cost of utilities, particularly for households who may use heating or cooling more frequently due to additional risk factors.

Natural Disaster and Emergency Response

Power outages from both natural disasters and increased stress on the power grid during extreme temperatures or poor air quality events are likely to increase due to continued climate changes. A lack of electricity puts people's health at risk, especially for those who depend on vital, electricity-dependent medical equipment or refrigeration to safely store medication or other critical supplies.[80]

- **Portable power supply.** People using electricity-dependent durable medical equipment (DME) — such as oxygen concentrators, infusion pumps, and mobility devices — may risk serious health consequences during power outages that last eight hours or longer, when battery life often runs out.[81] Portable power supplies can also help maintain access to necessary refrigerated food and medications during a power outage.

Housing and Housing-Related Services

Stakeholders noted certain housing services may be relevant to people affected by extreme weather — specifically transitional housing for people with homes that were lost or damaged by a natural disaster and utility assistance for people living in areas prone to extreme heat or cold. Both services are described in the Housing Services section.

Additionally, some stakeholders noted that specific housing quality services like mold remediation and weatherization are important for people affected by extreme weather. These services are listed in Appendix C.

Prioritized Extreme Weather Services Populations

Table 6 provides estimates for populations prioritized for extreme weather services through stakeholder engagement and research.

Potential Service Costs

Table 7 displays the unit cost of prioritized extreme weather services. A portion of the cost of implementing these services would be funded through both federal and state entities, however cost sharing is not explored in this study. Unit costs use relevant available codes from Colorado Medicaid where possible. If Colorado does not have a relevant billing code for the service, a similar billing code from another state is applied. All costs for extreme weather services involving a device installed in the home include the associated shipping and delivery costs.

Table 6. Prioritized Population Estimates for Extreme Weather Services

Estimate of Colorado Medicaid members who are in each key population during a given year. Data is based on the most recent year available for each population. See Appendix B, Table 18 for more detail and information on sources for these estimates.

Social Need		
Medicaid Population	**Medicaid Estimate**	**Prioritized Services**
People who are exposed to extreme heat	1.07 million	Extreme Temperature
People who are exposed to extreme cold	1.06 million	Extreme Temperature
Households without air conditioning	84,000	Extreme Temperature
Households without heating	13,000	Extreme Temperature
People who live in the counties with the highest extreme weather risk (Adams, Arapahoe, Denver, El Paso, Jefferson, and Larimer)	890,000	Natural Disaster and Emergency Response
Households experiencing homelessness	45,000	Extreme Temperature, Natural Disaster and Emergency Response
People who are unsheltered	3,000	Extreme Temperature, Natural Disaster and Emergency Response
Social and Medical Need		
Medicaid Population	**Medicaid Estimate**	**Prioritized Services**
Families with a member who experienced the worsening of a chronic illness due to climate change	69,000	Extreme Temperature
Families with a member who experienced heat illness, stress, or stroke due to climate change	64,000	Extreme Temperature
Households without heating that have a member with a chronic condition	7,000	Extreme Temperature
Households without heating that have an older adult member	4,000	Extreme Temperature
Households experiencing housing insecurity with a member with a disabling condition	23,000	Extreme Temperature, Natural Disaster and Emergency Response
Adults with electricity-dependent medical equipment	223,000	Natural Disaster and Emergency Response
People with medication that requires temperature control	89,000	Extreme Temperature

Case Study: Oregon

In 2024 Oregon implemented a climate-focused home modification program called HRSN Home Changes for Health.[82] The program provided devices such as air conditioners, heaters, air filters, mini fridges, and portable power supplies. In the first five months of operation, the program delivered 3,600 home health devices to more than 2,000 Medicaid members, costing about $12 million. Overall, air conditioners were the most common device delivered (46% of total device count). About 28% of the Oregon Medicaid members who received devices were age 65 or older, and 67% of members who received devices were homeless or at risk of becoming homeless (this data cannot be ungrouped, but the majority were likely at risk of becoming homeless).[83] Oregon's Medicaid enrollment is roughly 10% higher than Colorado's.[84]

Table 7. Unit Costs and Prioritized Populations of Extreme Weather Services

Service	Service Type	Cost	Prioritized Population with a Social and Medical Need
Air Conditioning	Extreme Temperatures	$680 per air conditioning unit Source: Oregon Medicaid Code S5165	• Families with a member who experienced the worsening of a chronic illness due to climate change • Families with a member who experienced heat illness, stress, or stroke due to climate change • Households without heating that have a member with a chronic condition • Households without heating that have an older adult member • Households experiencing housing insecurity with a member with a disabling condition
Heating	Extreme Temperatures	$290 per heating unit Source: Oregon Medicaid Code S5165	• Families with a member who experienced the worsening of a chronic illness due to climate change • Families with a member who experienced heat illness, stress, or stroke due to climate change • Households without heating that have a member with a chronic condition • Households without heating that have an older adult member • Households experiencing housing insecurity with a member with a disabling condition
Mini Fridges	Extreme Temperatures	$170 per mini fridge Source: Oregon Medicaid Code S5165	• People with medication that requires temperature control
Utility Assistance	Extreme Temperatures	Dependent on member housing type and size, the utilities and appliances in a member's home, and utility costs per region. e.g. Medicaid would cover $389 per month in utility assistance for a member living in a two-bedroom apartment in Denver, using bottle gas as a heat source and other typical household appliances and utilities Source: Colorado Division of Local Affairs Payment Standards, Utility Allowances, and Income Limits	• Families with a member who experienced the worsening of a chronic illness due to climate change • Families with a member who experienced heat illness, stress, or stroke due to climate change • Households without heating that have a member with a chronic condition • Households without heating that have an older adult member • Households experiencing housing insecurity with a member with a disabling condition • People with medication that requires temperature control
Portable Power Supply	Natural Disaster and Emergency Response	$1,590 per portable power unit Source: Oregon Medicaid Code S5165	• Adults with electricity-dependent medical equipment • People with medication that requires temperature control

Impacts on Cost and Savings

A 2021 pilot by Kaiser Permanente in Oregon and southwest Washington found that providing air conditioning to 81 patients prevented $42,000 in heat-related emergency department use and $400,000 in hospital admissions, an average of $5,000 per person annually.[85]

Additional data on cost and savings impacts for these services is limited. The Oregon Health Authority launched its climate benefit in March 2024. Annual reporting published in late 2024 found that air conditioners were the most frequently delivered device as part of this benefit, but cost and outcome data were not yet available.[86] Other state Medicaid programs include these services as part of a general "home modification" or other service bundle, and data on the impacts of these services as discrete interventions is not readily available.[87]

Implementation Considerations

State Medicaid agencies have taken different approaches to providing extreme weather-related services. Many states, including Massachusetts and North Carolina, provide similar services under a home modification or healthy home initiative, rather than a distinct climate-focused initiative, as is the case in Oregon. Regardless of how these services are implemented, they will require new partnerships with organizations that provide the services and supplies necessary. Colorado has many stakeholders across a broad spectrum of industries, expertise, and backgrounds focused on the impacts of extreme weather and health who will be important partners for successful implementation. Cities, including Denver, have implemented grant programs to provide air conditioning to vulnerable households.[88] Evaluation outcomes from this Denver-based program and others like it can inform possible cost reductions and health outcomes of climate initiatives. Additionally, this program may inform future eligibility considerations by highlighting which populations had the highest uptake or experienced positive impacts of these services.

Social and Community Support

Need and Evidence Base

Social support and connection are important aspects of individual well-being and are associated with positive health and well-being outcomes. Social isolation and loneliness are associated with increased risk for heart disease, stroke, depression and anxiety, suicidality and self-harm, and dementia.[89] The Colorado Belonging Barometer, a 2024 study to understand Coloradans' sense of belonging in their communities, found that about 62% of Coloradans felt they belonged within the state. However, among those making less than $30,000 per year, only 48% felt they belonged in Colorado.[90] This statistically significant difference by income may suggest that Health First Colorado members may experience fewer aspects of belonging and could benefit more from social and community support. Additionally, data from the 2025 CHAS finds that 27.5% of Health First Colorado members are lonely.[91]

Stakeholders also noted that the following member populations could benefit the most from services that address social connection and support:

- Older adults
- Parents and caregivers
- People transitioning out of correctional facilities
- People affected by interpersonal violence
- People who speak a language other than English

While it is clear there is a need to address social connection, evidence on discrete services that can address these challenges is limited. The 2023 Surgeon General Advisory noted the importance of social and community connection on health.[92] The report recommends systemic changes such as investment in community infrastructure to connect people to each other, improvements in health care provider education and screening, and stronger enforcement and design standards for technology companies rather than discrete services that HCPF could fund.

