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States Can Use Medicaid to Help Address Health-Related Social Needs

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Research shows that access to affordable housing and nutritious foods can have a significant impact on a person's physical and mental health and ability to thrive. The Centers for Medicare & Medicaid Services (CMS) has issued guidance and waiver approvals that broaden and clarify the ways in which states can use Medicaid funds to help pay for clinically appropriate, evidence-based services that address these health-related social needs (HRSN). These changes reflect a growing recognition of the impact HRSN have on health and of Medicaid's ability to help address unmet needs, which contribute to poorer health among people who have low incomes or are part of historically marginalized communities. This paper describes those changes and outlines key considerations for health care advocates and other partners — especially housing advocates — to help their states respond to these important needs.

People with incomes low enough to be eligible for Medicaid are less likely to be able to afford decent housing and sufficient food. Traditional Medicaid benefits include services like inpatient and outpatient care, prescription drugs, and home- and community-based services (to some degree), but when people's housing, nutrition, and other social needs go unmet, this can reduce their access to traditional health care services and worsen their health.

Unmet needs for food and housing affect people's physical and mental health. For example, lack of nutritious foods can make it harder to manage a chronic illness, and lack of stable housing can make it harder to store medications, schedule and attend health care appointments, or address mental health challenges. Due to systemic racism, people of color are more likely to have unmet HRSN. For example, generations of discrimination in employment and education have contributed to higher unemployment and lower pay among many families of color, putting them at higher risk of eviction or food insecurity. Unmet health-related social needs contribute significantly to health inequity.

The growing recognition of the connection between social needs and health led states to look to their Medicaid programs to help address these needs. State requests coupled with recent attention to advancing health equity have resulted in CMS adopting new approaches to broaden allowable HRSN supports provided through Medicaid. CMS recently articulated new flexibility for states to use section 1115 waivers to cover services to address HRSN, clarified Medicaid managed care organizations' ability to provide services to address HRSN, and clarified that Money Follows the

Person (MFP) demonstration funds can be used to include temporary rental assistance and utility services for people transitioning from institutional settings to the community.

Policies CMS articulated in 2022 and summarized in a November 2023 bulletin to states significantly widened states' flexibility to use waivers (technically called Section 1115 demonstrations) to address HRSN, while balancing that flexibility with guardrails that ensure Medicaid's role as health coverage remains paramount:¹

- States may use Section 1115 demonstrations to cover up to six months of transitional housing (including rent), up to six months of nutrition services (such as medically tailored meals, pantry stocking, or food boxes), or both.
- States can also use Medicaid funding to develop the infrastructure to effectively deliver social needs services.
- In exchange, states will have to follow guardrails designed to make sure that new investments in HRSN spending don't substitute for existing services or weaken investments in more traditional Medicaid services.
- To ensure that states are providing adequate access to key Medicaid services at the same time they are expanding HRSN spending, states are also required to ensure that provider payment rates in primary care, obstetrics care, and care for mental health and substance use disorders meet minimum levels — or they must commit to improving payment rates.

In 2023, CMS also clarified how states can structure Medicaid contracts with managed care organizations to allow them to provide services addressing unmet social needs to their members:²

- New CMS policies clarify how states, rather than relying on Section 1115 demonstrations, can build social needs spending into a managed care organization's capitation rate (the per-member, per-month rate it receives for providing Medicaid services).
- Managed care plans can offer alternative services “in lieu of” services or settings described in the state Medicaid plan as long as they are medically appropriate, optional to recipients, and cost effective. Examples include offering a dehumidifier to an enrollee with asthma or offering medically tailored meals to an enrollee with chronic health needs who lives in a food desert. This authority allows states to offer services that can prevent or reduce future health care needs and thus address social needs that can worsen health if they go unmet.

¹ Centers for Medicare & Medicaid Services (CMS), All-State Medicaid and CHIP Call, “Addressing Health-Related Social Needs in Section 1115 Demonstrations,” December 6, 2022, <https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf>; CMS, CMCS Informational Bulletin, “Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program,” November 16, 2023, <https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf>; CMS, “Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP),” November 2023, <https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf>.

² CMS, SMD #: 23-001, Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care, January 4, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>.

In addition, in 2022 CMS issued a notice clarifying that funds from Medicaid’s MFP demonstration program — which supports state efforts to increase the use of home- and community-based services and reduce institutionally based services — can be used to address HRSN in more expansive ways.

These CMS policies on using Medicaid to address HRSN reflect the Biden Administration’s growing focus on addressing unmet social needs.³ They are also part of CMS’s strategy to help advance health equity, defined as ensuring all people have a “fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.”⁴

CMS’s new policies are designed to maximize Medicaid’s potential to help address social needs while preserving Medicaid’s primary role as a health care program. They give states the flexibility to forge cross-sector partnerships among human services programs and to responsibly leverage Medicaid as a bridge to other social supports, like rental or food assistance, but not as a substitute for services that other programs can and should provide on a longer-term basis. Still, a state’s decision to pursue new authority to address HRSN is only a first step; state Medicaid agencies must take care to implement the new authorities effectively, including by establishing and strengthening partnerships with other state agencies and social services providers.

Even states that fully leverage the new policies will not be able to address all HRSN for everyone enrolled in Medicaid. Significant needs for additional support for housing and nutrition lie outside Medicaid’s scope, and Medicaid alone cannot address food insecurity and significant shortfalls in assistance that make housing affordable. But CMS’s new policies allowing states to broaden Medicaid’s role in addressing HRSN will provide temporary supports and connections to services and may help build bridges among health, housing, food, and other systems to address unmet needs. This can make it easier for Medicaid enrollees to connect with housing supports and nutrition assistance that are critical for their health and well-being.

