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CENTER FOR CHILDREN AND FAMILIES

State Use of Section 1115 Demonstrations to Support the Health-Related Social Needs of Pregnant and Postpartum Women, Infants, and Young Children

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Executive Summary

In an effort to better address the maternal and infant health crisis, states are increasingly seeking to use Medicaid to cover health-related social needs (HRSN) services and supports for pregnant and postpartum individuals and their children, particularly through Medicaid section 1115 demonstrations. Addressing unmet HRSNs among these populations can help stabilize coverage, improve their access to care, and complement traditional medical care to promote maternal and child health more broadly.

- Fifteen states have approved (AZ, AR, MA, NC, NJ, NY, OR, WA) or pending (CA, CT, HI, IL, PA, RI, VT) section 1115 requests to cover housing services for pregnant and postpartum individuals or young children who meet specific eligibility criteria.
- Seven states (DE, MA, NC, NJ, NY, OR, WA) have approval to provide nutrition supports for pregnant and postpartum individuals or young children that qualify while four states (HI, IL, NM, PA) have pending proposals to do so.

States have previously used Medicaid to provide housing linkages, like helping individuals complete applications for housing and providing education on tenancy rights and obligations. Similarly, section 1115 demonstrations have allowed states to offer nutrition counseling and education to individuals enrolled in Medicaid. Medicaid funding has also been authorized more recently to be used for housing and items necessary to establish a basic household and provision of meals or grocery items for medically necessary nutritional supports, including Massachusetts and North Carolina in 2018.[1] The allowable services that states were authorized to provide through Medicaid were expanded upon and broadened by the Massachusetts and Oregon section 1115 demonstration extensions in 2022.

The Biden Administration has made supporting state's efforts to address health-related social needs a priority, approving section 1115 demonstrations targeting HRSNs in nine states, in order to fill gaps to promote better health outcomes. Approval of these policies have encompassed explicit conditions and guardrails for implementing HRSN supports to ensure that provision of medical services remains paramount and existing funding for social supports is not supplanted. For example, spending on HRSN services is capped at 3% of total Medicaid spending for each state and states are prohibited from using HRSN funding for certain services or activities (e.g., construction costs, capital investments, coverage for individuals not eligible for Medicaid due to immigration status). More broadly, CMS has established parameters around the populations that may be eligible to receive HRSN supports through Medicaid—eligibility must be medically appropriate and based on clinical and social risk factor criteria. Additionally, long-standing CMS policy requires that all section 1115 demonstrations must be "budget neutral," meaning the costs to the federal government will not exceed expected federal Medicaid spending absent the demonstration.

This report examines states' use of Medicaid section 1115 demonstrations to cover housing, nutrition, and other HRSN services and supports for pregnant and postpartum individuals and young children who are experiencing or at risk of unmet HRSNs.

Introduction

A person's health is influenced by a wide range of variables, including dynamics well beyond direct access to health care services, often called the social determinants of health (SDOH). Social determinants of health describe the societal, non-medical factors affecting health outcomes. Where a person was born, lives, works, and spends time shape the circumstances they may face. These social determinants of health, such as racism, educational access, or variable state and local policy decisions have a significant impact on health outcomes and drive health inequities.

SDOH is sometimes used interchangeably with the term "health-related social needs," but the concepts differ. Health-related social needs (HRSN) are individual-level social conditions that stem from how a SDOH may impact a given person, which encompass immediate needs that an individual or family may face, such as affordable housing or food security. Unmet social needs have been shown to worsen health outcomes and can increase lapses in health coverage. This can exacerbate unmet health needs, leading to higher downstream medical costs, and perpetuate health inequities.