However, there are some promising approaches to address these challenges more concretely through community-based physical activity and recreation, technology and phone-based programs, skill development and support groups,

and intergenerational programs.[93] Additionally, access to and utilization of other HRSN services like housing and nutrition can support individuals in their day-to-day activities, and by meeting those needs they are able to focus on education, jobs, community, and healthy relationships. This study examines discrete social and community focused services elevated by stakeholders, as well as stakeholder feedback and research regarding systems-level opportunities to connect members to existing services.

Prioritized Social and Community Support Services

- Caregiver education
- Parenting classes
- Home visiting programs
- Home internet access

Discrete Social Support Services

Discrete services prioritized by stakeholders include the following:

- **Primary caregiver education.** Caregiver burnout is a known issue that can lead to compounding health issues for both the caregiver and person receiving care.[94] Evidence for interventions to address caregiver burnout is limited, but evidence suggests interventions that address problem-solving and coping skills show promise in improving caregiver outcomes.[95] Primary caregiver education may include consulting, training on the family member's needs, resource materials, registration costs to attend relevant conferences and workshops, and other informational resources. This benefit is currently available through the HCBS Children's Extensive Support Waiver to parents of children with certain intellectual and developmental disabilities but may be considered for expansion to other populations.[96]
- **Parenting classes.** Several evidence-based parenting education curricula, such as Triple P and The Incredible Years, teach parents with young children (with or without physical, intellectual, or developmental disabilities) positive interaction skills and behavioral management techniques.[97] Not only do these programs improve parent-child relationships long term, they are effective at reducing child maltreatment risk and abuse and have success across diverse parent-child populations.

Stakeholders and subject matter experts also highlighted the following supports as important considerations for future expansion of HRSN coverage. These services have sufficient evidence and stakeholder support but would require longer-term infrastructure or policy alignment between state agencies to pursue. As a result, HCPF can coordinate with other state agencies to consider possible ways to expand and sustain coverage of these services, but population and cost estimates are not provided in this study.

- **Home visiting programs.** Home visiting programs — such as Family Connects, Nurse-Family Partnership, and HealthySteps — have robust evidence of positive health and cost impacts on families who participate. Some home visiting programs, like SafeCare, have been found to be protective against interpersonal violence in the home.[98] While these services are often available to Health First Colorado members free of charge through local public health agencies, the Colorado Department of Early Childhood, and other entities, there may be a role for HCPF to further invest in and support their sustainability and expansion throughout the state. While HCPF currently allows certain home visitors to bill for designated services through a fee-for-service model, other state Medicaid agencies have developed per-member per-month reimbursement mechanisms that allow for more comprehensive reimbursement.[99]
- **Internet access.** Some member stakeholders raised the importance of high-speed internet access to help people connect to telehealth services or with family members, friends, and neighbors. The 2025 CHAS finds that 12.4% of Health First Colorado members do not have broadband internet access.[100] While existing programs provide internet discounts to eligible members, they only cover a portion of a monthly internet bill. In 2025, only 13.2% of Medicaid members were enrolled in a government internet discount program. There is no precedent for state Medicaid agencies to subsidize internet access, though many state Medicaid agencies, including HCPF, are involved in programs with other state agencies to broadly address access to telehealth.

Connection to Existing Supports

Many stakeholders noted the importance of connecting Health First Colorado members to services that already exist and are available to them free of charge. They emphasized the importance of helping members get these services through their medical providers, care coordinators, and other case managers. Case management or care coordination is needed to connect members to the following existing services:

- Home visiting programs for parents of young children
- Education and vocational supports
- Interpersonal violence case management services (such as domestic violence shelters, victim's assistance organizations, and referral to legal support)
- Group nutrition or chronic disease management classes
- Health-related legal supports
- Communal meals, particularly for older adults.[101]

While not covered in this study, stakeholders prioritized non-medical transportation to social activities to help members actively engage with existing resources in their community.

Populations Prioritized for Social Support Services

Table 8 provides estimates for populations prioritized for social support services through stakeholder engagement and research.

Table 8. Prioritized Population Estimates for Social Support Services

Estimate of Colorado Medicaid members who are in each key population in a given year. Data is based on the most recent year available for each population. See Appendix B, Table 19 for more detail and information on sources for these estimates.

Medicaid Population	Medicaid Estimate	Prioritized Services
Households with an older adult (65+)	161,000	Caregiver Education
Households with a child aged 0 to 3	63,000	Parenting Classes

Potential Service Costs

Table 9 displays the unit cost of prioritized services. A portion of the cost of implementing these services would be funded through both federal and state entities, however cost sharing is not explored in this study. Unit costs use relevant available codes from Colorado Medicaid where possible. If Colorado does not have a relevant billing code for the service, a similar billing code from another state is applied.

CASE STUDY: **North Carolina**

In 2022, North Carolina implemented a suite of interpersonal safety services through its Health Opportunities Pilot (HOP), along with a broad suite of HRSN services, including housing, food, transportation, and cross-domain services.[102] The interpersonal safety services include case management, violence intervention services, evidence-based parenting classes, home visiting services, and dyadic therapy. In the first 20 months of operation, the HOP delivered about 317 interpersonal safety services to 74 members, costing about $33,000 overall. In the evaluation of its program, North Carolina's Medicaid agency noted that interpersonal violence needs are known to be underreported and that screening for this need is particularly challenging. This made uptake of these services difficult to accomplish. North Carolina's Medicaid program enrollment size is roughly 2.6 times larger than Colorado's.[103]

Table 9. Unit Costs and Prioritized Populations for Social Support Services

Service	Service Type	Cost	Prioritized Medicaid Population
Caregiver Education	Discrete Social Support Services	Up to $1,000 per year Source: Colorado Medicaid Code H1010 (Parent Education)	Households with an older adult (65+)
Parenting Classes	Discrete Social Support Services	$27.96 per person per class Source: North Carolina Medicaid	Households with a child aged 0 to 3

Impact on Cost and Savings

Interventions described in this section have demonstrated evidence of cost savings and avoidance. For example, the Triple P parenting education program described under discrete services found that making the program available to a broad population results in decreased hospitalizations from child abuse injuries, which is associated with cost savings. A Canadian analysis found the program associated with a reduction in conduct disorder, which has the potential to save up to $10.2 million in Canadian dollars if a 25% reduction in conduct disorder was achieved.[104] An analysis of the SafeCare Augmented program described under Home Visiting was also found to return $20.80 in measured benefits per dollar spent.[105]

Implementation Considerations

North Carolina, through its Healthy Opportunities Pilot, set up regional hubs to appropriately screen, enroll, and reimburse the cost of social support services.[106] The forthcoming work of the Colorado Social Health Information Exchange (CoSHIE) could play a critical role in improving accessibility and coordination of services. Additionally, RAEs also serve as a focal point for members to access care coordination and other health and HRSN resources, and may play an important role in connecting members to appropriate local resources. Additional considerations regarding connection to social support services are described in the next section.

Finally, the Surgeon General's report recommended that insurers and payers provide adequate reimbursement to health care providers for time spent assessing and addressing concerns about social connection. As a starting point, HCPF may consider ways to incorporate reimbursement or incentives for social connection and isolation screening into value-based payment models.[107]

Overall HRSN Considerations

Research conducted on HRSN service implementation in other states, as well as ongoing work in Colorado, informed the following considerations for HRSN service feasibility.

Opportunity for Savings. Robust evaluation data from North Carolina concluded that while initial spending to implement these services led to increased costs, cost savings were realized over time.[108] These cost savings were primarily driven by a statistically significant reduction in emergency department visits; trends in hospitalizations and outpatient visits were not found to be statistically significant. Additionally, cost savings or avoidance are most likely to be realized in adults, rather than in children, where the benefits of addressing health-related social needs may not be realized until later in life.[109]

HRSN Service Uptake. Based on interviews with state Medicaid agencies and evaluation results, it is apparent that HRSN service uptake varies by service. For example, in North Carolina in 2022, 67% of participants who screened positive for food-related needs ended up receiving that service.[110] However, services specific to interpersonal violence and toxic stress had minimal, if any, uptake. State Medicaid staff offered that uptake may be low because these individuals may access services through a direct service provider who receives compensation through other means, rather than by accessing them through a Medicaid agency or contracted hub. Staff in North Carolina suggested that there may be lower uptake of services related to interpersonal violence through their regional hubs due to lower trust in the system or in the staff conducting the screening. Internal subject matter experts also noted that many adults experiencing interpersonal violence are not able to enroll in Medicaid in the first place because their current household income precludes them from doing so, but they may qualify after transitioning into a separate household. Additionally, while only 2,705 participants enrolled in any HRSN service in the first year of implementation in North Carolina, that number grew significantly over the next 12 months, with approximately 13,000 participants enrolled by November 2023, and nearly 46,000 enrolled by June 2025.[111, 112] Peer state Medicaid staff recommended a staged implementation of any expanded services to help ensure that the appropriate infrastructure, supply, and funding are available for when uptake increases.