³ White House Domestic Policy Council and Office of Science and Technology Policy, “The U.S. Playbook to Address Social Determinants of Health,” November 2023, <https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf>; Department of Health and Human Services (HHS), “The Biden-Harris Administration Takes Action to Improve Health and Wellbeing By Addressing Social Determinants of Health,” November 16, 2023, <https://www.hhs.gov/about/news/2023/11/16/biden-harris-administration-takes-action-improve-health-and-wellbeing-addressing-social-determinants-health.html>; HHS, “Call to Action: Addressing Health-Related Social Needs in Communities Across the Nation,” November 2023, <https://aspe.hhs.gov/sites/default/files/documents/3e2f6140d0087435cc6832bf8cf32618/hhs-call-to-action-health-related-social-needs.pdf>. In November 2023, HHS (through the Administration for Community Living) and the Department of Housing and Urban Development announced a “Housing and Services Partnership Accelerator” and in February 2024 announced that eight states and the District of Columbia would receive support to develop or expand housing-related supports and services for Medicaid-eligible people with disabilities and older adults who are experiencing or at risk of homelessness. HHS, “Biden-Harris Administration Partners with States to Address Homelessness,” February 9, 2024, <https://www.hhs.gov/about/news/2024/02/09/biden-harris-administration-partners-states-address-homelessness.html>.

⁴ CMS Framework for Health Equity 2022-2023, <https://www.cms.gov/priorities/health-equity/minority-health/equity-programs/framework>.

How People Live, Work, and Play Affects Their Health

Decent housing and nutritious food, accessible transportation, jobs that provide fair pay, quality schools, clean air, and social supports all influence a person’s opportunities to achieve health and well-being, affecting measurable outcomes such as life expectancy, infant mortality, and rates of chronic disease.⁵ Having a low income — which is more common among Black people, Indigenous people, and other people of color due to systemic racism — is associated with greater barriers to health and well-being, and with a greater number of unmet health-related social needs.

Medicaid Can Help Address Health-Related Social Needs

Medicaid covers approximately 87 million people, or about 1 in 4 people in the United States.⁶ Enrollees include roughly half of all children and, as of June 2023, 24.5 million adults with low incomes in states that have adopted the Affordable Care Act (ACA) Medicaid expansion.⁷ Medicaid historically has provided a robust set of health care services, including preventive, acute, and long-term care services. Medicaid is also the main source of funding for home- and community-based services, which help older adults and people with disabilities live independently and safely in the community instead of institutions.

Many Medicaid enrollees have unmet social needs. Over half of Medicaid enrollees had unaffordable or inadequate housing prior to the pandemic.⁸ And roughly one-fifth of enrollees reported that they couldn’t afford adequate food in a given week in 2020; most of these enrollees still couldn’t afford it four months later.⁹

Medicaid is well suited to help address many HRSN by connecting Medicaid enrollees to needed services and supports available in the community.¹⁰ States have used Medicaid funding to cover housing-related supports, home-delivered meals, community integration and social supports, and

⁵ Jennifer Sullivan, “Better State Budget, Policy Decisions Can Improve Health,” CBPP, February 21, 2019, <https://www.cbpp.org/research/state-budget-and-tax/better-state-budget-policy-decisions-can-improve-health>.

⁶ CMS, October 2023 Medicaid & CHIP Enrollment Data Highlights, <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>.

⁷ CMS, Medicaid Enrollment Data Collected Through MBES, January 2024, <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/medicaid-enrollment-data-collected-through-mbes/index.html>. These numbers are likely to drop as states continue “unwinding” pandemic-era continuous coverage protections.

⁸ Bradley Corallo, “Housing Affordability, Adequacy, and Access to the Internet in Homes of Medicaid Enrollees,” KFF, September, 22, 2021, <https://www.kff.org/medicaid/issue-brief/housing-affordability-adequacy-and-access-to-the-internet-in-homes-of-medicaid-enrollees/>.

⁹ Cornelia Hall *et al.*, “Food Insecurity and Health: Addressing Food Needs for Medicaid Enrollees as Part of COVID-19 Response Efforts,” KFF, August 14, 2020, <https://www.kff.org/medicaid/issue-brief/food-insecurity-and-health-addressing-food-needs-for-medicaid-enrollees-as-part-of-covid-19-response-efforts>.

¹⁰ Peggy Bailey, “Housing and Health Partners Can Work Together to Close the Housing Affordability Gap,” CBPP, January 17, 2020, <https://www.cbpp.org/research/housing/housing-and-health-partners-can-work-together-to-close-the-housing-affordability>; Hannah Katch, “Medicaid Can Partner with Housing Providers and Others to Address Enrollees’ Social Needs,” CBPP, updated January 27, 2020, <https://www.cbpp.org/sites/default/files/atoms/files/17-20health.pdf>.

case management.¹¹ States have also encountered limitations and uncertainty with respect to the types of services that can be covered, which guidance across multiple administrations has sought to clarify.¹² The most recent guidance from CMS provides clarity and is enabling states to push forward and experiment with services that respond to other important health-related needs, often on a time-limited basis.

Interest in health-related social needs has grown since enactment of the ACA. The ACA Medicaid expansion has made Medicaid accessible to more adults with low incomes who may also have high rates of unmet social needs, including homelessness, chronic health conditions, and mental health and substance use issues. In 2021, 25 percent of adults aged 18-64 and enrolled in Medicaid had multiple chronic conditions.¹³ An estimated 29 percent of Medicaid enrollees have a mental health condition and 21 percent have a substance use disorder.¹⁴

States can use the Medicaid authorities discussed in this paper and Appendix to address unmet HRSN regardless of whether they have expanded Medicaid. States that have expanded Medicaid — a crucial step in addressing unmet acute health care needs among people with low incomes — are positioned to take a more holistic approach to addressing HRSN, and such initiatives are likely to have a greater impact.

Recent CMS Policies Broaden Opportunities to Use Medicaid to Address HRSN

CMS's recent guidance outlines opportunities to use Medicaid to help address HRSN in service of supporting better health for Medicaid enrollees. CMS has now clarified: (1) how states can use Section 1115 demonstrations to help finance spending on HRSN; (2) opportunities to deliver services to address HRSN through managed care organizations; and (3) flexibility to address HRSN through the Money Follows the Person demonstration.

The new CMS policies give states more opportunities to cover services that respond to Medicaid beneficiaries' health-related social needs while remaining consistent with important, long-standing Medicaid principles including:

- ensuring Medicaid continues to perform its primary function of providing people with access to clinical health care services;
- ensuring that Medicaid's investments in HRSN services are evidence-based and medically appropriate;

¹¹ Elizabeth Hinton and Amaya Diana, "Medicaid Authorities and Options to Address Social Determinants of Health," KFF, January 29, 2024, <https://www.kff.org/report-section/medicaid-authorities-and-options-to-address-social-determinants-of-health-sdoh-issue-brief/>.