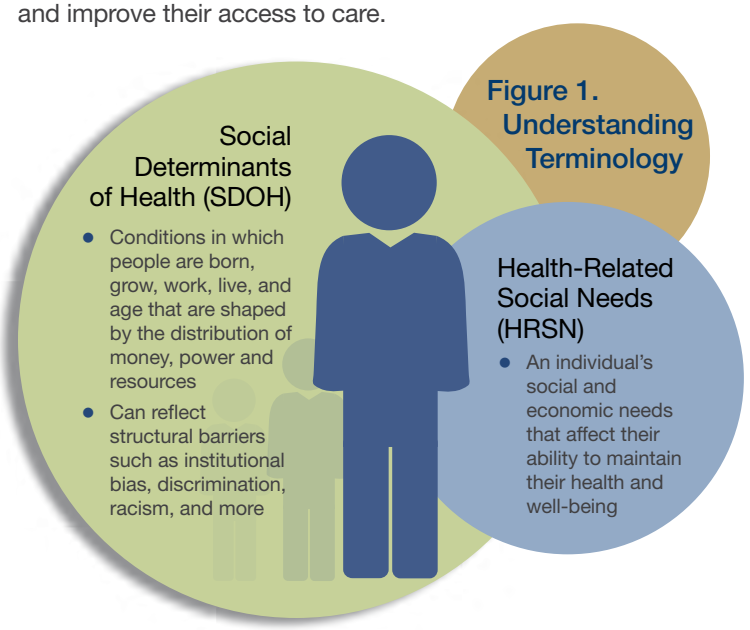
States and the federal government have been working for years to understand and tackle the root causes of unmet HRSN, which includes a recent surge in policy actions, most notably within the Medicaid program. Medicaid, a jointly-run state and federal health insurance program, offers states significant flexibility in how they operate the program as long as they meet federal minimum standards. The Centers for Medicare & Medicaid Services (CMS) has highlighted the flexibilities that exist within federal rules and requirements that may allow states to use Medicaid to cover certain services aimed at addressing unmet HRSN, when medically appropriate, for specific populations covered by the program.[2]

Though a variety of different Medicaid populations may be eligible for HRSN services based on state-defined criteria, pregnant and postpartum individuals are a key group states may target with HRSN policies.[3] Pregnant individuals are more vulnerable to pregnancy complications and adverse outcomes like pre-term birth, preeclampsia, and low birth weight due to unmet social needs or the associated stress.[4] During pregnancy, individuals are recommended to have 14 prenatal visits[5] to help identify and address potential compilations; HRSNs can affect the access and ability to attend all recommended appointments throughout pregnancy.[6]

Young children may also experience negative effects from unmet social needs that can put them at greater risk of developmental delays, mental health challenges, and poor educational outcomes. From the prenatal period to the preschool years, a children's brain is developing most rapidly compared to other life stages. Health and development during the early childhood years can be influenced by both positive and negative experiences like maternal nutrition, parental stress, employment status of caregivers, and home environment. Food insecurity among mothers is associated with greater incidences of inpatient hospitalizations and missed immunizations for their children in the first six months of life.[7] Children in households with HRSN may also be more likely to experience social-emotional challenges within the first year of life that may require early intervention, such as inflexibility, difficulty with routines, and irritability.[8] Addressing the social drivers of health, especially during critical early childhood years, can help promote a child's healthy development and growth.

Medicaid finances more than 40% of births in the United States and provides coverage to approximately 1.4 million postpartum individuals during the year after delivery.[9] Given the important role of Medicaid for pregnant and postpartum individuals and young children, states are increasingly seeking to leverage the program's flexibilities to address HRSN during this time-sensitive period of family change and rapid brain development during pregnancy and early childhood. This report provides an analysis of state efforts to use Medicaid section 1115 demonstrations to cover HRSN services and supports for pregnant and postpartum individuals and their children, which can help stabilize coverage and improve their access to care.

Figure 1. Understanding Terminology



Opportunities to Address Health-Related Social Needs Through Medicaid

At the end of 2023, the CMS issued guidance on how states can use Medicaid to address unmet HRSN.[10] There are several pathways available for states to do so—home- and community-based service (HCBS) authorities, Health Service Initiatives (HSIs) funded through the Children's Health Insurance Program (CHIP) administrative dollars, managed care in lieu of services or settings (ILOS), and section 1115 demonstrations.