Delivery Infrastructure. Several state Medicaid programs deliver HRSN services through the Community Care Hub model. These hubs serve as a single point of contact for health care and community-based organization partners.[113] While Colorado has not adopted this specific model, the state does have similar structures in place through the RAEs and the Office of eHealth Innovation's planned Regional CoSHIE Proof of Concept Project to build regional SHIE hubs. RAEs serve as the point of delivery for Medicaid using a regional model throughout the state. RAEs currently strengthen relationships and referral processes with organizations that address food and housing security and play a key role in ensuring members have access to care coordination, including to other social and community support services, if desired. In the coming years, the CoSHIE regional hubs will use technology to connect Medicaid members to social care services and supports. Additionally, CDLE's Division of Housing operates Navigation Campuses, or regional facilities that provide programming to move individuals and families into permanent housing options.[114] These care networks could ultimately be used to implement a robust package of HRSN services to a broader Health First Colorado population.

Trust Building. In interviews with peer Medicaid agencies, state officials emphasized the long timeline necessary to develop the appropriate infrastructure to implement these services and to garner trust with both eligible Medicaid members and the community-based organizations providing these services. Medicaid agencies said that despite multiyear stakeholder and community engagement initiatives, uptake was extremely low for sensitive interventions, such as those related to interpersonal violence and toxic stress in North Carolina. Infusing trust throughout the delivery system involves thoughtful and equitable decision-making.

Food and Commodity Distribution Show Promise. Across many states, nutrition- and food-related services were of highest demand. These services tend to have the most immediate benefit

to a family or individual by addressing a basic need in a relatively quick and straightforward manner, while giving households an opportunity to redirect money that would otherwise be spent on food to other needs such as rent, medical bills, or transportation. Nutrition services may be a good way to start expanding HRSN services, given the population need, historic uptake data, stakeholder buy-in, and associated policy and resource supports. Partner agencies, such as CDHS, also have strong precedent in implementing food and nutrition services and can serve as a critical partner to inform successful implementation by building off their existing food assistance programs and infrastructure. Starting with nutrition and expanding from there may help ensure the appropriate infrastructure is in place to administer these HRSN benefits at a larger scale. HCPF could leverage sites where nutrition services are already being provided to offer additional services, supports, and navigation to eligible members receiving nutrition services at that time. Additionally, HCPF could consider other forms of commodity distribution, such as distributing air conditioners to eligible members, given that HCPF can build from existing regional pilots in Colorado and members benefit quickly from receiving them.

Lower barriers to services for people experiencing interpersonal violence. External stakeholders and internal subject matter experts noted the necessity of HRSN such as food and housing for people transitioning away from violent living situations. Barriers to services such as one-time moving costs, transitional housing, and food provision services should be lowered so that adults experiencing interpersonal violence can leave an unsafe household for a safer living situation. Stakeholders also noted that some adults experiencing interpersonal violence face barriers enrolling in Medicaid more broadly because their current household income may preclude them from enrollment; however, if they were to leave their current household living situation, they would likely have a household income that would qualify them for Medicaid. Future HRSN work might consider how HRSN screening can inform Medicaid enrollment more broadly, in addition to specific benefits within Medicaid.

Feasibility of Continuous Eligibility Expansion

Evidence of Continuous Eligibility on Health Care Access and Outcomes

Background and Need

Continuous eligibility supports consistent medical coverage and continuity of care by keeping children and adults enrolled in Health First Colorado or CHP+ regardless of the changes in their eligibility circumstances, such as income, which would otherwise cause them to lose their coverage. Enrollment churn, described as those who are disenrolled and reenrolled in Medicaid due to changes in eligibility, is common. Nationally, about one in 10 enrollees lose and regain their coverage within 12 months. This is often caused by two key reasons: those with low incomes are often prone to household income fluctuations, and people may face barriers when attempting to renew Medicaid coverage.[115]

People in the lowest income brackets can include those who have hourly or seasonal jobs, young adults, those leaving incarceration, and families with young children.[116] One study showed that those living in low- to moderate-income households experienced on average 2.5 months per year where their income fell by more than 25%, and 2.6 months on average where their income rose by 25%.[117] Additionally, income fluctuations are more likely to affect people of color and those with lower educational attainment. For example, a study found that 38% of Black households and 45% of Hispanic households experienced income volatility, compared with 32% of white households.[118] These fluctuations can cause unnecessary disenrollments, and the burden of enrollment churn often falls on groups that are already facing systemic barriers.

In addition to income fluctuations, many people also are affected by enrollment barriers. Procedural disenrollment may occur because enrollees faced issues that resulted in them not completing the redetermination process. Sometimes,

administrative issues occur that impair enrollment, like processing documentation before a case is closed. Nationally, over 70% of disenrollments are due to procedural reasons.[119] Continuous eligibility as a policy reduces the burden on the individual enrolled and provides continuous coverage without the worry of being procedurally disenrolled or because of income fluctuations throughout the year.

Access to Care and Health Outcomes

The impact of continuous enrollment on care-seeking behaviors and overall health outcomes is even greater. Those affected by coverage churn are more likely to forgo care. They have reduced access to preventive services, do not fill their prescriptions when they need them, and have more emergency department visits.[120] Continuous eligibility is especially important for children and pregnant people, both of whom have distinct health care needs. Continuous eligibility reduces the uninsured rate of children, especially those in low-income households with fluctuating incomes.[121] People leaving incarceration have higher rates of chronic health conditions and have more acute behavioral health care needs, most critically in the period directly after release when they are at highest risk of overdose or death. Making sure that formerly incarcerated people have access to timely, consistent care is integral to ensuring their health concerns are addressed and reducing acute risk of death upon release.[122]

HB23-1300 Continuous Eligibility Study Findings

HB23-1300 directs HCPF to study the feasibility of expanding continuous eligibility for specific scenarios. These scenarios are:

- **Scenario A:** Children ages 3 to 18 remain continuously eligible for 24 months after they are deemed eligible or until they turn 19 years old (Medicaid and CHP+).
- **Scenario B:** Children ages 3 to 5 remain continuously eligible until the child reaches 6 years old (Medicaid and CHP+).
- **Scenario C:** Eligible adults remain continuously eligible without regard to income for 12 months after they are first determined eligible.
- **Scenario D:** Eligible adults remain continuously eligible without regard to income for 24 months after they are first determined eligible.

In this study, eligible adults are those ages 19 and older in any of the following categories:

- With incomes under 33% of the federal poverty level (or an income less than $5,165 per year for a single adult in 2025)
- Experiencing homelessness
- Who have been in community corrections, are on parole, or have been released from another carceral setting. In this study, this is limited to adults leaving the Colorado state Department of Corrections (CDOC)

Federal Update Regarding Continuous Eligibility

On July 17, 2025, the CMS sent state Medicaid programs a letter saying that CMS will no longer approve or renew 1115 waivers for continuous eligibility in Medicaid or the Children's Health Insurance Program. As a result, Colorado will no longer move forward with continuous eligibility expansions planned to begin January 1, 2026, for children from birth until they turn 3, and 12 months of continuous eligibility for adults recently released from state prison, regardless of income change. This new policy does not affect current federal law of 12 months continuous eligibility for members 19 and under.[123]

This study evaluates the cost and feasibility of possible continuous eligibility scenarios as described in the HB23-1300 legislation, which was passed prior to this federal policy change. It is also important to note that historically, CMS has only approved 1115 waivers if the project is determined to be budget neutral over the five-year implementation period of the demonstration. This means there would be no net increase in costs to the federal government when the demonstration is implemented, as well as neutral to the state's General Fund budget.[124]

Table 10. Estimated Total Cost per Year for Possible Child Expansion by Population Cohorts

Analysis for child expansion populations for continuous eligibility is based on data from calendar years 2018 and 2019. PMPM costs were adjusted to better align with fiscal year 2024–25 costs. Analysis includes ineligible months calculated for children covered by both Medicaid and CHP+.

Children Age	Eligible Member Months	Ineligible Member Months	Percentage of Months Ineligible	Total Cost per Year (Rounded)
Age 3 to 5 (Preschoolers)	2,353,629	318,494	11.9%	$74,700,000
Age 6 to 12 (School-age)	5,479,906	675,269	11.0%	$156,800,000
Age 13 to 18 (Adolescents)	3,912,604	583,484	13.0%	$146,600,000
TOTAL	**11,746,139**	**1,577,247**	**11.8%**	**$378,100,000**

CHI reviewed existing methodologies to identify a practical and validated approach to calculating continuous eligibility costs that was in alignment with past methodologies used by HCPF. Findings for cost to provide continuous eligibility are described below. These findings use the methodology described in the Study Approach and data in Appendix D.

In summary, CHI used past administrative HCPF data to identify the number of months members were ineligible that hypothetically would be covered via continuous eligibility. This was then multiplied by the cost per member per month (PMPM) for that coverage. The PMPM amount used in this analysis includes the sum of all capitation and claim payments associated with members within the population. These rates use data over many months, and are then averaged to create a PMPM for analysis. This PMPM rate is different from the PMPM rate described for payment to the RAEs or for capitation behavioral health payments.