¹² CMS, SHO# 21-001 RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), January 7, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf>.

¹³ CBPP analysis of 2021 National Health Interview Survey.

¹⁴ Heather Saunders and Robin Rudowitz, "Demographics and Health Insurance Coverage of Nonelderly Adults with Mental Illness and Substance Use Disorders in 2020," KFF, June 6, 2022, <https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/>.

- ensuring that Medicaid’s investments in HRSN are time-limited, appropriately targeted to people who need them, and don’t merely replace existing spending on social needs; and
- respecting that Medicaid cannot address the underlying causes or the full scope of these unmet HRSN, which would require broader systemic changes.

The new policies enable states to test strategies that otherwise contradict Medicaid’s statutory prohibition on paying for “room and board” outside of institutional settings (e.g., nursing facilities), while protecting against federal Medicaid dollars supplanting social spending that has traditionally been the responsibility of states and other federal programs. CMS’s new policies also include important monitoring mechanisms to evaluate the effectiveness of new approaches and to ensure that HRSN spending does not exceed certain thresholds.

The following sections describe how recent changes to Section 1115 demonstrations, Medicaid managed care policies, and Money Follows the Person policies expand states’ opportunities to use Medicaid flexibilities to address HRSN. (For more information about these and other authorities that states can use to address unmet social needs, see the Appendix.)

Opportunities to Use Section 1115 Demonstrations to Address HRSN

Section 1115 of the Social Security Act permits the Secretary of Health and Human Services (HHS), acting through CMS, to waive certain provisions of the Medicaid statute and to provide “expenditure authority,” which authorizes Medicaid matching funds to help pay for expenditures not otherwise allowable under the statute, so long as the Section 1115 demonstration meets Medicaid’s objectives and is used to test novel hypotheses. Section 1115 demonstrations must also meet certain financial guardrails, and recent CMS guidance facilitates new coverage of HRSN services. (See text box, “States Will No Longer Have to Offset HRSN Spending.”)

For decades, states have used Section 1115 demonstrations to test new strategies to improve coverage and care for Medicaid beneficiaries. CMS has approved Section 1115 demonstrations featuring a wide range of HRSN services. These include supportive housing services like pre-tenancy services that assist people with housing access (e.g., housing search assistance, landlord engagement, move-in assistance, and home furnishings) and tenancy sustaining services, which can also be covered through state plan amendments.

In recent years, states have expressed growing interest in using Section 1115 demonstrations to pay for housing and nutrition services that would not otherwise be permissible uses of Medicaid dollars. Until recently, Medicaid’s long-standing prohibition on paying for room and board in non-institutional settings meant that CMS was generally unwilling to approve Section 1115 demonstrations to allow such spending.¹⁵ But CMS’s December 2022 framework, first articulated in its Fall 2022 approvals of Oregon and Massachusetts demonstrations and then outlined in slides shared with states and reflected in additional demonstration approvals in 2023 and early 2024, reflects an approach that is explicitly tied to the Biden Administration’s agenda to address health equity.

¹⁵ North Carolina previously received approval for short-term, post-hospitalization housing, but CMS did not express openness to similar requests until recently. See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf>.

CMS's new approach allows states to provide additional time-limited housing and nutrition services as well as the infrastructure necessary to implement these and other services to address social needs, subject to overall limitations on such spending.¹⁶ In November 2023, CMS reiterated its HRSN waiver policy in a bulletin to states, accompanied by a chart that provides more detail about the services and supports that CMS considers allowable under waivers as well as other federal authorities.¹⁷ The box "HRSN Services That Can Be Covered Under Section 1115 Demonstrations" gives examples of these services.

¹⁶ CMS, All-State Medicaid and CHIP Call, "Addressing Health-Related Social Needs in Section 1115 Demonstrations," December 6, 2022, <https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf>. For initial approvals of new HRSN expenditures in Massachusetts and Oregon, see Chiquita Brooks-LaSure, Letter to Amanda Cassel Kraft, Executive Office of Health and Human Services, September 28, 2022, <https://www.medicaid.gov/sites/default/files/2022-09/ma-masshealth-ca1.pdf>; Chiquita Brooks-LaSure, Letter to Dana Hittle, Oregon Health Authority, September 28, 2022, <https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf>. Both demonstrations have since been updated (with current terms and conditions available on CMS's state waiver list), <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>; these citations include the original approval letters outlining new CMS policies.

¹⁷ CMS, CMCS Informational Bulletin, "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program," November 16, 2023, <https://www.medicaid.gov/sites/default/files/2023-11/cib11162023.pdf>; CMS, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," November 2023, <https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf>.

HRSN Services That Can Be Covered Under Section 1115 Demonstrations

CMS's Section 1115 demonstration policy changes specify that HRSN case management and the following HRSN services are approvable if states meet specified guardrails and conditions. CMS will consider certain other services as well.

Housing Supports

- Short-term, post-transition housing for up to six months for people transitioning out of institutional or congregate care, people experiencing or at risk of homelessness, or youth transitioning out of the child welfare system
- Traditional respite services for primary caregivers to give them short-term relief, provided by an at-home provider, health care facility, or adult day center
- Day habilitation programs to support skills needed to live successfully in the community
- Sobering center programs (for less than 24 hours, no room and board)
- Pre-tenancy and tenancy-sustaining services, including tenant rights education and eviction prevention
- Housing transition and navigation services, including individualized case management
- One-time transition and moving costs, including security deposit, utility activation fees, movers, relocation expenses, application and inspection fees, fees to meet identification requirements, etc.
- First month's rent, as a transitional service
- Medically necessary home accessibility modifications and remediation services, including carpet replacement, mold and pest removal, and ventilation improvements
- Medically necessary home environment modifications, including air conditioners, heaters, air filtration devices, and generators

Nutrition Supports

- Case management services for access to food/nutrition
- Nutrition counseling and instruction
- Medically tailored meals (up to three meals per day for up to six months)
- Home-delivered meals or pantry stocking (up to three meals per day for up to six months)
- Nutrition prescriptions, such as fruit and vegetable prescriptions and/or protein boxes (up to three meals/day for up to six months)
- Grocery provisions for high-risk individuals (up to three meals/day for up to six months)

Sources: <https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall12062022.pdf>;
<https://www.medicaid.gov/sites/default/files/2023-11/hrsn-coverage-table.pdf>

Under CMS's new guidance, states can also use Section 1115 demonstrations to finance investments in infrastructure to build capacity to deliver these services. Investments could include technology, development of business and operational practices, and outreach and education, as well as workforce development (but not construction or capital costs).

