DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

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FROM: Daniel Tsai, Deputy Administrator and Director
Center for Medicaid and CHIP Services

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

This guidance 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). An individual's HRSN are derived from a person-specific assessment of social determinants of health (SDOH),[1] and extensive research has indicated that SDOH and associated HRSN can account for as much as 50 percent of health outcomes.[2] 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.[3]

By addressing HRSN, state Medicaid and CHIP program can help their enrollees stay connected to coverage and access needed health care services, and supplement – but not supplant – existing local, state, and federal supports. The Centers for Medicare & Medicaid Services (CMS) supports states in addressing HRSN through multiple Medicaid and CHIP authorities and mechanisms. These 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.

[1] 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.
[2] https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf
[3] https://aspe.hhs.gov/reports/building-evidence-base-social-determinants-health-interventions

As indicated in a letter to State Health Officials (SHO) on January 7, 2021,[4] 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.[5]

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 a service or setting that is provided to an enrollee in lieu of a service or setting (known as an "in lieu of" service or ILOS) covered under the state plan.[6,7] In 2022, CMS also announced a section 1115 demonstration opportunity to support states in addressing HRSN,[8] and as of November 2023, CMS has approved section 1115 demonstrations in seven states that cover certain evidence-based housing and nutritional services designed to mitigate the negative health impacts of unmet HRSN.[9] 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.

Accompanying this Informational Bulletin, CMS has published a framework of services and supports to address HRSN that CMS considers allowable under specific Medicaid and CHIP authorities.[10] This document includes important guidelines to ensure that interventions provided under 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 medically appropriate for the population of focus based on clinical and social risk factors. States have flexibility to propose clinically focused, needs-based criteria to define the medically appropriate population, subject to CMS approval. Examples of populations

[4] https://www.medicaid.gov/sites/default/files/2022-01/sho21001_0.pdf
[5] https://www.medicaid.gov/sites/default/files/2022-04/mfp-supplemental-services-notice.pdf
[6] 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.
[7] ILOSs are authorized in accordance with 42 CFR § 438.3(e)(2).
[8] https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf.
[9] 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
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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
[10] https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf

that could be served across Medicaid authorities include children and pregnant individuals identified as high risk, 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.[11] 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. These services will be the choice of the enrollee; enrollees can opt out anytime; and provision of these services does not absolve the state or managed care plan of its responsibility to provide coverage for other medically necessary 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 framework and separate guidance on provision of ILOSs. Additionally, for section 1115 demonstrations, these requirements include that expenditures on HRSN services cannot exceed 3 percent of the state's total computable Medicaid spending, infrastructure costs cannot exceed 15 percent of total HRSN spending, and state spending on related social services must be maintained or increased (as compared to state spending prior to approval of 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 required 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 received.[12] Further, states must adhere to systematic monitoring and robust evaluation requirements, including performance reporting on quality and health equity measures.[13]

The flexibilities allowed under the HRSN framework provide state Medicaid and CHIP programs with the opportunity for innovation and new mechanisms to achieve these goals. For additional information about this Bulletin or technical assistance, please contact your state lead or section 1115 demonstration project officer.

[11] Examples of high-risk care transitions include transitions from emergency shelters, carceral settings, foster care settings, and hospitals or nursing homes for people with disabilities and older adults.
[12] 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.
[13] https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf