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CMCS Informational Bulletin

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SUBJECT: **Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and the Children's Health Insurance Program**

This CMCS Center Informational Bulletin (CIB) discusses opportunities available under Medicaid and the Children's Health Insurance Program (CHIP) to cover clinically appropriate and evidence-based services and supports that address health-related social needs (HRSN). As discussed in a CMCS CIB on this topic dated November 16, 2023,[1] an individual's HRSN are derived from a person-specific assessment of social determinants of health (SDOH),[2] and extensive research has indicated that SDOH and associated HRSN can account for as much as 50 percent of health outcomes.[3] While SDOH are broad environmental conditions, HRSN are specific to an individual and when unmet, these individual-level adverse social conditions contribute to poor health outcomes. These needs, when unmet, can drive lapses in coverage and access to care, higher downstream medical costs, worse health outcomes, and perpetuation of health inequities, particularly for children and adults at high risk for poor health outcomes, and individuals in historically underserved communities.[4]

With the issuance of the November 16, 2023 CIB, CMCS also published a document entitled, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," referred to as the "Framework of Coverage of HRSN Services in Medicaid and CHIP" or the "HRSN Framework."[5] In light of the Centers for Medicare & Medicaid Services' (CMS's) additional experience with the approval of HRSN services and supports since the release of the November 2023 CIB and HRSN Framework, this Informational Bulletin clarifies, updates, and supersedes those documents. For clarity and ease of reference, this Informational Bulletin includes the updated HRSN Framework at the end of the document.

By addressing HRSN, state Medicaid and CHIP programs can help their beneficiaries stay connected to coverage and access needed health care services. CMS supports states in addressing HRSN through multiple Medicaid and CHIP authorities and mechanisms. These

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf
[2] The World Health Organization (WHO) defines social determinants of health as the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.
[3] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf
[4] https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions
[5] https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf

initiatives include coverage of clinically appropriate and evidence-based HRSN services and supports; care delivery transformations, including improvements in data sharing; and performance measurement to create accountability for HRSN screening and connecting to needed supports as part of successful care management. Generally, to receive an HRSN intervention, a beneficiary must meet both clinical and social risk factors, defined by the state and approved by CMS.

As indicated in a letter to State Health Officials (SHO) on January 7, 2021,[6] states can address HRSN through a variety of Medicaid authorities, including state plan authorities, section 1915 home and community-based services (HCBS) waivers and state plan programs, managed care in lieu of services and settings (ILOSs) and section 1115 demonstrations, as well as CHIP Health Service Initiatives (HSIs). For example, the housing and nutrition supports provided under HCBS authorities have served as an important precedent for helping individuals stay connected to coverage and needed care, and in connecting eligible individuals to additional services necessary to meet their comprehensive health needs. Since the publication of the January 2021 SHO, CMS has issued additional HCBS guidance in a continued effort to improve health equity and outcomes for Medicaid beneficiaries by addressing HRSN.[7,8]

CMS has also described ways in which state Medicaid and CHIP programs may cover services and supports addressing HSRN for specific populations not traditionally eligible for HCBS programs. On January 4, 2023, CMS published a State Medicaid Director Letter (SMDL) that describes innovative options states may consider employing in Medicaid managed care programs to address HRSN through the use of ILOSs.[9,10] In 2022, CMS also announced a section 1115 demonstration opportunity to support states in addressing HRSN,[11] and as of November 2024, CMS has approved section 1115 demonstrations in ten states that cover certain evidence-based housing and nutritional services designed to mitigate the negative health impacts of unmet HRSN.[12]

Coverage of targeted HRSN services and supports is likely to assist in promoting the objectives of Medicaid because it is expected to help beneficiaries stay connected to coverage and access to needed health care. The housing and nutritional support services authorized in demonstrations are expected to stabilize the housing and nutritional situations of eligible Medicaid beneficiaries and thus increase the likelihood that they will keep receiving and benefitting from the Medicaid-covered services to which they are entitled.