California is using new infrastructure funding to help develop the capacity to provide HRSN services, including through the “in lieu of services and settings” authority described below.¹⁸ Arizona, Massachusetts, New Jersey, New York, Oregon, Washington, and, to a lesser degree, Arkansas also have received Section 1115 demonstration approvals that include funding for infrastructure and capacity building.¹⁹ Nearly a dozen states have similar requests pending with the federal government. States can use these investments to improve the beneficiary experience in accessing HRSN services, such as by building enough provider capacity to serve everyone who qualifies for and needs the services.

New 1115 Demonstration Authority Comes With Guardrails and Conditions

In broadening state flexibility under Section 1115 demonstrations, CMS also established new guardrails and conditions to ensure that spending on HRSN supports beneficiaries’ health while they connect to more sustainable resources — such as long-term rental assistance — without supplanting existing funding sources for HRSN or displacing other important Medicaid spending that provides access to health care.

States that receive approval will be subject to limits on total HRSN spending, implementation requirements, and enhanced monitoring and evaluation standards. For example, they must develop a plan to track and increase the share of Medicaid enrollees who are enrolled in programs that address other social needs, including the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), and federal housing assistance, relative to the total number of Medicaid enrollees in the state who are eligible for those programs.²⁰ This requirement helps to ensure that states work to maximize participation in programs intended to address HRSN, so that Medicaid can primarily fill in gaps and address transitional periods rather than substitute for existing services.

¹⁸ California Department of Health Care Services, “California Awards \$144 Million to Break Down Barriers to Care,” Press Release, October 31, 2023, <https://www.dhcs.ca.gov/formsandpubs/publications/oc/Documents/2023/23-45-PATH-CITED-10-31-23.pdf>.

¹⁹ KFF, “Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State,” Table 3, <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/#Table3>. For current terms and conditions governing these demonstrations, see Danielle Daly, Letter to Dawn Stehle, Arkansas Department of Human Services, December 28, 2022, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-demo-appvl-12282022.pdf>; Daniel Tsai, Letter to Carmen Heredia, Arizona Healthcare Cost Containment System, June 7, 2023, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-coid-chip-demonstn-aprl-ca.pdf>; Angela Garner, Letter to Mike Levine, Executive Office of Health and Human Services, June 21, 2023, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-appvl-06212023.pdf>; Daniel Tsai, Letter to Amir Bassiri, Medicaid Director, Deputy Commissioner, New York Department of Health, January 9, 2024, [ny-medicaid-rdsgn-team-appvl-01092024.pdf](https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ny-medicaid-rdsgn-team-appvl-01092024.pdf); Chiquita Brooks La-Sure, Letter to Jennifer Jacobs, Division of Medical Assistance and Health Services, March 30, 2023, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-cms-exten-demnstr-aprvl-03302023.pdf>; Daniel Tsai, Letter to Dana Hittle, Oregon Health Authority, April 20, 2023, <https://www.medicaid.gov/sites/default/files/2023-04/or-health-plan-ca-04202023.pdf>; Daniel Tsai, Letter to Charissa Fotinos, Washington Health Care Authority, June 30, 2023, <https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf>.

²⁰ See, e.g., Angela Garner, Letter to Mike Levine, Executive Office of Health and Human Services, June 21, 2023, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ma-masshealth-appvl-06212023.pdf>.

In some cases, states must also commit to increase and sustain Medicaid payment rates for primary care, behavioral health, and obstetric care in order to demonstrate their commitment to maintaining and improving access to clinical care, alongside their HRSN investments.

CMS's new policy includes the following guardrails:

- **Newly covered services must be time-limited, and states must have partnerships with other state and local entities to help enrollees obtain non-Medicaid housing and nutrition supports.** CMS will authorize allowable room and board services and nutrition services for up to six months. As CMS works with states, it is becoming increasingly clear that some services may only be approved for an enrollee once per demonstration period, while other services may be available more than once per demonstration period if the enrollee continues to meet clinical and needs-based criteria.

CMS also reiterates that HRSN services must be integrated with existing social services and housing assistance. For example, in the case of nutrition supports, CMS requires state Medicaid agencies to partner with other state agencies and social service providers to connect enrollees to other federal programs that can help address unmet needs, like SNAP, WIC, and TANF.²¹ States also must partner with state and local housing agencies to implement allowable short-term rental assistance. And states must align clinical and social risk criteria for Medicaid services with criteria to receive other non-Medicaid social supports, to the extent possible.

- **Services must be medically appropriate and evidence-based, and they must center beneficiary choice.** The state must determine that an HRSN service is clinically appropriate for an individual enrollee, using state-defined clinical and social risk criteria that are documented in the enrollee's care plan or medical record. CMS makes clear that it is each enrollee's choice to receive HRSN services, and they can opt out at any time. States and managed care plans cannot condition Medicaid coverage on the receipt of HRSN services and must still provide other medically necessary services, such as primary care.
- **The new financing flexibility is subject to limits.** CMS has clarified several aspects of waiver financing to support more widespread adoption of HRSN services, within defined limits.

First, CMS will work with states to establish a baseline level of state funding for social services related to their approved HRSN demonstration and is requiring states to maintain spending at that level over the course of the demonstration.²² This is an important guardrail

²¹ For more information on how state Medicaid agencies can partner with WIC agencies to connect enrollees to WIC, see Sonya Schwartz *et al.*, "State Medicaid Agencies Can Partner With WIC Agencies to Improve the Health of Pregnant and Postpartum People, Infants, and Young Children," CBPP and Georgetown Center for Children and Families, December 20, 2023, <https://www.cbpp.org/research/food-assistance/state-medicaid-agencies-can-partner-with-wic-agencies-to-improve-the>.