Continuous Eligibility for Children up to Age 3

Estimated costs to provide continuous eligibility for this age group were included in the Fiscal Note for HB23-1300. Because the fiscal note applied a similar methodology, this analysis is not repeated in this study. The fiscal note estimated that the total one-year cost of continuous eligibility for children from birth up to age 3 in FY 2025–26 would be $11,791,862 and in FY 2026–27 $23,583,725, or a total of $35,375,587 for the two fiscal years.[125]

Scenario A: Children age 3 to 18 remain continuously eligible for 24 months after they are deemed eligible or until they turn 19 years old (Medicaid and CHP+).

As shown in Table 10, the total cost to provide continuous eligibility for children ages 3 to 18 for 24 months is approximately $378,100,000 per year. Of the age categories, the lowest cost population is children ages 3 to 5. Children under 6 are also more likely to experience churn compared to older children, based on the 2019 CHAS (data from the 2019 CHAS are a better representation of churn than the 2023 survey, which took place during the unwind of expanded continuous eligibility provisions established during the Public Health Emergency. Data from the 2025 CHAS are not reportable due to sample size limitations for this age group). About 27% of children ages 0 to 5 who had coverage through Medicaid experienced churn some time during the previous year. This is greater than the 19% of children 6 to 12 and 24% of children 13 to 18 covered by Medicaid who experienced churn.

Scenario B: Children ages 3 to 5 remain continuously eligible until the child reaches 6 years old (Medicaid and CHP+).

As shown in Table 11, the total cost to provide continuous eligibility for children ages 3 to 5 until age 6 is $74,700,000 per year. When ungrouped, there are not large differences in total cost per year by age within the 3 to 5 group.

Beyond age-based eligibility, HCPF could consider continuous eligibility specifically for former foster care youth. These youth, who are no longer eligible for Foster Medicaid, automatically receive Health First Colorado benefits through the MAGI-child Medicaid category. Continuous eligibility in this period is for up to 12 months.[126] Some states, such as Arizona, submitted an 1115 waiver amendment to provide continuous eligibility for former foster youth up to age 26.[127]

Table 11. Estimated Total Cost per Year for Possible Child Expansion by Age

Analysis for child expansion populations for continuous eligibility is based on data from calendar years 2018 and 2019. PMPM costs were adjusted to better align with fiscal year 2024–25 costs. Analysis includes ineligible months calculated for children covered by both Medicaid and CHP+.

Children Age	Eligible Member Months	Ineligible Member Months	Percentage of Months Ineligible	Adjusted PMPM	Total Cost per Year (Rounded)
3	793,750	105,964	11.8%	$463.64	$24,600,000
4	788,925	106,607	11.9%	$481.52	$25,700,000
5	770,954	105,923	12.1%	$461.18	$24,400,000
TOTAL	**2,353,629**	**318,494**	**11.9%**		**$74,700,0000**

A Note on Data Availability and Limitations

CHI used HCPF administrative data to identify adults experiencing homelessness. This data indicator, captured once upon enrollment, includes adults in a homeless-related living arrangement, including shelters, emergency housing, or temporary housing. Based on this indicator, over 121,000 people indicated a homeless-related living arrangement in the data at some point during the 2024–25 fiscal year. This estimate is larger than the estimated number of homeless adults captured through the COHMIS State of Homelessness report, as this data indicator represents any member who ever experienced homelessness at any point since their original Medicaid enrollment, even if their living situation has since resolved. Thus, total costs are likely an overestimation of the population that may qualify for Medicaid under this priority population expansion.

The estimate for adults leaving carceral settings is limited to those leaving the Colorado Department of Corrections (CDOC). This definition currently aligns with HCPF's justice involved efforts.[128] HCPF does not have data about those leaving other carceral settings. On average, about 7,800 were released from state or private prisons and community corrections per year in Colorado between fiscal year 2019 and 2023, based on data from the CDOC. These counts represent an expected number of eligible individuals leaving CDOC as a setting, if HCPF decides to limit this eligibility population to match previous carceral setting definitions. Additionally, data from the Federal Bureau of Prisons shows that there were, on average, 280 people released from federal prisons per year in Colorado between 2019 and 2024.[129] Between June 2023 and June 2025, there was an average of about 9,300 active individuals on parole per month in Colorado.[130] These additional carceral setting data show that higher costs could be incurred for other adults, as only adults leaving Colorado's Department of Corrections are flagged in HCPF's current data system.

Finally, due to data availability, per member per month (PMPM) costs in several analyses in the study incorporate actual costs averaged across 2018 and 2019 to account for month-to-month variation in health care utilization and costs. To account for changes in actual costs to more recent years, an adjusted PMPM rate was used to more appropriately estimate current PMPM costs. In future years, HCPF may rerun the cost analysis with more current data to get more accurate costs for implementing continuous eligibility for selected groups.

Scenario C: Eligible adults remain continuously eligible without regard to income for 12 months after they are first determined eligible.

Total costs to provide continuous eligibility for 12 months for low-income adults, adults experiencing homelessness, and adults leaving carceral settings range from $3,400,000 to $248,600,000 per year (Table 12). There are likely overlapping individuals in each of these categories. Following the practice of other state Medicaid programs, implementation could begin with the narrowest group (adults leaving carceral settings) and gradually expand to broader populations that encompass those who have already gained continuous eligibility through other initiatives (e.g. adults with very low incomes).

Those experiencing homelessness were more likely to experience Medicaid churn during the study period, as 19% of the months during that time period were considered ineligible.

Table 12. Estimated Total Cost per Year for Possible Adult Expansion by Population Cohort (12 Months)

Analysis for adult Medicaid members with incomes less than 33% of the Federal Poverty Level (FPL) is based on data from calendar years 2018 and 2019. For this population, PMPM costs were adjusted to better align with fiscal year 2024–25 costs for this adult population. Analysis for adult Medicaid members with a homelessness indicator and those leaving carceral settings are based on data from fiscal year 2024–25. These differ based on data availability for these distinct adult populations.

Population	Eligible Member Months	Ineligible Member Months	Percentage of Months Ineligible	PMPM	Total Cost per Year (Rounded)
Adults With Incomes Less Than 33% FPL	5,549,669	512,770	8.5%	$969.50 (Adjusted PMPM)	$248,600,000
Adults Experiencing Homelessness	1,126,409	263,883	19.0%	$610.08	$80,500,000
Adults Leaving Carceral Settings	46,077	8,964	16.3%	$757.23	$3,400,000

Scenario D: Eligible adults remain continuously eligible without regard to income for 24 months after they are first determined eligible.

Total costs to provide continuous eligibility for 24 months for low-income adults, adults experiencing homelessness, and adults leaving carceral settings range from $5,000,000 to $832,000,000 (Table 13). As in Scenario C, these populations likely overlap. Additionally, expansion implications cited in Scenario C are also relevant to the Scenario D populations.

Cost and Administrative Impacts

Administrative Impacts

Continuous eligibility substantially reduces the administrative burden on county administrators who are fielding applications and working on redetermination of eligibility. The administrative cost of one person's churning on and off Medicaid can be between $400 and $600.[131] While churning may reduce overall monthly caseloads, it actually increases monthly per member expenditures because forgone care increases people's need for services once they re-enroll.[132] One study found that adults who had a full year of continuous coverage had lower average costs per month than those who had three or six months of continuous coverage.[133] In this study, churning was associated with disruptions in physician care and medication adherence, and increased emergency department use.

Administrative Barriers

Data availability and access present an administrative barrier to implementing continuous

Table 13. Estimated Total Cost per Year for Possible Adult Expansion by Population Cohort (24 Months)

Analysis for adult Medicaid members with incomes less than 33% FPL is based on data from calendar years 2018 and 2019. For this population, PMPM costs were adjusted to better align with fiscal year 2024–25 costs for this adult population. Analysis for adult Medicaid members with a homelessness indicator and those leaving carceral settings are based on data from fiscal year 2024–25. These differ based on data availability for these distinct adult populations.