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[6] https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf
[7] https://www.medicaid.gov/sites/default/files/2022-04/mfp-supplemental-services-notice.pdf
[8] https://www.medicaid.gov/medicaid/section-1115-demonstrations/health-related-social-needs/index.html
[9] Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. https://www.medicaid.gov/sites/default/files/2023-01/smd23001.pdf.
[10] ILOSs are authorized in accordance with 42 CFR § 438.3(e)(2).
[11] https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf.
[12] See examples: https://www.medicaid.gov/sites/default/files/2022-06/ca-calaim-ext-appvl-12292021.pdf
https://www.medicaid.gov/sites/default/files/2022-09/or-health-plan-09282022-ca.pdf
https://www.medicaid.gov/sites/default/files/2022-09/ma-masshealth-ca1.pdf
https://www.medicaid.gov/sites/default/files/2022-10/az-hccc-ca-10142022.pdf
https://www.medicaid.gov/sites/default/files/2022-11/ar-arhome-ca-11012022_0.pdf
https://www.medicaid.gov/sites/default/files/2023-03/nj-1115-cms-exten-demnstr-aprvl-03302023.pdf
https://www.medicaid.gov/sites/default/files/2023-06/wa-medicaid-transformation-ca-06302023.pdf

The Medicaid statute, including both sections 1905 and 1915 of the Social Security Act (the Act), already includes mechanisms that reflect the critical role of upstream services (i.e., those that help avert more intensive medical interventions) in meeting the medical assistance needs of certain Medicaid-eligible populations (e.g., individuals with disabilities).

Medical assistance made available under a state plan option authorized under section 1915(i) of the Act provides that same package of HCBS to individuals meeting needs-based criteria that are less stringent than criteria required for institutional placement. These services are also intended to avert a need for nursing facility care.

Available evidence[13] suggests there may be populations in addition to those eligible under section 1915(c) or 1915(i) criteria that would benefit clinically from the section 1915(c) or 1915(i) services described above, as well as additional upstream HRSN services. Additional research is needed to better understand the effects of providing these types of services to a broader group of people. To that end, providing HRSN services through section 1115 demonstrations will test whether expanding eligibility for these services to additional populations or providing additional services can improve the health outcomes of certain Medicaid beneficiaries, as well as test whether extending eligibility for a broader range of Medicaid beneficiaries or providing additional services will help to maintain coverage by preventing health-related incidents that could lead to enrollment churn.[14]

Moreover, access to these services for individuals with poorer health outcomes may help to reduce health disparities. Expanding who can receive these services is expected to help a broader range of Medicaid beneficiaries not only receive, and benefit from, the medical assistance to which they are entitled, but also, these services are expected to further reduce health disparities often rooted in socioeconomic factors.[15] Thus, broadening the availability of certain HRSN services is expected to promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost-effective alternatives or supplements to traditional medical services.

The HRSN Framework included in this Informational Bulletin describes services and supports to address HRSN that CMS considers allowable under specific Medicaid and CHIP authorities. This HRSN Framework includes important guidelines to ensure that interventions provided under section 1115 authority are clinically appropriate, do not supplant existing social services and housing assistance, and adhere to statutory authorities and program goals. All interventions must be evidence-based and clinically appropriate for the population of focus based on clinical and social risk factors.[16] States have flexibility to propose clinically focused, needs-based

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[13] September 23, 2021. ASPE Contractor Project Report: Building the Evidence Base for Social Determinants of Health Interventions. https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

[14] April 12, 2021. Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic. https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

[15] April 1, 2022. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Effort.
https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

[16] CMS expects that minimum social risk criteria will reflect the following for HRSN interventions covered under a

criteria to define the appropriate population, subject to CMS approval. Examples of populations that could be served across Medicaid authorities include children identified as high risk, pregnant individuals, plus twelve months postpartum, individuals who are or are at risk of becoming homeless, individuals with serious mental illness and/or substance use disorder, and individuals experiencing high-risk care transitions.[17] 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 (SNAP). These services will be the choice of the beneficiary; beneficiaries can opt out anytime; and provision of these services does not absolve the state or managed care plan of its responsibility to make payment for other covered services.