²² Through its demonstration Special Terms and Conditions and in its November 2023 informational bulletin, CMS reiterates that services to address HRSN should complement, not supplant, existing social services or housing assistance. For example, CMS states: "Medicaid-covered services and supports to address HRSN will not supplant the work or funding of another federal or state non-Medicaid agency, and must be complementary to existing social services such as those provided by the U.S. Department of Housing and Urban Development and the U.S. Department of Agriculture Supplemental Nutrition Assistance Program." CMCS Informational Bulletin, 2023.

to ensure that federal Medicaid funds add to, rather than supplant, other sources of funding for HRSN.

Second, states will no longer be required to offset their HRSN expenditures with savings; this will make it easier for all states to utilize demonstrations to deliver HRSN regardless of whether they have such savings. (See the text box, “States Will No Longer Have to Offset HRSN Spending.”) In exchange for giving states this flexibility, CMS is capping spending on HRSN services and infrastructure at 3 percent of a state’s total computable Medicaid spending; CMS is also limiting spending on infrastructure to 15 percent of the state’s total HRSN spending.

Third, CMS will again allow state spending on Designated State Health Programs (DSHP) to receive federal Medicaid matching funds.²³ DSHPs are existing state-funded health programs that did not previously qualify for federal funding, including Medicaid, but for which CMS allows Medicaid matching funds under an approved waiver. By getting permission to claim federal matching funds for services that states previously funded on their own, states can free up state funding to invest in HRSN services or infrastructure. For example, if a state was already using state funds to pay for cancer detection and treatment for low-income, uninsured, and medically underserved people, it could receive federal matching funds to continue those services, which would allow the state to reinvest the freed-up state dollars in HRSN infrastructure to support the Medicaid population.

Under CMS’s new policy, DSHP-funded initiatives will be limited to programs that are aligned with Medicaid’s objectives and are expected to improve overall coverage of low-income individuals, improve health outcomes for Medicaid beneficiaries and other low-income populations, reduce health disparities, or otherwise increase the efficiency and quality of care. CMS is also capping DSHP-funded expenditures at 1.5 percent of a state’s total Medicaid spending during the demonstration period and is requiring states to agree to other conditions. For example, the DSHP investment must add to the state’s Medicaid program, not supplant existing services or programs.²⁴

- **States must pair significant investments in HRSN with provider payment increases.** As a condition of approving the DSHP expenditure authority described above or robust

²³ DSHP authority has supported an array of delivery system reform initiatives, but in 2017, the Trump Administration announced that it would no longer approve DSHP expenditures, expressing concern that DSHP was not adding value, or any additional services, to Medicaid. CMS Letter to State Medicaid Directors #17-005, Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 Demonstrations, December 15, 2017, <http://web.archive.org/web/20171218153915/https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf>. The Biden Administration revived DSHP to support investments in HRSN spending while establishing guardrails to cap overall DSHP spending and tie DSHP authority to other Medicaid improvements. CMS has approved DSHP spending in Arizona, California, New York, and Oregon; a DSHP request in Washington is still pending.

²⁴ States that have received DSHP authority over the last year have also agreed to contribute state funds for expenditures under the DSHP-supported demonstration initiative. CMS also is requiring that newly authorized DSHP spending be time-limited, that states submit a sustainability plan that describes the scope of the DSHP-supported initiatives that the state wants to maintain, and that states commit to increasing provider payment rates for selected services, as described below.

federal investments in services to address HRSN,²⁵ CMS requires a parallel state investment in improving payment rates in other parts of the state’s Medicaid program.²⁶ This new requirement is intended to bolster access to traditional health care services alongside the state’s investments in new services to address social needs. It is another important strategy to ensure that HRSN spending does not displace core Medicaid services.

Under these requirements, state Medicaid reimbursement rates for primary care, obstetrics care, and care for mental health and substance use disorders in both managed care and fee-for-service delivery systems must be at least 80 percent of Medicare rates. If they are not at that level already, by year three of the demonstration the state must commit to increasing payment rates by two percentage points in the category with the lowest rates and sustain that increase throughout the demonstration period.

- **HRSN spending is subject to new evaluation, monitoring, and reporting standards.**

CMS, which always requires monitoring and evaluation as part of approved 1115 demonstrations, will require states to submit implementation plans and protocols and has articulated specific standards for reporting on HRSN service implementation. These requirements are designed to gain insights into state progress and challenges and to track HRSN service utilization as well as health outcomes for individuals receiving the services.

In addition, waiver evaluations will be required to consider whether HRSN services effectively address unmet HRSN, reduce potentially avoidable high-cost services, and/or improve physical and mental health outcomes. Consistent with its focus on health equity, CMS is also requiring states implementing these demonstrations to track and report equity outcomes, broken down not just by race and ethnicity but also by language, geography, disability status, sexual orientation, and gender.

As with other elements of the demonstration, if the data a state submits as part of the monitoring process suggest that efforts to address HRSN are not promoting Medicaid’s objectives, CMS may require a state to revise its implementation plan or submit a corrective action plan; as is true of all demonstrations, CMS could opt not to renew a waiver where there is no evidence of success.

CMS has set meaningful standards for these waivers, and states will have to undertake careful implementation planning to launch successful HRSN waivers and State Plan Amendments. In recognition of the cross-sector collaboration that may be necessary to successfully implement these efforts, HHS and the Department of Housing and Urban Development launched a “Housing and Services Partnership Accelerator,” which recently selected the District of Columbia and eight states that are already on the leading edge of securing authorities to address HRSN to “help strengthen partnership across housing, disability, aging, and health sectors” and to receive “intensive federal technical assistance” to support implementation of clinically-indicated housing-related services and supports for people with complex health needs experiencing or at-risk of homelessness.²⁷

²⁵ States are required to increase provider rates as a condition of receiving approval for HRSN investments if annual HRSN expenditure authority equals at least \$50 million or 0.5 percent of the state’s total annual Medicaid spending, whichever is less.

²⁶ To date, the following states have agreed to provider payment rate increases: Arizona, California, Massachusetts, New Jersey, New York, Oregon, and Washington.

²⁷ HHS, “Biden-Harris Administration Partners with States to Address Homelessness.”