Population	Eligible Member Months	Ineligible Member Months	Percentage of Months Ineligible	PMPM	Total Cost per Year (Rounded)
Adults with Incomes Less Than 33% FPL	9,244,653	1,716,182	15.7%	$969.50 (Adjusted)	$832,000,000
Adults Experiencing Homelessness	1,955,355	687,901	26.0%	$661.12	$227,400,000
Adults Leaving Carceral Settings	58,378	13,833	19.2%	$722.46	$5,000,000

eligibility for some of the adult populations described in this study. The data used to inform these estimates, particularly for adults involved in the criminal justice system and adults experiencing homelessness, was limited. In this study, data on adults involved in the criminal justice system was limited to those who were released from CDOC; however, this estimate does not include adults who are on parole or who have been released from other carceral settings such as jails or federal prisons. Similarly, the estimate of adults experiencing homelessness includes members with a homeless-related living arrangement flag at the time of eligibility, but it may not represent real-time counts of whether someone is currently housed or unhoused. Conversations with other states emphasized that data integration between different state entities and their respective systems can alleviate some of the administrative burden around continuous eligibility implementation. By leveraging the necessary partnership required to implement its 1115 waiver, Massachusetts successfully brought key stakeholders and legal experts to the table to integrate its Medicaid Management Information System (MMIS) with the state's multiple Homeless Management Information Systems (HMIS).[134] This type of data interoperability remains a priority in Colorado, as defined in the state's Health IT Roadmap, and is an important step to streamlining the technological infrastructure needed to support continuous eligibility efforts.[135]

Overall Continuous Eligibility Considerations

While continuous eligibility expansion is currently on hold, the data and evidence to support it for certain populations remain true. Populations that are more prone to churn, such as young children, as well as those that are already systemically disconnected from health, such as people leaving incarceration, stand to benefit the most. The analysis methodology outlined in this study can be reapplied in future years to get more accurate cost estimates.

Recommendations

Moving forward with any of these recommendations must take into account relevant state and federal regulations, including CMS requirements for demonstrated budget neutrality.

HRSN Recommendations

To determine which HRSN services to expand upon and implement, HCPF should take into account the following factors:

- **Population Need.** To what extent does the Health First Colorado population need this service?
- **Stakeholder Prioritization.** To what extent do Health First Colorado members, providers, and community partners prioritize this service?
- **Cost.** Is the cost to implement reasonable and something HCPF can afford over the long term?
- **Evidence of Cost Savings or Avoidance.** Is there evidence to indicate implementing this service will lead to future cost savings or avoidance for HCPF?
- **Precedent to Implement.** Has HCPF or another state agency implemented this service and does the infrastructure and mechanism exist to do so?

Table 14 summarizes the findings around possible implementation of services within each domain. The green, yellow, and orange boxes indicate whether that criteria is met for that domain holistically with high, medium, or low evidence, prioritization, or precedent.

The following services and populations are prioritized for each domain based on services with the greatest degree of stakeholder prioritization within that domain and reasonable evidence to support. The associated populations are prioritized for that service based on stakeholder feedback or an evidence review. Prioritized populations are narrow enough to serve as a starting point for potential implementation.

Table 14. Considerations for HRSN Prioritization

Service Domain	Population Need	Stakeholder Prioritization	Cost	Evidence of Cost Savings or Avoidance	Precedent to Implement
Housing	Medium	High	High	High	High
Food	High	High	Medium	High	High
Extreme Weather	High	Low	Low	Medium	Low
Social Support	High	Medium	Low	Low	Low

Housing: Pre-tenancy and tenancy sustaining services for people experiencing housing insecurity with a chronic condition with a child under 18 in the household

Food: Home-delivered or medically tailored meals for children experiencing food insecurity with a diet-sensitive condition

Extreme Weather: Portable/back-up power supplies for people who depend on electricity for medical equipment

Social Support: Connection to existing resources for caregivers and parents

Continuous Eligibility Recommendations

These findings suggest prioritizing the following populations for continuous eligibility expansion:

Expanding continuous coverage for the youngest Health First Colorado members. Coloradans ages 0 to 5 experience the highest rate of churn and are the lowest-cost population to cover. As federal policy changes, the Colorado state legislature could first consider revisiting continuous eligibility for age 0 up to age 3, as the underlying infrastructure for this policy change has already been developed and previously approved by federal authorities under 1115 waiver authority. Given that costs do not change by meaningful amounts to cover ages 3, 4, or 5, the state legislature may consider incrementally expanding continuous eligibility to eventually cover children until they reach their sixth birthday. Additionally, the state legislature could also consider prioritizations within this age group, such as youth involved in the foster system. Based on data from the 2017-2019 CHAS, 20% of children age 3 to 5 covered by Medicaid churned sometime in the past year, meaning that about 12,000 children in this age group would benefit from expansion of this policy.

Expanding continuous coverage for adults leaving carceral settings. Adults leaving carceral settings are more likely to have unaddressed health care needs, like substance use or mental health concerns, which could put them at risk for recidivism and increased emergency department use or premature death. This adult population is much smaller than others that were investigated for this analysis, with lower costs to provide care for them continuously for 12 or 24 months. The state legislature may consider first revisiting continuous eligibility expansion for adults leaving CDOC settings for 12 months, which federal authorities previously approved under an 1115 demonstration waiver and then rescinded. The state could then expand continuous eligibility to 24 months for this population. Continuous eligibility for other populations, such as people experiencing homelessness, is also beneficial, but will require improvement in data systems before implementing them effectively.

Conclusion

This study examines two areas for possible Medicaid service expansions that may be accomplished through multiple mechanisms, including submission and approval of an 1115 waiver. The first area of focus is to assess the feasibility of extending continuous Medicaid eligibility for additional children and adult populations. Although at the time of writing, further expansions related to continuous eligibility are on pause due to federal guidance and other significant changes to federal policy that have occurred through H.R. 1, this study provides estimates for possible future expansions, as well as the methodology and tools to develop updated estimates in a future study.

The second area of focus around implementing HRSN services is an ongoing priority of HCPF and other state and local partners. While HCPF has already implemented several HRSN services to specific member populations, this study reviews possible expansions of service types — including those that mitigate extreme weather impacts — and targeted populations — including people affected by interpersonal violence and food insecurity. These estimates and populations should be a starting place to further refine population screening and implementation based on ongoing stakeholder input.

Finally, while this study primarily focused on the feasibility for HCPF to directly reimburse for existing HRSN services, many important services are already available to Health First Colorado members through other eligibility criteria and qualifications. HCPF should not lose sight of ways to better connect Health First Colorado members to these existing services in a streamlined manner — by leveraging the RAEs, incentivizing providers to screen and refer, and making ongoing investments in state infrastructure like the CoSHIE to connect with existing programs at other state agencies. Additionally, ongoing relationship and trust-building and education about Medicaid services and enrollment between the state and organizations that serve people with HRSN, such as sites that serve people leaving interpersonal violence, is a critical first step to future service expansion. As HCPF continues to iterate and evolve its ability to provide HRSN benefits, it can continue to lay the groundwork and build collaborative relationships for a successful implementation and uptake of these services when they are more widely available.

Appendix A. Key Population Estimates

Table 15 provides estimates for the key populations defined in the HB23-1300 legislation. Prioritized population estimates were calculated using the best available data. The primary source was HCPF administrative data, however some estimates were calculated using survey data from other sources. Estimates are rounded to the nearest thousand.

Table 15. Key Population Estimate Sources and Notes

Medicaid Population	Best Available Data	Medicaid Estimate
Perinatal recipients	HCPF administrative data is not currently able to capture all members in the perinatal stage. The estimate for this population is the number of members who gave birth based on FY23-24 Medicaid claims data.	26,000
Youth transitioning in and out of foster care	HCPF administrative data is not currently able to capture all members who are transitioning in and out of the foster care system. Therefore, the estimate for "former foster care youth" below can be used as a best available data point for this estimate.	--
Former foster care youth	The number of Medicaid members who are former foster care children, based on FY23-24 Medicaid claims data.	2,000
People with substance use disorders	The number of members with an SUD claim based on FY23-24 Medicaid claims data.	89,000
High-risk infants and children	High-risk infants and children are defined in this estimate as children having an adverse childhood experiences (ACEs) score of 4 and above. This score range is considered high risk for toxic stress. HCPF administrative data does not currently contain ACEs score information. Therefore, this estimate is based on a 2024 Ohio Medicaid assessment that showed that 8.9% of children ages 0 to 17 in Ohio Medicaid had an ACEs score of 4 or higher. This estimate assumes the rate is the same among Colorado Medicaid members in the 0 to 17 age range.	57,000
People earning low incomes who have been impacted by natural disasters	There is no data source available for the number of people impacted by natural disasters by income level in Colorado. This estimate instead uses 2025 Colorado Health Access Survey (CHAS) data to estimate the number of adult Medicaid members (18 and older) who reported a member of their family experienced an adverse health impact or housing, property, or income loss or due to climate change.	322,000
Adults at risk of or experiencing interpersonal violence	There is a lack of data about the rate of people experiencing violence in Colorado. For this estimate, CHI extrapolated a population size based on a rate from HRSN screening data from Denver Health, which showed 4.9% of roughly 1,000 Medicaid members ages 18 and older reported safety concerns related to violence or abuse in the first six months of 2025. Because violence is underreported, this is likely an underestimation.	60,000
People who are experiencing homelessness or at risk of homelessness	This estimate is based on 2024 Colorado's Homeless Management Information System (COHMIS) service access counts. This estimate assumes all people who accessed services are eligible for Medicaid or Medicaid members.	53,000
People transitioning out of an emergency shelter, non-congregate shelter, or micro-community	This estimate is based on 2024 COHMIS shelter exit data via a data request. COHMIS tracks exit data from emergency shelters, defined as all emergency shelter project types tracked by COHMIS, including non-congregate shelters and micro-communities. This study assumes that all people leaving emergency shelters are eligible for Medicaid.	24,000

Appendix B. Prioritized Population Estimates

Prioritized population estimates were calculated using the best available data. This involved applying estimates from survey data or other sources to existing administrative data sources. Tables 16 through 18 provide additional details on how these estimates were derived and relevant sources. Where possible, CHI aimed to overestimate the population, rather than underestimate. While these estimates provide information on the potential need for a specific HRSN service, HCPF should consider additional screening and eligibility criteria before implementing a service. Estimates are rounded to the nearest thousand.