There are also other requirements and limitations, including fiscal limitations, in the provision of Medicaid-covered HRSN services as an ILOS, which are further delineated in the HRSN Framework and separate guidance on provision of ILOSs. Additionally, for section 1115 demonstrations, CMS expects that expenditures on HRSN services will not exceed 3 percent of the state's total computable Medicaid spending, infrastructure costs will not exceed 15 percent of total HRSN spending, and state spending on related social services will be maintained or increased (as compared to state spending prior to the approval of the section 1115 demonstration). Further, as a condition of approval for HRSN services and related infrastructure under section 1115 demonstrations, states have been and will be expected to ensure provider payment rates in primary care, obstetrics care, and care for mental health and substance use disorders meet minimum thresholds, or commit to improving those payment rates. This condition of approval reflects that connections to care can only be successful if beneficiaries have timely access to health care providers. Research shows that increasing Medicaid payments to providers improves beneficiaries' access to health care services and the quality of care

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section 1115 demonstration: in general, HRSN housing interventions that include room and board are limited to beneficiaries who are homeless or at risk of homelessness. Generally, states should use the definitions for these terms prescribed by the Department of Housing and Urban Development (HUD) in 24 CFR 91.5. States may propose variations from these definitions (e.g., based on implementation concerns), after completing an assessment of how the proposed modified definition of homeless affects eligibility for housing assistance programs available to people experiencing homelessness. Any proposed variations are subject to CMS approval, provided the state's alternative definition would identify a similar population and the state has verified that its housing providers that also provide benefits supported by HUD programs are able to implement all applicable definitions accurately. In some situations, CMS may approve HRSN housing interventions with room and board for beneficiaries who are experiencing housing instability but are not homeless or at risk of homelessness, where these interventions help the beneficiary address or transition out of unhealthy housing. HRSN nutrition interventions with the provision of food are limited to beneficiaries who have low or very low food security as defined by the Department of Agriculture.

[17] Examples of high-risk care transitions include transitions out of institutional care (nursing facilities, institutions for mental diseases, intermediate care facilities, acute care hospitals); out of congregate residential settings such as large group homes; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined in 24 CFR 91.5; out of carceral settings; and individuals transitioning out of the child welfare setting including foster care.

received.[18] Further, states must adhere to systematic monitoring and robust evaluation requirements, including performance reporting on quality and health equity measures.[19]

Together, these flexibilities and accompanying safeguards to protect program and fiscal integrity comprise a framework for coverage of HRSN, complementing but not supplanting existing social services, that states can use to improve consistent access to needed care, health outcomes, and health equity among Medicaid beneficiaries. The HRSN Framework provides state Medicaid and CHIP programs with the opportunity for innovation and new mechanisms to achieve these goals. For additional information about this Informational Bulletin or technical assistance, please contact your state lead or section 1115 demonstration project officer.

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[18] Polsky, D., Richards, M. Basseyn, S., et al. *Appointment Availability after Increases in Medicaid Payments for Primary Care*. The New England Journal of Medicine; 2015; https://www.nejm.org/doi/10.1056/NEJMsa1413299; Decker, S. L., *Medicaid Physician Fees and the Quality of Medical Care of Medicaid Patients in the USA*. Review of Economics in the Household; 2007; https://link.springer.com/article/10.1007/s11150-007-9000-7.
[19] https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf

HRSN Framework

This HRSN Framework lists HRSN services and supports that can be allowable under specific Medicaid and Children's Health Insurance Program (CHIP) authorities and provides a discussion of the relevant considerations for each authority.[20] In particular, this guidance separately identifies distinct HRSN housing interventions with room and board[21] that were included but not clearly distinguished in the 2023 HRSN Framework and clarifies parameters for the duration and frequency of coverage that CMS expects to approve for these interventions.