States Will No Longer Have to Offset HRSN Spending

CMS has long required that Section 1115 demonstrations be budget neutral – that is, they must cost the federal government no more than it would spend in the absence of the demonstration. For each approved demonstration, CMS develops a budget neutrality model that includes certain assumptions about spending under the demonstration (including the projected rate of growth year over year), and CMS tracks state spending throughout the course of the demonstration.

Over time, many states with long-standing demonstrations have accrued savings under their demonstrations when their federal spending was lower than projections and, in some cases, have used those savings to invest in new services, including services to support HRSN. States without demonstrations, or without sufficient savings, have been limited in their ability to make new investments that are not guaranteed to produce savings over time. Even states with sufficient savings to fund investments up front have expressed concern about their ability to sustain spending on HRSN, particularly in light of policies that CMS set to “rebase” (recoup) demonstration savings over time.

The 1115 HRSN demonstrations approved in 2022 and 2023 respond to these concerns in several ways:

- CMS will treat HRSN spending as “hypothetical” expenditures under demonstrations (i.e., expenditures states could have made without the waiver), which means that states will no longer have to use savings to pay for it (but they will have to live within the caps on overall HRSN spending described in this report).
- CMS will now consider state requests to make annual adjustments to budget neutrality in response to unexpected costs, rather than adjusting budget neutrality only at renewal. The new policy will help sustain innovative investments in the face of other cost increases that would have occurred even without the waiver.
- CMS will assume cost growth based on national spending projections, no longer relying on *the lower of* national or state projections. This could help states with lower-than-average Medicaid spending increase investments in their programs.
- CMS will revise its policy of “rebasing” 1115 demonstrations at renewal in a way that will give states more flexibility to continue investing in experimental projects.*

These and other changes create space for states to invest in HRSN and other delivery system reforms. But ongoing monitoring will be essential to ensure that each demonstration benefits enrollees and advances health equity.

* For details see Cindy Mann, Anne O’Hagen Karl, and Heather Howard, “CMS Updates Its Budget Neutrality Policy,” Health Affairs Forefront, January 26, 2023, <https://www.healthaffairs.org/content/forefront/cms-updates-its-budget-neutrality-policy>

Source: Centers for Medicare & Medicaid Services, All-State Medicaid and CHIP Call, December 6, 2022, <https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf>

New Flexibility in Medicaid Managed Care

Addressing HRSN through managed care organizations is a strategy that holds promise because 74 percent of Medicaid enrollees are enrolled in managed care.²⁸ States and managed care organizations can use a variety of different approaches to address enrollees' HRSN, and a growing number of states are incorporating HRSN into their Medicaid managed care contracts.²⁹ Recent CMS guidance and recently proposed regulations clarify the use of one approach to delivering HRSN through managed care: the so-called “in lieu of services or settings” (ILOS) authority.

A state can authorize managed care organizations to provide alternative services in lieu of services or settings described in the state plan if the state determines it is medically appropriate and cost effective to do so.³⁰ States have used ILOS authority to pay for things like in-home prenatal visits for at-risk pregnant beneficiaries as an alternative to traditional office visits.³¹

States specify allowable ILOS in their contracts with managed care organizations, but those organizations elect whether to provide the services, and enrollees can choose whether to receive the ILOS instead of the underlying covered item. ILOS are treated as clinical services for purposes of capitation rate-setting, which has encouraged states and managed care organizations to adopt them.³² However, it has long been unclear to what extent states can use ILOS authority to cover HRSN services, which has limited adoption of these services.

Since late 2021, the standards for ILOS have become clearer. First, CMS approved California's request to use ILOS authority to support a broader array of services and supports than it had allowed in other states.³³ (See text box, “California Using ILOS to Offer Community Supports to Address HRSN.”) CMS's approval included a number of conditions that the agency has now articulated in both guidance and a proposed regulation.³⁴

²⁸ KFF, “Total Medicaid MCO Enrollment,” 2021, <https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

²⁹ For a comprehensive overview of authorities to advance HRSN in managed care, see Bailit Health, “Addressing Health Related Social Needs Through Medicaid Managed Care,” State Health & Values Strategies, updated December 2023, <https://www.shvs.org/wp-content/uploads/2023/12/Addressing-HRSN-Through-Medicaid-Managed-Care-December-2023.pdf>.

³⁰ 42 C.F.R. § 438.3(e)(2).

³¹ David Machledt, “Addressing the Social Determinants of Health Through Medicaid Managed Care,” Commonwealth Fund, November 29, 2017, <https://www.commonwealthfund.org/publications/issue-briefs/2017/nov/addressing-social-determinants-health-through-medicaid-managed>.

³² MACPAC, “Medicaid Managed Care Capitation Rate Setting,” March 2022, <https://www.macpac.gov/wp-content/uploads/2022/03/Managed-care-capitation-issue-brief.pdf>.

³³ Cindy Mann and Dori Reyneri, “New Policy Opens the Door for States to Address Drivers of Health in Medicaid,” Commonwealth Fund, April 19, 2022, <https://www.commonwealthfund.org/blog/2022/new-policy-opens-door-states-address-drivers-health-medicaid>.

³⁴ CMS, SMD #: 23-001, Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care, January 4, 2023, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf>; CMS, Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Proposed Rule, 88 Fed. Reg. 28092, May 3, 2023, <https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08961.pdf>.

With its new guidance and proposed regulation, CMS is making clear that ILOS do not have to be an *immediate* substitute for state plan services or settings; they can be a longer-term substitute aimed at preventing or reducing future health care needs and thereby addressing social needs that can have a detrimental impact on health. For example, in the preamble to the proposed rule, CMS explains that:

- Medically tailored meals could help prevent an emergency room visit or inpatient hospital stay for an individual with a diabetes diagnosis and poorly managed blood sugar levels.
- Housing transition navigation services could reduce an individual's likelihood of needing a covered state plan service or setting, such as institutional care.
- ILOS could be expected to reduce or prevent the need to use a covered service or setting, such as inpatient hospital stays for populations with chronic conditions who are determined to be at risk of homelessness.³⁵

CMS has also established several principles to help ensure the appropriate and efficient use of ILOS, consistent with its goal of improving health outcomes and advancing health equity. Under the new guidance (and the proposed regulation), ILOS must advance the objectives of Medicaid and must be:

- cost effective;
- documented to be medically appropriate for the enrollee;
- provided in a manner that preserves enrollee rights and protections (including grievances, appeals, and fair hearings);
- subject to appropriate monitoring and oversight; and
- subject to retrospective evaluation in certain circumstances.