Table 16. Housing Population Estimate Sources and Notes

Social Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
People experiencing housing insecurity	145,000	2025 Colorado Health Access Survey (CHAS)	Housing insecurity is defined in this estimate as people who are worried about having stable housing in the next two months.
Adults experiencing housing insecurity with a child under 18 in the household	50,000	2025 CHAS	Housing insecurity is defined in this estimate as people who are worried about having stable housing in the next two months.
Youth transitioning out of foster care	2,000	FY23-24 internal HCPF enrollee data	Estimate is based on the number of former foster care children (18 and under) enrolled in Medicaid in FY 2023–24.
People leaving incarceration	4,000	FY24-25 Colorado Department of Corrections (DOC) general statistics	Leaving incarceration is defined as parole releases from DOC facilities. This study assumes that all people leaving incarceration are eligible for Medicaid.
People leaving emergency shelters	24,000	2024 Colorado's Homeless Management Information System (COHMIS) shelter exit data	Emergency shelters are defined as all emergency shelter project types tracked by COHMIS, including non-congregate shelters and micro-communities. This study assumes that all people leaving emergency shelters are eligible for Medicaid.
Adults experiencing interpersonal violence	60,000	2025 Denver Health HRSN screening data via data request, received August 2025	There is a lack of data about the rate of people experiencing violence in Colorado. For this estimate, CHI extrapolated the population size based on a rate from HRSN screening data from Denver Health patients. HRSN screening from January to August 2025 showed 4.9% of Medicaid members 18 and older reported safety concerns related to violence or abuse. Because violence is underreported, this is likely an underestimation.
People experiencing homelessness	53,000	2024 COHMIS service access counts	This estimate is the number of people who sought housing and services related to homelessness through COHMIS partner agencies in 2024. This estimate assumes all people accessing services are eligible for Medicaid or Medicaid members.
People who are chronically homeless	16,000	2024 COHMIS	Chronic homelessness is defined by the U.S. Department of Housing and Urban Development as those who have lived without stable housing for at least 12 consecutive months or experienced repeated episodes totaling 12 months or more during the past three years. The estimate assumes all people experiencing chronic homelessness are eligible for Medicaid or Medicaid members.

Social and Medical Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
People experiencing housing insecurity who have a chronic condition	65,000	Estimate based on 2025 CHAS and FY23-24 internal HCPF enrollee data about the rate of chronic conditions	A chronic condition in this estimate is COPD, asthma, diabetes, heart failure, hypertension, hyperlipidemia, chronic pain, or anxiety and depression.
Adults experiencing housing insecurity who have a chronic condition and a child under 18 in the household	26,000	Estimate based on 2025 CHAS and internal HCPF enrollee data about the rate of chronic conditions	A chronic condition in this estimate is COPD, asthma, diabetes, heart failure, hypertension, hyperlipidemia, chronic pain, or anxiety and depression.
People leaving incarceration with a behavioral health condition	3,000	Estimate based on FY24-25 DOC general statistics and inmate population profile data rate of substance use need, retrieved August 2025	This estimate approximates behavioral health conditions by applying the rate of inmates with a substance use need to the number of people leaving incarceration. Because DOC does not report on inmates with both substance use and mental health needs, the CHI used the larger of the two percentages — substance use need — as a stand-in. This approach, however, likely underestimates the true need.
People leaving emergency shelters with a disabling condition	12,000	Estimate based on 2024 COHMIS shelter exit and disabling condition rate data	A disabling condition is defined in this estimate as a self-reported physical disability, mental health disorder, substance use challenge, or chronic illness. This estimate assumes people leaving emergency shelters have the same rate of disabling conditions as the number of people who have accessed COHMIS services generally.
People experiencing homelessness with a disabling condition	26,000	2024 COHMIS service access counts and disabling condition rate data	A disabling condition is defined in this estimate as a self-reported physical disability, mental health disorder, substance use challenge, or chronic illness.
People experiencing chronic homelessness with a disabling condition	9,000	Internal HCPF analysis based on data from the Continuums of Care (CoCs) in FY 22-23	A disabling condition is defined in this estimate as a physical disability, mental health disorder, substance use challenge, or chronic illness.
People experiencing chronic homelessness with a disabling condition who experienced an inpatient stay in the past year	2,000	Internal HCPF analysis based on data from the CoCs in FY 22-23	A disabling condition is defined in this estimate as a physical disability, mental health disorder, substance use challenge, or chronic illness. Inpatient stays are indicated by HCPF claims data.

Table 17. Food Population Estimate Sources and Notes

Social Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
People experiencing food insecurity	248,000	2025 CHAS	Food insecurity is defined in this estimate as people who ate less than they thought they should in the past year because they could not afford food.
Children experiencing food insecurity	38,000	2025 CHAS	Children are defined in this estimate as ages 0 to 18. Food insecurity is defined in this estimate as people who ate less than they thought they should in the past year because they could not afford food.
Older adults (65+) experiencing food insecurity	12,000	2025 CHAS	Food insecurity is defined in this estimate as people who ate less than they thought they should in the past year because they could not afford food.
People with disabilities experiencing food insecurity	111,000	2025 CHAS	Disability in this estimate is defined as people who reported difficulty performing daily activities such as bathing, climbing stairs, or errands due to a physical, mental, or emotional condition. Food insecurity is defined in this estimate as people who ate less than they thought they should in the past year because they could not afford food.
Youth transitioning out of foster care	2,000	FY23-24 internal HCPF enrollee data	Estimate is based on the number of former foster care child enrollees (18 and under) in Medicaid in FY23-24.
People leaving incarceration	4,000	FY24-25 DOC general statistics	Leaving incarceration is defined as parole releases from DOC facilities. This study assumes that all people leaving incarceration are eligible for Medicaid.
Adults experiencing interpersonal violence	60,000	2025 Denver Health HRSN screening data via data request, received August 2025	There is a lack of data about the rate of people experiencing violence in Colorado. For this estimate, CHI extrapolated the population size based on a rate from HRSN screening data from Denver Health patients. HRSN screening from January to August 2025 showed 4.9% of Medicaid members 18 and older reported safety concerns related to violence or abuse. Because violence is underreported, this is likely an underestimation.
Social and Medical Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
Adults experiencing food insecurity with a diet-sensitive condition	75,000	2025 CHAS and FY23-24 internal HCPF enrollee data about the rate of diet-sensitive conditions	Diet-sensitive conditions in this estimate are Type 2 diabetes, HIV/AIDS, heart failure, chronic liver disease, cancer, end-stage renal disease, hemodialysis, COPD, hypertension, and hyperlipemia.
Youth experiencing food insecurity with a diet-sensitive condition	2,000	2025 CHAS and FY23-24 internal HCPF enrollee data about rate of diet-sensitive conditions	Youth are defined in this estimate as ages 0-20. Diet-sensitive conditions in this estimate are Type 2 diabetes, HIV/AIDS, heart failure, chronic liver disease, cancer, end stage renal disease, hemodialysis, COPD, hypertension, and hyperlipemia.
Older adults (65+) experiencing food insecurity with a diet-sensitive condition	5,000	2025 CHAS and FY23-24 internal HCPF enrollee data about rate of diet-sensitive conditions	Diet-sensitive conditions in this estimate are Type 2 diabetes, HIV/AIDS, heart failure, chronic liver disease, cancer, end stage renal disease, hemodialysis, COPD, hypertension, and hyperlipemia.