Under Medicaid authorities, CMS will not approve federal financial participation payments for room and board outside of specifically enumerated care or housing transitions,[22] nor beyond durations and frequencies discussed in this guidance.[23] Under section 1115 demonstrations, CMS does not expect to approve HRSN housing interventions with room and board beyond a maximum combined duration of 6 months per rolling 12-month period. Additionally, rent-only interventions are limited to a combined duration of 6 months per household, per demonstration period. However, a beneficiary to whom coverage of a rent-only intervention is attributed because that benefit was provided to a member of the beneficiary's household may still qualify for up to 6 months of coverage of episodic interventions with clinical services with room and board during the same 12-month period. These terms are defined, and these limitations on duration and frequency further explained, in the chart below.

Information About Specific Authorities Available to States to Address HRSN

CMS has issued additional guidance for states seeking to support HRSNs through the use of ILOS.[24,25] An ILOS is only available if it is a clinically appropriate and cost-effective substitute for a service or setting covered in the Medicaid or CHIP state plan, and it complies with regulatory requirements, including those in 42 CFR 438.3(e) and 438.16. An ILOS must not violate any applicable

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[20] In general, coverage parameters and guardrails for HRSN services covered under a section 1915(c) waiver or Money Follows the Person demonstration should be implemented when covering similar HRSN services under a section 1115 demonstration.
See https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html

[21] Unless otherwise specified in law, section 4442.3.B.12 of the State Medicaid Manual defines "room" as hotel or shelter-type expenses, including all property-related costs (e.g., rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services) and defines "board" as three meals a day or any other full nutritional regimen.

[22] Allowable transitions are those identified in footnote 17.

[23] For additional information on the availability of Medicaid payment for housing and nutritional supports that are not considered room and board, see https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf.

[24] Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care.
https://www.medicaid.gov/sites/default/files/2023-01/smd23001.pdf.

[25] Medicaid and Children's Health Insurance Program Managed Care Access, Finance and Quality Final Rule.
https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

federal requirements, including general prohibitions on payment for room and board under title XIX of the Social Security Act (the Act). The ILOS must be approvable through a state plan amendment authorized under the Act, including sections 1905(a), 1915(i), or 1915(k) of the Act, or a waiver under section 1915(c) of the Act, and is subject to the same limitations as those authorities, including the limitations outlined in this guidance (e.g., concerning payment for room and board).

Home and community-based services (HCBS) authorities in section 1915 of the Act give states the option to provide a robust array of services and supports to facilitate beneficiary independence and community integration. Each authority has specific functional eligibility requirements. For example, section 1915(c) and 1915(k) Community First Choice programs require individuals to meet an institutional level of care. Section 1915(i) of the Act requires individuals to meet state-defined needs-based criteria.

Section 1115 of the Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program (or CHIP). The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid (or CHIP) populations. As always, CMS considers state proposals for section 1115 demonstrations on a case-by-case basis; state proposals for section 1115 demonstration HRSN initiatives that conform to the parameters outlined in this guidance may be possible for CMS to review and approve more quickly than nonconforming proposals, which could require more extensive review and negotiation with the state.

CHIP health services initiatives (HSIs) are programs aimed at improving the health of low-income children that states can implement with title XXI funding under their CHIP 10 percent administrative cap. HSIs are permitted under section 2105(a)(1)(D)(ii) of the Act and are defined in 42 CFR 457.10. HSIs must include activities that: protect the public health, protect the health of individuals, improve or promote a state’s capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals related to improving the health of children.

Tables of Allowable Services by HRSN domain and by Medicaid and CHIP authority

NPA = "Not previously approved" but potentially approvable under CHIP HSI authority; MFP = Money Follows the Person demonstration

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
Case Management for all HRSN Interventions				
1. Case management services for access to housing and nutrition supports, including, for example: • Outreach and education • Linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees	Yes	Yes	Yes	NPA
Housing/Home Environment Interventions <u>Without</u> Room and Board				
2. Housing supports, for example: • Pre-tenancy navigation services (e.g., finding and securing housing) • One-time transition and moving costs <u>other than</u> rent (e.g., security deposit, application and inspection fees, utilities activation fees and payment in arrears, movers)[26] • Tenancy and sustaining services (e.g., eviction prevention, tenant rights education)	Yes	Yes[27]	Yes	Yes

[26] One-time transition and moving costs <u>other than</u> rent include security deposit, utilities activation fees and payments in arrears to allow an individual to re-establish service (up to 6 months of arrears), movers, relocation expenses, pest eradication, pantry stocking (up to 30 days of food), cooking supplies, and the purchase of household goods and furniture. This does not include clothing. A beneficiary can only use this service once per qualifying transition.
[27] For section 1915(c) and 1915(i) authorities, the one-time transition costs included here are only permissible under a community transition service that aligns with SMDL #02-008.