States that adopt ILOS will need to agree to these standards. Finally, consistent with CMS's position that spending on social needs should not crowd out other Medicaid spending, CMS also established limitations on the amount of a state's ILOS spending.³⁶

More widespread adoption of ILOS would be a powerful strategy to help address HRSN, but it would require partnership among states and managed care organizations — and, ideally, community-based organizations, which could provide ILOS in many cases. While states can encourage managed care organizations to offer ILOS, they must allow the managed care organizations to decide whether to cover any, some, or all authorized ILOS, which means there is no guarantee that enrollees will have access to ILOS even if states adopt them.

³⁵ 88 Fed. Reg. 28092 at 28167.

³⁶ CMS has indicated that it will not approve ILOS that are expected to exceed 5 percent of managed care capitation. And for both new and previously approved ILOS, states will be required to certify ILOS spending annually as part of their annual managed-care-rate submissions; states with costs exceeding 1.5 percent of capitation will be subject to enhanced evaluation and reporting requirements.

And even if states encourage managed care organizations to offer ILOS, some states — like California — may still rely on Section 1115 demonstrations either to fund services that include room and board (like time-limited housing and nutrition services) or to support the infrastructure necessary to make ILOS successful. For example, small community-based providers often lack the capacity or infrastructure to partner with large health plans, such as the ability to effectively negotiate rates or the systems required to collect and report data. As in California, Section 1115 demonstrations could be used to help fund investments in infrastructure to help facilitate connections among community-based providers who provide ILOS services, network providers who refer enrollees to community-based ILOS services, and the managed care entities or state agency paying for such services.

California Using ILOS to Offer Community Supports to Address HRSN

Given that more than 65 percent of Medi-Cal enrollees are from communities of color, California identified addressing HRSN as key to advancing health equity and helping people with high health care and social needs. In 2021, California received approval to use ILOS to offer 12 “Community Supports” for people with complex, unmet needs. Medi-Cal managed care plans can offer all, some, or none of the following supports as alternatives to traditional medical services or settings:

- Housing transition navigation services
- Housing deposits
- Housing tenancy and sustaining services
- Day habilitation programs
- Caregiver respite services
- Nursing facility transition/diversion to assisted living facilities
- Community transition services/nursing facility transition to a home
- Personal care and homemaker services
- Environmental accessibility adaptations (home modifications)
- Medically supportive food/meals or medically tailored meals
- Sobering centers
- Asthma remediation

California includes these services in managed care payment rates (that is, the capitation rates that the state negotiates with managed care plans account for ILOS spending). California also received approval to provide two additional community supports — recuperative care (medical respite) and short-term post-hospitalization housing — through Section 1115 demonstration authority. Those two supports include spending on room and board, which is not typically allowable in Medicaid and thus is only permitted through 1115 demonstrations, not as an ILOS.

Managed care organizations are contracting with community-based providers to provide all of the community supports, regardless of the authority by which they are authorized.

Source: “Medi-Cal Transformation: Community Supports,” California Department of Health Care Services (DHCS), <https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-CS-a11y.pdf>; “Transformation of Medi-Cal: Community Supports,” DHCS, <https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf>

Changes in Money Follows the Person Facilitate Transitions to Community

Congress authorized Money Follows the Person in 2005 to give states grant funding and flexibility to help beneficiaries safely transition from nursing facilities and other institutions to their own home, the home of a caregiver, or a community-based residential facility. MFP allows states to provide non-traditional services such as home-delivered meals, wheelchair ramps and other home modifications, and support for caregivers. The program is funded at \$450 million per year through 2027.

Lack of community resources is a key challenge for states in successfully implementing MFP, a national evaluation of the program found.³⁷ In particular, lack of affordable housing has prevented some individuals who may have been able, from a clinical perspective, to transition out of a nursing facility from doing so. Other frequently cited barriers to wider MFP implementation include workforce shortages, uncertainty about federal funding availability, and state caps on home- and community-based services that many people need to live in the community.³⁸

In 2022, CMS issued a notice clarifying that MFP funds used for “supplemental services” (one-time services not otherwise allowed under Medicaid) can include up to six months of rental assistance and utility expenses for people transitioning to the community.³⁹ Supplemental services also could include food pantry stocking for up to a 30-day period to help address food insecurity. These supplemental services are now 100 percent covered by federal grant funds; no state funding is required. However, states that opt to provide these services must do so with the funding Congress makes available under MFP, and states must describe how to ensure continued access to housing or food assistance services once the demonstration funding is no longer available. CMS is applying this standard across its authorities to encourage sustainability of services.

³⁷ HHS, “Report to the President and Congress: The Money Follows the Person (MFP) Rebalancing Demonstration,” June 2017, <https://www.medicaid.gov/sites/default/files/2019-12/mfp-rtc.pdf>.

³⁸ See MACPAC, “Revisiting the Money Follows the Person Qualified Residence Criteria,” March 2022, <https://www.macpac.gov/wp-content/uploads/2022/03/Chapter-1-Revisiting-the-Money-Follows-the-Person-Qualified-Residence-Criteria.pdf>.

³⁹ CMS, Note to MFP Recipients: Announcement of Certain Changes to Supplemental Services under the MFP Demonstration, <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/mfp-supplemental-services-notice.pdf>.