- **HCBS Authorities.** Services provided using HCBS authorities, such as those available via section 1915 of the Social Security Act, generally support individuals with disabilities and over the age of 65 that need more intensive supports and who may otherwise require an institutional level of care.[11]
- **CHIP Health Service Initiatives.** CHIP HSIs must be used to improve the health of low-income children eligible for CHIP and/or Medicaid, but need not directly be tied to their eligibility.[12] States have used CHIP HSIs to implement a range of different policies including cover lead testing and abatement, improve access to vision services, and create programs focused on promoting early childhood development, Wisconsin uses HSI funds to provide some housing-related supports including tenancy and tenancy sustaining supports and transition-related costs like security deposits (up to a capped amount).[13]
- **Managed Care "In Lieu of Services or Settings".** ILOS allow states and managed care plans to cover services or settings that are determined to be a medically appropriate substitute for services or settings covered under the state plan. CMS has outlined opportunities to use ILOS to address HRSN, including the parameters states must follow and required oversight activities.[14] These requirements were recently codified in the updated Medicaid managed care regulations.[15]
- **Section 1115 demonstrations.** Section 1115 demonstrations are experiments or demonstration projects authorized by the Secretary of Health and Human Services that he/she determines promote the objectives of Medicaid.[15] These demonstration projects may offer states additional flexibilities for HRSN services or duration of services they can cover, compared to ILOS. States are required to ensure that all approved 1115 demonstrations do not result in greater federal Medicaid spending than would occur without the demonstration, also known as "budget neutrality," whether the demonstration contains HRSN supports or not.

For the purposes of this paper, we focus on states with approved or proposed section 1115 demonstrations that cover HRSN services.

In general, based on CMS guidance and 1115 approvals to date, states may provide HRSN services through Medicaid 1115 demonstrations for housing, nutrition, and HRSN case management in certain limited circumstances.[17] Specific covered services vary by state, but all services must be targeted to populations based on state- and CMS-determined criteria (see Box 1) within fiscal and beneficiary protection guardrails (see Box 2) specified in the standard terms and conditions (STCs) of each state's demonstration approval.

1 Defining Eligible Populations

CMS guidance requires states to target eligibility for HRSN services to populations based on clinical need and social risk factors to ensure interventions are medically appropriate. States have flexibility to choose the qualifying criteria to define the eligible population, subject to CMS approval.

Risk factors may include:

- Homelessness, at risk of homelessness, or transitioning out of an emergency shelter
- Transitioning out of institutional care or congregate setting (e.g., correctional facilities, Institutions for Mental Diseases (IMDs), and acute care hospitals)
- Experiencing food or financial insecurity

Clinical or health needs-based criteria may include:

- Complex behavioral health needs, including substance use disorder
- Chronic physical health conditions
- High-risk pregnancy or within twelve months postpartum
- Children under six experiencing, at risk of, or with a history of certain physical health conditions or social risk factors

Individuals who are pregnant or postpartum may qualify on a clinical basis for HRSN services depending on how states define medically appropriate populations. In some states, these individuals may alternatively qualify on a clinical basis other than pregnancy, like having an assessed behavioral health need. Additionally, eligibility criteria often varies depending on the type of service (i.e., housing versus nutrition supports services). Appendix Tables 1 and 2 outline the pathways pregnant and postpartum individuals and young children may be eligible to receive HRSN housing and nutrition services.