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
3. Caregiver respite without room and board[28]	Yes	Yes	Yes	Yes; also coverable under CHIP state plan
4. Utility assistance	No	No, except MFP	Yes, up to 6 months per demonstration period.[29]	Yes
5. Day habilitation programs	Yes	Yes	Yes	NPA
6. Sobering centers (<24 hour stay)	Yes	Yes	Yes	NPA

[28] Respite services provided in the beneficiary's home, with no room and board expenses incurred, so that the beneficiary's usual at-home caretaker can have a break from caretaking.

[29] Utilities can be a component of "room" as defined in the State Medicaid Manual, *see* footnote 18, when they are included in the payment for the hotel or shelter-type expense. When they are paid separately, CMS does not consider utilities to constitute room. This intervention for separately-paid utility assistance is intended for beneficiaries who meet qualifying criteria to receive HRSN housing interventions with or without room and board, addressed later in this chart. Receipt of utility assistance can be complementary to and does not limit beneficiary qualification for coverage of the hotel or shelter-type component of room. Utility assistance may be provided as part of transitions into the community, or to beneficiaries already in the community. Utility assistance can include water, garbage, sewage, recycling, gas, electric, internet, and phone (including land line phone service and cell phone service). This includes payment for utility arrears to allow an individual to re-establish service. Arrears payments and payment of any utility activation fees may not duplicate payments made as a one-time transition and moving cost under intervention 2 in the chart above. In no case may the combination of arrears payments and prospective payments exceed 6 months.

Intervention	Allowable			
	Medicaid/CHIP Managed Care In Lieu of Service or Setting	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
7. Home remediations that are medically necessary, including, for example:[30] • Air filtration, air conditioning, or ventilation improvements • Refrigeration for medications • Carpet replacement • Mold and pest removal • Housing safety inspections	Yes	Yes	Yes	Yes
8. Home/environmental accessibility modifications, including, for example[31]: • Wheelchair accessibility ramps • Handrails • Grab bars	Yes	Yes	Yes	Yes; also coverable under CHIP state plan
Housing Interventions with Room and Board				
HRSN housing interventions with room and board under a section 1115 demonstration can be covered for beneficiaries who have at least one clinical and one social risk factor and experience an allowable transition as defined in footnote 17. All section 1115 demonstration HRSN housing interventions with room and board are limited to a global HRSN housing cap of a combined 6 months per rolling 12-month period.[32]				
Episodic interventions with clinical services				
Limited to a clinically appropriate amount of time.				

[30] Home remediations that are medically necessary can include building component replacement and paint stabilization to abate lead exposure when covered under a CHIP HSI. When covered as an HRSN intervention other than under a CHIP HSI, this category also can encompass air conditioners, heat pumps, heaters, air filters, and generators in emergency/extreme climate situations but does not include lead abatement.
[31] Other allowable modifications generally align with allowable modifications under the Money Follows the Person or HCBS authorities.
[32] For example, a qualifying beneficiary could receive short-term pre-procedure housing for the month of March, short-term recuperative care for the months of April and May, and short-term post-transition housing for the months of June through August but could not receive coverage for any other section 1115 demonstration HRSN housing intervention with room and board before the following March.