APPENDIX

Common Medicaid Authorities States Use to Address Health-Related Social Needs

Medicaid authority	Examples of key health-related services or investments that can be included	How is eligibility for the services defined? ^a	Are there budget neutrality or other cost limits?	Must covered services be available statewide?	How do states use this authority?	State examples
State Plan Amendment — Rehabilitative Services Option	<p>Pre-tenancy and tenancy-sustaining services^b</p> <p>Case management and/or peer support services, which can help people find and secure stable housing or address other social needs</p>	<p>Services must be rehabilitative in nature, meaning they restore an individual’s functioning that was affected by their health condition.</p> <p>States can define who is eligible for services, including creating a service for people with specific disabilities or health conditions.</p>	No	Yes. Services covered through the state plan must be made available to all Medicaid enrollees who meet the needs-based criteria.	The state submits a state plan amendment to CMS. CMS has 90 days to approve or deny the amendment or request additional information from the state.	<p>New York</p> <p>Louisiana</p>
1915(c) Home- and Community-Based Services (HCBS) Waiver	<p>Pre-tenancy and tenancy-sustaining services</p> <p>Housing navigation services</p>	Services are for people who would otherwise require institutional care in the absence of HCBS. States typically have multiple 1915(c) waivers, each designed to serve a specific	Yes. The waiver must be cost-neutral for the federal government. This is often readily achieved because it is	No. States can limit services to geographic areas or cap the number of eligible beneficiaries, to limit the state’s costs or to reflect	The state must provide a public comment period on its waiver proposal and consider those comments prior to submitting a waiver request to CMS.	<p>Wisconsin Include, Respect, I Self-Direct Waiver</p> <p>Louisiana Community Choice Waiver</p>

	<p>One-time transition costs for people leaving institutional care</p> <p>Home modifications</p> <p>Meal preparation supports or home-delivered meals (cannot constitute three meals a day)</p>	<p>population, such as people with developmental disabilities, older adults with disabilities, people with physical disabilities, or people with brain injuries. These waivers rarely cover services for people with mental health or substance use disorders.</p>	<p>typically less expensive to deliver care in the community than in an institutional setting.</p>	<p>limited provider capacity to deliver services.</p>	<p>CMS has 90 days to decide whether to approve or deny the amendment or request additional information from the state.</p> <p>Initial waivers are approved for three years and can be renewed in five-year increments.</p>	<p>Maryland Community Supports Waiver</p>
<p>1915(i) State Plan Home- and Community-Based Services Option</p>	<p>Any services that can be covered under section 1915(c) waivers</p>	<p>States can use 1915(i) to cover services for people with disabilities living in the community regardless of whether they would need institutional levels of care in the absence of 24HCBS.</p> <p>States can define who meets the needs-based criteria, which must include health-related factors and non-health risk factors such as experiencing or being at risk of homelessness. The health-related factors can include specific disabilities or health conditions.</p>	<p>No</p>	<p>Yes. All services the state chooses to cover using 1915(i) must be available statewide for all eligible individuals.</p>	<p>The state submits a 1915(i) state plan amendment request to CMS. CMS has 90 days to approve or deny the amendment or request additional information from the state.</p> <p>If the state targets the benefit to a specific population (e.g., people with certain kinds of disabilities), the state must submit to CMS a renewal request every five years.</p>	<p>Connecticut</p> <p>District of Columbia</p> <p>Michigan</p> <p>Minnesota</p> <p>North Dakota</p>

**Section 1115
Demonstration**

Short-term post-transition housing for up to six months		Yes. Demonstrations must be budget-neutral for the federal government, but CMS offers flexibility for HRSN spending (see text box on spending offsets).		
Traditional respite services for caregivers				
Day habilitation programs and sobering centers	States have significant flexibility in defining eligibility and can target specific populations.			The state must provide a public comment period on its demonstration proposal and consider those comments prior to submitting the proposal to CMS.
Pre-tenancy and tenancy-sustaining services				Arizona
Housing transition navigation	Some services are only available for certain groups of Medicaid enrollees. For example, rent/temporary housing is only available for people transitioning out of institutional or congregate care, people experiencing or at risk of homelessness, and/or youth transitioning out of the child welfare system.	In addition, CMS caps state spending on health-related social needs at 3 percent of the state's total Medicaid spending, limits spending on HRSN infrastructure to 15 percent of total HRSN spending, and requires state spending on related social services to be maintained or increased.	No. States can limit services to geographic areas or cap the number of eligible beneficiaries to limit the state's costs.	California
One-time transition and moving costs				Massachusetts
Medically necessary home accessibility modifications and remediation services				New Jersey
Medically necessary home environment modifications				New York
Case management services for access to food/nutrition				Oregon
Nutrition counseling and education				Washington
				Demonstrations must include an evaluation of outcomes.
				Demonstrations are time limited and can be renewed after five years.

Medically tailored meals
(up to three meals/day
for up to six months)

Home delivered meals
or pantry stocking (up to
three meals/day for up
to six months)

Nutrition prescriptions,
such as fruit and
vegetable prescriptions
and/or protein boxes
(up to three meals for
up to six months)

Grocery provisions for
high-risk individuals (up
to three meals/day for
up to six months)

HRSN case
management

Infrastructure needed to
build capacity to
address HRSN (limited
to 15 percent of the
state's total HRSN
spending and excludes
construction or capital
costs)

Managed Care In Lieu of Service or Setting	Pre-tenancy and tenancy-sustaining services	The state can define who is eligible for the covered service or setting, as long as the service is medically appropriate, cost effective, and voluntary for beneficiaries.	Yes. CMS must determine that ILOS are cost effective, and approved ILOS cannot exceed 5 percent of the managed care capitation.	No. Managed care organizations can choose whether to provide one or all of the services selected by the state, so access to services may depend on which managed care plan an individual is enrolled in.	The state requests CMS approval to use ILOS authority for certain services. The state must agree to certain standards, including monitoring and oversight.	California New York Oregon
	Housing navigation				If CMS grants approval, the state can include allowable ILOS in its managed care contracts.	
	One-time transition costs, such as a home deposit				States must certify ILOS spending annually; states that spend more than 1.5 percent of managed care capitation on ILOS must submit a retrospective evaluation for the managed care program that includes such ILOS to examine such spending.	
	Home modifications	The managed care organizations choose whether to cover the service in their plans. But if they choose to offer a service, it must be offered to eligible enrollees and subject to grievance and appeal rights.				
	Day habilitation					
	Caregiver respite					
	Sobering centers					
	Medically tailored meals					

a All covered services must be medically necessary.

b Pre-tenancy and tenancy-sustaining services help people find and maintain housing. Sometimes these services are also called housing supports, or housing navigation and stabilization services. As noted, states can also use case management and peer support services to help people find and maintain stable housing.