Housing Supports

Housing Instability and Health Outcomes Among Pregnant and Postpartum Individuals and Young Children

Individuals experiencing homelessness, a growing problem in the U.S., have considerable unmet social needs which are only exacerbated for pregnant, postpartum individuals, and young children. Between 2016 and 2020, the prevalence of homelessness among pregnant individuals increased by more than 70%—from 76.1 to 131 per 100,000 deliveries.[18] Unstable housing and/or homelessness is also a concern for babies and toddlers. In 2021-2022, an estimated 360,000-plus infants and toddlers experienced homelessness. Young children under age five also experience greater risk of eviction as well as living in crowded housing.[19]

Research links homelessness during pregnancy with extreme preterm delivery as well as severe maternal morbidity and mortality.[20] Additionally, pregnant individuals who experience homelessness are less likely to have a prenatal visit during the first trimester and to complete a follow-up visit for their newborn with a pediatrician.[21]

Infants of individuals experiencing homelessness also have a greater chance of being admitted into the neonatal intensive care unit.

Infants in households experiencing homelessness have very low enrollment rates in early childhood development programs[22] which support school readiness and overall development. Children who experience homelessness at a young age also face longer-term consequences. People who experienced homelessness as infants are more likely to develop health conditions like upper respiratory infections, developmental disorders, and asthma,[23] which can result in increased health care costs from emergency department visits and/or hospitalizations.

Nearly 11 million families in the U.S. spend 50% or more of their income on housing putting them at risk of being insecurely housed.[24] Though the Department of Housing and Urban Development (HUD) Housing Choice Voucher program can help offset the costs of housing for families with low-incomes, there are often long waiting periods to receive assistance through the program. Even for those that may have or are able to obtain stable housing,

there may be concerns about the quality of housing that can affect health, such as mold or pest issues, presence of lead paint, or availability of functioning appliances like air conditioning or refrigeration units. Many if not most pregnant and postpartum individuals and their children experiencing or at risk of homelessness qualify for Medicaid services and are likely to either have Medicaid coverage or be uninsured.

Services to Address Unmet Housing Needs

Given the evidence linking access to safe, stable housing and health, more than a dozen states have requested or been approved to provide housing support services through section 1115 demonstrations. States have options on what services they choose to provide within the guidelines laid out by CMS. For example, Arizona covers the full scope of allowable housing services described in Appendix Table 1, while New Jersey has selected to provide a more limited set of supports.

States have previously received authority under section 1115 demonstrations to offer pre-tenancy and tenancy sustaining services, like assisting individuals with completing applications for housing and education on tenancy rights and obligations. The Biden Administration's recent approval of Massachusetts and Oregon's demonstration extensions, however, marked the first time Medicaid funding was allowed to be used directly for costs needed to secure housing and establish a basic household. The focus of this report's analysis of state actions to address housing HRSN is on these supports and those that contribute to the direct provision of housing; it does not reflect pre-tenancy and tenancy sustaining services that other states may be providing.[25]

Housing supports CMS has approved range from housing deposits to rent or temporary housing for up to six months. Services are time limited, either as one-time payment/services or provided for a limited period of time. For example, rent or temporary housing supports are only allowed for up to six months. A closer analysis of implementation documents required by CMS provide additional details on allowable services where states' approaches may start to vary, including more targeted actions for pregnant and postpartum people or young children.[26] For example, Oregon's "HRSN Services Protocol" identifies cribs as a covered household good under one-time transition and moving costs supports.

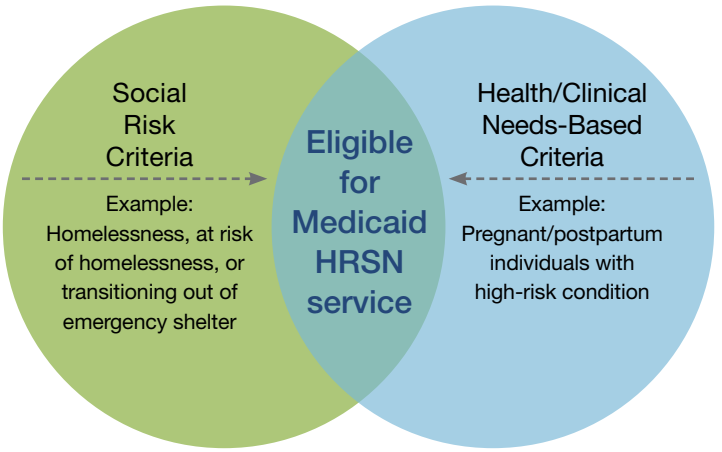
Appendix Table 1 provides more details on the scope of housing supports states offer or have requested to provide.