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
9. Short-term pre-procedure housing, where a provider has determined that preparatory steps are required for an upcoming procedure or treatment and integrated, clinically oriented recuperative or rehabilitative services and supports are provided.	No	No	Yes, up to HRSN housing cap of 6 months per rolling 12-month period.	NPA
10. Short-term recuperative care, where integrated, clinically oriented recuperative or rehabilitative services and supports are provided for individuals who require ongoing monitoring and continuous access to medical care.	No	No	Yes, up to HRSN housing cap of 6 months per rolling 12-month period.	NPA
11. Short-term post-transition housing (e.g., post-hospitalization), where integrated, clinically oriented rehabilitative services and supports are provided, but ongoing monitoring of the individual's condition by clinicians is not required.	No	No	Yes, up to HRSN housing cap of 6 months per rolling 12-month period.	NPA
12. Caregiver respite with room and board[33]	Yes	Yes[34]	Yes, up to 90 days, renewable following transition to institutional care. Limited to HRSN housing cap of 6 months per rolling 12-month period.	Yes; also coverable under CHIP state plan

[33] Respite services that include temporary placement of a beneficiary who otherwise lives at home into an institutional setting (e.g., nursing home) so that the beneficiary's at-home caretaker can have a break from caretaking.
[34] For section 1915(c) and 1915(i): Room and board may be claimed for temporary short-term respite services that are furnished in settings that are not the participant's own private residence, and a state may elect to pay the portion of the rent and food that can be attributed to a live-in, unrelated caregiver who furnishes services to a participant in the participant's private residence. There are no federal limitations on the frequency of respite services under these authorities.

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
Room and board-only (or rent-only) interventions				
In addition to the global HRSN housing cap of a combined 6 months per rolling 12-month period, room and board-only interventions are limited to a combined 6 months per household per demonstration period, limited to a clinically appropriate amount of time.[35]				
13. First month's rent, as a transitional service	Yes	Yes, but only 1915(k) and via ARP 9817[36] No for 1915(c), 1915(i), and 1915(j)	Yes, renewable up to a combined 6 months of room & board-only per demonstration period following add'l allowable transitions. Limited to HRSN housing cap of 6 months per rolling 12-month period.[37,38]	Yes

[35] For example, if Sonja and Pierre are qualifying beneficiaries and make up a household together, if Sonja receives short-term rental assistance for 6 months, neither Sonja nor Pierre can receive coverage of further rent-only HRSN housing interventions during the demonstration period. If Pierre qualified for episodic housing interventions with clinical services during the same rolling 12-month period, he would be able to receive that coverage notwithstanding that a member of his household (Sonja) received 6 months of rental assistance during the same rolling 12-month period, which is attributed to him for purposes of the 6-month per demonstration period limit on room and board-only HRSN housing interventions with room and board.

[36] American Rescue Plan Act of 2021 Section 9817. See: https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817/index.html

[37] First month's rent, as a transitional service, may be offered to individuals who do not meet a CMS-approved definition of homelessness or at-risk of homelessness only when it is more cost-effective to provide first month's rent rather than a home remediation or home modification.

[38] Allowable settings for housing include: apartments, single room occupancy (SRO) units, single-family homes, multifamily homes, mobile home communities, accessory dwelling units (ADUs), co-housing communities, trailers, manufactured homes, manufactured home lots, motel or hotel when it is serving as the member's primary residence, permanent supportive housing, and transitional and recovery housing including bridge, site-based, population-specific, and community living programs that may or may not offer supportive services and programming. Allowable settings do not include congregate sleeping space, facilities that have been temporarily converted to shelters (e.g., gymnasiums or convention centers), facilities where sleeping spaces are not available to residents 24 hours a day, or facilities without private sleeping space.

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
14. Short-term rental assistance, with room alone or with room and board together, without clinical services included in the rental assistance payment.	No	No, except MFP	Yes, up to a combined 6 months of room and board-only per demonstration period. Limited to HRSN housing cap of 6 months per rolling 12-month period.[38,39]	NPA

[39] Short-term rental assistance can include rent and housing fees necessary to secure and maintain the unit (including storage fees, amenity fees, renter's insurance, and landlord-paid utilities that are part of the rent payment and not duplicative of other HRSN utility payments). It can include past due and/or forward rent as necessary to maintain tenancy. The combination of past due and forward rent cannot exceed the applicable duration limits stated in the chart above. Short-term rental assistance cannot include pet fees, parking fees, amenity fees not necessary to secure and maintain the unit, mortgage payments, or brokerage fees.