Table 18. Extreme Weather Population Estimate Sources and Notes

Social Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
People who are exposed to extreme heat	1.07 million	2022 U.S. Census Community Resilience Estimates for Heat and FY23-24 internal HCPF enrollee data	Includes people who live in counties that experience extreme heat as defined by census research. The census research indicates that 31 of Colorado's counties are at risk of extreme heat.
People who are exposed to extreme cold	1.06 million	Federal Emergency Management Agency (FEMA) National Risk Index, retrieved August 2025 and FY23-24 internal HCPF enrollee data	Includes people who live in counties at risk of extreme cold weather, including cold waves, ice storms, or winter weather as defined by FEMA. The census data indicates that 14 of Colorado's counties are at risk of extreme cold.
Households without air conditioning	84,000	2020 U.S. Energy Information Administration, Residential Energy Consumption Survey	Based on the percentage of households earning $60,000 a year or less that lack air conditioning.
Households without heat	13,000	2023 Integrated Public Use Microdata Series (IPUMS) (One-year estimates)	Households without heat are defined in this estimate as lacking a heating source or safe heating source (i.e. the household relies on wood as a source of fuel). Exact value: 13,410 households.
People who live in the counties with the highest extreme weather risk (Adams, Arapahoe, Denver, El Paso, Jefferson, and Larimer)	890,000	FEMA National Risk Index, retrieved August 2025	The highest extreme weather risk is based on a composite score for multiple hazards including wildfire, flooding, drought, heat and cold waves as defined by FEMA. The counties included in this estimate are in the top 10th percentile risk for extreme weather.
Households experiencing homelessness	45,000	2024 COHMIS service access counts	This estimate is the number of households who sought housing and services related to homelessness through COHMIS partner agencies in 2024. This estimate assumes all people accessing services are eligible for Medicaid or a Medicaid member.
People who are unsheltered	3,000	2024 COHMIS	Unsheltered people refers to persons living in tents, cars, and other places not meant for human habitation.
Social and Medical Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
Families with a member who experienced the worsening of a chronic illness due to climate change	69,000	2025 CHAS	This data is self-reported and chronic illness is defined as heart/cardiac conditions, high blood pressure, diabetes, kidney disease, or other chronic illness.
Families with a member who experienced heat illness, stress, or stroke due to climate change	64,000	2025 CHAS	
Households without heating that also have a member with a chronic condition	7,000	2025 CHAS and FY23-24 internal HCPF enrollee data about rate of chronic conditions	A chronic condition in this estimate is COPD, asthma, diabetes, heart failure, hypertension, hyperlipidemia, chronic pain, or anxiety and depression.
Households without heating that also have an older adult member	4,000	2025 CHAS and 2023 IPUMS (1-year estimates)	Households without heating are defined in this estimate as lacking a heating source or safe heating source (i.e. household relies on wood as a source of fuel).

Table 18 Continued.

Social and Medical Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
Households experiencing housing insecurity with a member with a disabling condition	23,000	2024 COHMIS	A disabling condition is defined in this estimate as a physical disability, mental health disorder, substance use challenge, or chronic illness.
Adults with electricity-dependent medical equipment	223,000	2022 Weld County Community Health Survey, data request indicated that 18.1% of Medicaid enrollees in Weld County use electricity-dependent medical equipment	No statewide data exist for the number of people who use electricity-dependent medical equipment. Therefore, the data from Weld County was extrapolated to the entire state. Better data collection is needed in this area.
People with medication that requires temperature control	89,000	Internal HCPF enrollee data FY23-24	No statewide data exist for the number of people who use medications that require temperature control. The number of unique Medicaid members with any type of diabetes diagnosis is used as an approximation for this population, as insulin requires refrigeration. This is an underestimate as many other medications also require refrigeration. Better data collection is needed in this area.

Table 19. Social Support Population Estimate Sources and Notes

Service Need			
Medicaid Population	**Medicaid Estimate**	**Sources used to calculate estimate**	**Additional Notes**
Households with an older adult (65+)	161,000	2023 IPUMS (One-year estimates)	Exact value: 160,644 households
Households with a child age 0 to 3	63,000	2023 IPUMS (One-year estimates)	Exact value: 63,028 households

Appendix C. HRSN Services Considered

Tables 20 to 23 below list HRSN services considered for this study, and how each was assessed using the Feasibility Analysis Selection Funnel (Figure 1) described in the Study Approach section. The tiers of the approach include:

- Tier 1: Implemented vs Innovative Service
- Tier 2: High or Low Evidence of Impact and/or Stakeholder Prioritization
- Tier 3: Sufficient or Insufficient Data Availability

Tier 1 was determined by research that CHI conducted on Colorado and other state Medicaid programs. If a service has been implemented in several state Medicaid programs, it is considered "implemented." Otherwise, a service is considered "innovative" in the context of Medicaid, meaning it has not been broadly implemented among states. Tier 2 was also informed by research about state Medicaid programs and by stakeholder input. See Appendix E for a list of stakeholders involved in discussions that informed Tier 2. Finally, Tier 3 was determined by the availability of data to calculate potential service costs or inform implementation considerations.

Table 20. Housing Services Considered for Study

Cells with N/A indicate that a tier was not assessed because the service did not qualify for the study based on a previous tier or the service was out of scope for the study.

Service	Tier 1	Tier 2	Tier 3	Study Prioritization
Pre-tenancy navigation and tenancy-sustaining services	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Tenancy-sustaining services (eviction prevention and tenant rights education)	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Utility assistance	Implemented	Medium stakeholder prioritization	Sufficient	Prioritized
One-time transition and moving costs, including first-month's rent	Implemented	Low stakeholder prioritization, high evidence	Sufficient	Prioritized
Transitional housing	Implemented	Medium stakeholder prioritization	Sufficient	Prioritized
Short-term housing intervention with clinical services or medical respite care	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Short-term rental assistance without clinical services (respite services)	Implemented	Medium stakeholder prioritization	Sufficient	Prioritized — included in discussion of service with clinical support
Rental assistance (up to six months)	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Permanent supportive housing	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Security deposits	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization
Housing application, inspection, or identification requirement fees	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization
Housing quality improvements — pest, mold, lead, radon, etc.	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization
Household goods and furniture	Implemented	Low stakeholder prioritization	N/A	Not in study — incorporate into moving costs
Medically needed home accessibility and safety modifications	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization

Table 20 Continued.

Service	Tier 1	Tier 2	Tier 3	Study Prioritization
Peer support services	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization
Skill building — financial literacy, life skills	Implemented	Medium stakeholder prioritization	N/A	Included in discussion about connection to existing supports
On-site physical and behavioral health care	Innovative	N/A	N/A	Not in study — out of scope of study
End-of-life housing	Innovative	Medium stakeholder prioritization	N/A	Included in discussion

Table 21. Food Services Considered for Study

Cells with N/A indicate that a tier was not assessed because the service did not qualify for the study based on a previous tier or the service was out of scope for the study.

Service	Tier 1	Tier 2	Tier 3	Study Prioritization
Home-delivered meals	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Pantry stocking	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Medically tailored meals	Implemented	Medium stakeholder prioritization, high evidence	Sufficient	Prioritized
Produce prescription boxes	Implemented	Medium stakeholder prioritization, high evidence	Sufficient	Prioritized
Nutrition counseling and instruction	Implemented	Medium stakeholder prioritization	Sufficient	Prioritized
Case management with SNAP coordination	Implemented	High stakeholder prioritization	Insufficient	Included in discussion about connection to existing supports
Farmers market/ Community Supported Agriculture (CSA) vouchers	Implemented	High stakeholder prioritization	Insufficient	Included in discussion about implementation considerations
Congregate meals	Innovative	High stakeholder prioritization	Insufficient	Included in discussion about implementation considerations
Child-specific nutrition services	N/A	Medium stakeholder prioritization	N/A	Included in discussion about implementation considerations

Table 22. Extreme Weather Services Considered for Study

Cells with N/A indicate that a tier was not assessed because the service did not qualify for the study based on a previous tier or the service was out of scope for the study.

Service	Tier 1	Tier 2	Tier 3	Study Prioritization
Air conditioning	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Heaters	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Mini fridges	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Utility assistance	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Portable power supply	Implemented	High stakeholder prioritization	Sufficient	Prioritized
Air filtration devices	Implemented	Low stakeholder prioritization	N/A	Not in study — low prioritization
Mold remediation	Implemented	Medium stakeholder prioritization	N/A	Included in discussion
Water filtration	Innovative	Medium stakeholder prioritization	N/A	Not in study — insufficient data and evidence
Cooling shelters	Innovative	Medium stakeholder prioritization	N/A	Not in study — out of scope of study

Table 23. Social Support Services Considered for Study

Cells with N/A indicate that a tier was not assessed because the service did not qualify for the study based on a previous tier or the service was out of scope for the study.