CMS has set clear guardrails for use of Medicaid funding for HRSN housing supports. Under approved 1115s to date, CMS explicitly prohibits states from using HRSN housing funding for construction costs (i.e., brick and mortar except for allowable home modifications), capital investments, and most room and board.[27] Additional conditions for HRSN approvals are described in Box 2.

Eligibility for housing services (and other HRSN services) is generally based on two factors: (1) social risk criteria and (2) health or clinical needs criteria,[28] as illustrated in Figure 2. All states that have sought to cover housing supports define the social risk criteria as experiencing homelessness, at risk of homelessness, or transitioning out of an emergency shelter, which CMS approvals define based on HUD regulations. In other words, to be eligible for any housing services in any state, an individual must be homeless or at risk of homelessness and meet health needs-based criteria selected by each state.

In some states, pregnancy or being within the postpartum period or under age six have been proposed as a qualifying clinical need to be eligible for HRSN services. To date though, a subset of these populations are eligible in most states based on having or being at risk of developing certain conditions (e.g., malnutrition, low birth weight, or high-risk pregnancy), or on other clinical factors, such as an identified mental health condition. The health needs criteria for which pregnant and postpartum people and young children may indirectly or more explicitly qualify are detailed in Appendix Table 1.

Figure 2. Factors Determining Eligibility for HRSN Services



Nutrition Supports

Food Insecurity Among Pregnant and Postpartum Mothers and Young Children

Lack of adequate or available food, known as food insecurity, is an unfortunately common occurrence with serious health consequences, especially for young children and individuals who are pregnant or in their postpartum period. Almost 17% of households with children under six experienced food insecurity in 2022 (a significant increase from 12.9% in 2021).[29] Pregnant people require enhanced nutrition to avoid potential adverse maternal and infant health outcomes. For example, severe iron deficiency, or anemia, can lead to serious pregnancy complications and increased risk of an infant with low birth weight.[30] Accessing necessary nutrition to support a healthy pregnancy may be difficult for those experiencing food insecurity.

Food insecurity during the postpartum period can result in increased parental stress and maternal depression which affects both the mother and baby. Maternal depression rates are higher among families with low-incomes, where food insecurity is a more prevalent issue.[31] Both maternal depression and food insecurity can affect a young child's development. Infants and toddlers of parents with untreated depression are at risk of cognitive and social-emotional developmental delays as early as infancy.[32] Similarly, research has found household food insecurity to be associated with poor early child development among young children.[33]

While federal programs exist to help increase food security especially for children and pregnant people (e.g., Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), these supports may not be sufficient to meet the nutritional needs of this population. For example, a pregnant individual with or at risk for gestational diabetes requires substantially more fresh fruits and vegetables and/or protein and fewer shelf-stable products that may be higher in sugar. Though some of these grocery items may be available through other benefits, these programs may not be enough to support medically necessary nutritional needs throughout the entire month, especially with rising food costs.[34]

Services to Address Inadequate Nutrition

Eleven states have sought to provide nutrition services that can help address food insecurity and other HRSN through section 1115 demonstrations. Similar to the housing supports, the specific mix of nutrition supports offered or proposed vary across states. CMS has identified five types of nutrition supports that are considered allowable: (1) food/nutrition case management; (2) nutrition counseling; (3) home delivered meals or pantry restocking; (4) nutrition prescriptions like fruit and vegetable boxes; and (5) grocery provisions.[35]