	Allowable			
Intervention	**Medicaid/CHIP Managed Care In Lieu of Service or Setting**	**HCBS authorities Section 1915(c), 1915(i), 1915(j), 1915(k)**	**Section 1115 demonstrations**	**CHIP HSI**
Nutrition Interventions <u>Without</u> Provision of Food	Blank	Blank	Blank	Blank
15. Nutrition counseling and instruction, tailored to health risk, nutrition-sensitive health conditions, and/or demonstrated outcome improvement, including, for example: • Guidance on selecting healthy food • Healthy meal preparation	Yes	Yes	Yes	Yes
Nutrition Interventions <u>with</u> Provision of Food[40]				
16. Home delivered meals or pantry stocking (also referred to as grocery provisions),	Yes – less than 3 meals / day	Yes – less than 3 meals/day[41]	Yes – up to 3 meals/day, for up to 6 months (renewable)	NPA
17. Medically tailored meals to individuals with nutrition-sensitive conditions (e.g., pregnant individuals, individuals with diabetes)	Yes – less than 3 meals / day	Yes – less than 3 meals/day[41]	Yes – up to 3 meals/day, for up to 6 months (renewable) [42]	NPA
18. Nutrition prescriptions, including, for example: • Fruit and vegetable prescriptions • Protein boxes • Food pharmacies • Healthy food vouchers	Yes – less than 3 meals / day	Yes – less than 3 meals / day[41]	Yes – up to 3 meals/day, for up to 6 months (renewable)	NPA

[40] For interventions with provision of food, states must ensure that protocols are in place to ensure that vendor contracts require the provided meals to be tailored appropriately and that vendors are providing meals that meet the contract criteria.

[41] There are Medicaid room and board exclusions under sections 1915(c)(1), 1915(i)(1), and 1915(k)(1)(C)(i) of Act that prohibit making Medicaid payments for room and board in the context of nutritional supports.

[42] When medically tailored meals are covered as part of an HRSN initiative under a section 1115 demonstration, states must ensure that protocols are in place to tailor the intervention to the beneficiary's health risk, nutrition-sensitive health condition, and/or demonstrated outcome improvement.

Additional Considerations for Nutrition Interventions with Provision of Food Under Section 1115 Demonstrations

HRSN nutrition interventions with provision of food under a section 1115 demonstration can be covered for beneficiaries who have at least one clinical risk factor and one social risk factor (social risk factor expected to include low or very low food security as defined by the United States Department of Agriculture (USDA)). The clinical risk factor(s) should capture the individual's nutrition-sensitive health condition, or status as a child or pregnant person. All section 1115 demonstration HRSN nutrition interventions with provision of food (full board) are limited to a duration of 6 months, renewable while the beneficiary continues to meet qualifying criteria.[43]

Food may only be delivered to the beneficiary's home (and not, for example, to the home of another person). Nutrition interventions with the provision of food may be provided to pregnant individuals for up to the duration of the pregnancy plus twelve months postpartum, or for 6 months subject to renewal as noted in the chart. Additional meal support beyond the 3 meals/day limit for nutrition interventions may be permitted when provided to the household of a child or a pregnant individual (plus twelve months postpartum) who qualifies for the intervention. The intervention may apply to subsequent pregnancies during the demonstration period if the beneficiary still meets the clinical and social risk criteria, including that the beneficiary continues to experience low or very low food security as defined by USDA. Duration limits for nutrition interventions with provision of food only apply for full board (i.e., 3 meals/day or other full nutritional regimen). CMS expects states to align to state-specific SNAP definitions of households for purposes of defining qualifying beneficiaries for these nutrition interventions.

[43] HRSN nutrition interventions with provision of food are not available to the extent that the HRSN nutrition benefit or payment would be duplicative of other benefits or payments made on behalf of the beneficiary that include food. For example, medically tailored meal delivery is not available for an individual who is receiving short-term rental assistance for a stay in a facility that provides 3 meals per day included in the Medicaid payment to the facility, and pantry stocking is not available for an individual who is receiving a full board regimen of medically tailored meals.