Service	Tier 1	Tier 2	Tier 3	Study Prioritization
Caregiver education	Innovative	High stakeholder prioritization	Low	Prioritized
Parenting classes	Implemented	High evidence, medium stakeholder prioritization	N/A	Prioritized
Child care	Implemented	N/A	N/A	Included in discussion about connection to existing supports
Home visiting for parent education	Implemented	High evidence, medium stakeholder prioritization	N/A	Included in discussion
Medical-legal partnerships	Implemented	Low stakeholder prioritization	N/A	Included in discussion about connection to existing supports
Community integration and companion services	Innovative	Medium stakeholder prioritization	N/A	Included in discussion about connection to existing supports
Intimate partner violence case management and counseling	Innovative	N/A	N/A	Included in discussion about connection to existing supports
Violence intervention services	Innovative	N/A	N/A	Included in discussion about connection to existing supports
Nonemergency transportation	Implemented	N/A	N/A	Not in study — not in scope of study
Housing support	Innovative	N/A	N/A	Included in discussion about connection to existing supports
Built environment improvements	Innovative	N/A	N/A	Not in study — broad infrastructure improvements
Broadband	Innovative	High stakeholder prioritization	N/A	Included in discussion
Translation and interpretation services	Innovative	N/A	N/A	Included in discussion about connection to existing supports
Pet care	Innovative	Low stakeholder prioritization	N/A	Not in study — out of scope of study

Appendix D. Continuous Eligibility Cost Analysis

Analysis Approach

The continuous eligibility analysis uses administrative data prepared by the HCPF data team, both for counts of ineligible member months that would be covered via continuous eligibility as well as the cost per member per month (PMPM) for that coverage. Ineligible months were calculated by adding the number of months per member when they would have lost eligibility and churned off Medicaid coverage, for a 12-month or 24-month continuous period, based on the scenario.

The subsequent section outlines the analysis for each of the four continuous eligibility scenarios.

Scenario A: Children ages 3 to 18 remain continuously eligible for 24 months after they are deemed eligible or until they turn 19 years old (Medicaid and CHP+)

Ineligible months were calculated based on data for calendar years 2018 and 2019. Ineligible months were summarized by each year of age between the ages of 3 and 18. Then, an adjusted PMPM was multiplied by the total ineligible months for each individual age group. This calculation determined the final cost for each age, which was then summarized into the three age groups: ages 3 to 5, ages 6 to 12, and ages 13 to 18. Since the ineligible month data spanned two calendar years, the final costs were divided by two to get a per-year cost for each age group. Ineligible months were confirmed by HCPF's analysts based on previous analyses developed for the HB23-1300 fiscal note. Each analysis differs slightly, so ineligible months may not match their previous estimates. PMPM costs were not run again and are based on the same costs associated with the original analysis.

To adjust PMPM costs from 2018 and 2019 to represent more current costs, the team used cost data from HCPF's FY 2025–26 Medical Services Premium report to calculate a percent change in cost between FY 2018–19 and FY 2024–25.[136] The percent change used for this adjustment was an increase of 70.8% for children.

Table 24 below shows the ineligible months calculated for each age and the associated adjusted PMPM used to create the final cost estimate.

Table 24. Ineligible Month and Adjusted PMPM Counts, by Age, 2018-2019 (Medicaid and CHP+)

Child Age	Ineligible Member Months 2018-2019	Adjusted PMPM	Total Cost per Year
3	105,964	$463.64	$24,564,815
4	106,607	$481.52	$25,666,442
5	105,923	$461.18	$24,425,015
6	93,170	$476.21	$22,184,308
7	93,942	$472.30	$22,184,182
8	95,839	$461.73	$22,125,911
9	97,038	$447.08	$21,691,778
10	97,677	$456.24	$22,281,863
11	98,872	$467.66	$23,119,481
12	98,731	$469.99	$23,201,325
13	95,230	$472.49	$22,497,794
14	94,839	$492.68	$23,362,448
15	93,817	$513.54	$24,089,615
16	94,309	$530.49	$25,015,213
17	98,761	$522.37	$25,795,093
18	106,528	$485.94	$25,882,906
TOTAL	**1,577,247**		**$378,088,189**

Scenario B: Children ages 3 to 5 remain continuously eligible until the child reaches 6 years old (Medicaid and CHP+).

The same methodology used for Scenario A applies. However, rather than summarize ineligible months by age group, they were summarized by year of age between ages 3 and 5. See Table 24 for specific adjusted PMPM and total cost estimates.

Scenarios C and D: Eligible adults remain continuously eligible without regard to income for 12 months or 24 months after they are first determined eligible.

Based on data availability, years used in the analysis for ineligible months differ for each priority population. For those adults with incomes less than 33% of the FPL, HCPF analyzed data from calendar years 2018 and 2019, similar to the original HB23-1300 analysis, but expanded it to include the 24-month continuous coverage analysis. PMPM costs were used from the original fiscal note analysis as well. To adjust PMPM costs from 2018 and 2019 to represent more current costs, the team used cost data from HCPF's FY 2025–26 Medical Services Premium report to calculate a percent change in cost between FY 2018–19 and FY 2024-25.[137] The percent change used for this adjustment was an increase of 50.4% for adults.

For adults who are experiencing homelessness or those leaving the CDOC, FY 2024-25 counts were used to determine ineligible months. For the 12-month continuous eligibility period for this population, the PMPM costs were limited to the first 12 months of eligibility for FY 2024–25, regardless of the Federal Medical Assistance Percentage (FMAP). For the 24-month continuous eligibility period, a PMPM cost was used that was limited to a 24-month period of eligibility for FY 2024–25, regardless of FMAP.

For adults who left CDOC, a PMPM cost was used that was limited to the first 12 months after a CDOC release date, regardless of FMAP. The 24-month continuous eligibility period used a PMPM that included the first 24 months after a CDOC release date, regardless of FMAP.

To calculate the cost estimates, the PMPM was multiplied by the total ineligible months for each adult population. Since the ineligible month data spanned two calendar years, the final costs were divided by two to calculate a per year cost for each age. The adult populations are not mutually exclusive and are treated as separate priority populations.

Appendix E. Stakeholder Engagement

External stakeholders served a critical role in informing, and ultimately prioritizing, the findings of this study. From April to August 2025, CHI hosted four large public meetings engaging 142 unique participants. Additionally, CHI held 12 small group meetings or key informant interviews with external stakeholders, participated in two HCPF-facilitated committee meetings, and regularly met with internal subject matter experts at HCPF to inform the study.

Meeting summaries have been shared in English, Spanish, and Arabic, and recordings in English, Spanish, and ASL are posted on HCPF's HRSN webpage.

The following stakeholders contributed their insights to this study:

- Health First Colorado and CHP+ members and caregivers
- Miriah Nunnaley, Colorado Coalition for the Homeless
- Evan Caster, Leighanna Konetski, and Laura Strother, Colorado Department of Human Services
- Kirstin Toombs and Zac Schaffner, Colorado Department of Local Affairs, Division of Housing
- Ynke de Koe, Colorado Department of Public Health and Environment
- Dr. Sarah Stella and Katie Ryan, Denver Health
- Dr. Ben Li, Firearm Injury Prevention Center, CU Anschutz
- Thea Kachoris-Flores and Kristin Hartsaw, Illinois Department of Healthcare and Family Services
- Ryan Schwarz, Emily Cooper, Martha Farlow, and Gary Sing, MassHealth
- Selena Hajiani and Emily Engel, New York Medicaid
- Maria Perez and Julia Lerche, North Carolina Medicaid
- Keisha Sarpong, Rose Andom Center
- David Karnes, Violence Free Colorado

Representatives from the following organizations also contributed their feedback:

- Adams County Health Department
- Altitude Sports Nutrition
- Ariel Clinical Services
- Ascending to Health Respite Care
- Association for Community Living, Boulder and Broomfield Counties
- Aurora Housing Authority
- Bell Policy Center
- Blueline Development
- Boulder County Housing Authority
- Boulder County Public Health
- Catholic Charities
- Center for People with Disabilities, Boulder
- Children's Hospital Colorado
- City and County of Denver, Housing Programs
- Clinica Health Center
- Colorado Access
- Colorado Children's Campaign
- Colorado Coalition for the Homeless
- Colorado Community Health Alliance
- Colorado Cross-Disability Coalition
- Colorado Department of Early Childhood

- Colorado Department of Higher Education
- Colorado Department of Human Services
- Colorado Department of Public Health and Environment
- Colorado Perinatal Care Quality Collaborative
- Colorado School of Public Health at CU Anschutz
- CommonSpirit Health
- Contexture
- Crossroads Turning Point
- Corporation for Supportive Housing
- Deaf Dove
- Denver Health
- Denver Rescue Mission
- Doctors Care
- DRCOG
- Elephant Circle
- Growing Home
- Healthier Colorado
- Homeward Alliance
- Hunger Free Colorado
- Integrated Life Choices
- La Puente
- Larimer County Department of Human Services
- Lazarus Gate
- Lutheran Family Services Rocky Mountains
- Mesa County Public Health
- Metro Denver Homelessness Initiative
- Mom's Meals
- Muslim Youth for Positive Impact
- Northeast Health Partners
- Park County Senior Coalition
- Pikes Peak Home Care
- Provecho Collective
- RAND
- Rocky Mountain Health Plans
- The Arc Pikes Peak Region
- Thriving Families Colorado
- UC Health
- WellPower
- Western Slope Home Care
- Youth Health Care Alliance
- zTrip

- Additionally, members of the Colorado Department of Health Care Policy and Financing Member Experience Advisory Committee and the Program Improvement Advisory Committee Provider and Community Experience Sub-Committee were engaged and contributed their feedback and experience to this research.

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