Some of these services are meant to educate and improve nutrition skills, like nutrition counseling that provides guidance on selecting healthy foods and healthy meal preparations. Other services directly provide meals or groceries to eligible individuals; these direct services tend to be more targeted to specific populations or health conditions. Massachusetts and New York also received federal approval to cover cooking supplies, including pots and pans and refrigerators necessary for preparing nutritious meals.[36]

States must establish need-based eligibility criteria to ensure the supports are medically appropriate for the individuals receiving them, as with HRSN housing supports. However, eligibility criteria for nutrition services are generally easier to meet for pregnant and postpartum people and their children. In fact, CMS guidance on HRSN services specifically mentions children and pregnant individuals as groups that may receive home delivered meals or pantry stocking services. Several states, like New Jersey, will cover certain nutrition services for pregnant people at risk for or diagnosed with diabetes, who are at greater risk of compilations if nutritional guidelines are not carefully followed. Hawaii seeks to ensure all postpartum individuals up to twelve months after delivery may access covered nutrition supports such as fruit/nutrition prescriptions and pantry restocking as proposed in its HRSN request to CMS.[37]

Direct provision of meals or groceries are limited to up to three meals per day for up to six months under CMS guidance. However, some states, such as New York, include allowances for services to continue if an individual is determined to still meet the eligibility criteria. Appendix Table 2 provides further details on key nutrition supports states provide or are seeking to provide and identifies how pregnant and postpartum people or young children may be eligible to receive these supports. As with housing services, specific eligibility may vary by service.

2 Conditions for HRSN Approvals

In approving HRSN services, CMS has established important guardrails to protect and improve all Medicaid enrollees' access to medical services and ensure program integrity.

Enrollee Protections

The availability of HRSN services is not a replacement for providing state plan benefits - state approvals explicitly note that neither the state nor managed care organizations are allowed to forgo delivering medically necessary services. Importantly, given previous efforts to implement punitive "healthy behavior" requirements, Medicaid coverage or coverage of any benefit cannot be conditioned on an individual receiving HRSN services they may be eligible for. Individuals may also opt out of these services at any time.

Improving Provider Rates

To improve access to and quality of care, all states that have received approval for HRSN services will have to meet certain provider payment rate standards based on the ratio of Medicaid to Medicare provider rates. This is to ensure that HRSN for a smaller set of beneficiaries are not provided to the detriment of services for all Medicaid enrollees. States that have a Medicaid to Medicare provider payment ratio below 80% must implement and subsequently sustain increases for Medicaid fee-for-service and managed care network payment rates by at least two percentage points. These requirements apply to payment rates for the following services: primary care, behavioral health care, and obstetric care.

Program Integrity

CMS guidance requires HRSN services to be evidence-based and medically appropriate for the population defined by clinically focused, needs-based criteria. In other words, HRSN services cannot be provided to all Medicaid and/or CHIP enrollees; the eligible population must be targeted. CMS has outlined costs that may not be covered in HRSN demonstrations and these include construction costs, room and board (in most cases; see Massachusetts), and capital investments.

HRSN approvals also include a maintenance of effort requirement for existing state spending on social services related to housing and nutrition services. States must maintain current spending levels on these services throughout the entire demonstration period. Similarly, federal funding through the demonstration cannot supplant other available local, state, or federal funding sources (like using new HRSN dollars to fund local housing supports programs that were previously funded using state-only dollars).

Finally, CMS has established a cap on expenditures for HRSN services to ensure that state plan benefits for all eligible Medicaid enrollees remain the priority. Spending on HRSN services may not exceed 3% of total Medicaid spending.

Other HRSN Policies

Transportation to Non-Medical Services

Federal Medicaid law requires states to provide transportation to and from medical appointments through the non-emergency medical transportation (NEMT) benefit. Some states have extended or are seeking CMS approval to extend transportation benefits to provide transportation (public, private, or both) to covered HRSN services through 1115 demonstrations. For example, North Carolina currently offers reimbursement for public or private transportation to HRSN supports for eligible individuals.[38]

Case Management

States already have the ability to provide case management services to adults through state plan authority and as a required service for children under the Early and Periodic Screening, Diagnostic, and Treatment benefit. States increasingly include case management as a key component for specific populations prioritized by proposed or existing section 1115 demonstrations. Pennsylvania seeks CMS approval to use case management to help connect pregnant people and young children and other priority groups with HRSN services, such as connections to housing specialists. More than a dozen states are requesting demonstration project approval to provide case management services to justice-involved populations as part of a targeted set of allowable services covered in the 90 days prior to release from carceral settings;[39] many of these states plan to connect individuals to HRSN supports as they transition back into the community as part of the case management benefit. Some states, like Connecticut, identify pregnancy or being within twelve months postpartum as a qualifying eligibility criterion for the pre-release benefits.

Interpersonal Violence Programs

Interpersonal violence (IPV) and toxic stress have been shown to contribute to adverse health outcomes for pregnant individuals and their infants.[40] Illinois, New Jersey, and North Carolina are seeking or have been approved under 1115 waivers to provide IPV and prevention supports as part of the HRSN services offered through Medicaid. In New Jersey, part of the state's Home Visiting Pilot program includes education and screening for domestic and intimate partner violence. North Carolina's Healthy Opportunities Pilot (HOP) program is currently approved to provide IPV supports including legal assistance,[41] but implementation has been delayed.

Diapers and Changing Supplies

States are also beginning to explore the provision of diapers as a new HRSN support in Medicaid. Currently, diapers are covered through Medicaid almost exclusively for individuals age three and above in cases where the supplies are considered medically necessary.[42] Diaper need[43] has been associated with maternal depression and increased parental stress, which can have adverse effects on children's physical, behavioral, and emotional development, and diaper-related illnesses can occur from delayed diaper changes.[44, 45]

Two states have sought to address this HRSN by providing diapers to families of young children enrolled in Medicaid. CMS recently approved Tennessee's request to provide a monthly supply of diapers to all children under age two with Medicaid coverage, noting the health benefits to both infants and their parents.[46] Delaware has also received approval to cover diapers for a smaller subset of infants in Medicaid, building on an existing state-funded program that provides postpartum individuals enrolled in Medicaid with a weekly supply of diapers and changing supplies, for up to eight weeks postpartum. Through its demonstration, the state will expand its program to 12 weeks postpartum.[47]

Implementation Funding for HRSN Services

Most states are requesting additional federal funding in their section 1115 applications to invest in "infrastructure" needed to ensure approved HRSN services are available and utilized by eligible individuals. As defined in approvals, HRSN infrastructure funding is to be used by states to develop systems and partnerships that support implementation of HRSN services. This funding may be used for technology (e.g., electronic referral systems, screening tools and/or case management systems); development of business or operational practices like developing policies for referral management and trauma-informed practices; workforce development (e.g., cultural competency training); and outreach, education, and stakeholder convening.[48]

Outreach will be critical to ensuring that eligible populations receive available HRSN services. Eligibility criteria for HRSN services creates an additional layer of complexity beyond basic Medicaid eligibility rules. Ensuring pregnant and postpartum people and their children who meet qualifying criteria understand and receive HRSN services will require more nuanced, targeted, and sustained outreach.

Infrastructure funding for outreach may cover one-time opportunities like community-based outreach events, training for community-based health workers, and learning collaboratives for stakeholders, along with ongoing activities like education and the provision of outreach materials and their translation into languages other than English. Regardless of how infrastructure funding is used for outreach, the scope of HRSN services provided and the proportion of infrastructure dollars devoted to outreach will help determine the ultimate success of a state's efforts to connect eligible individuals to services. In Oregon and Washington, two of the three states with approved infrastructure protocols, outreach spending constitutes 15% of total infrastructure spending; in New Jersey, which has fewer HRSN services, 10% of infrastructure funds has been directed to outreach based on the state's approved protocol.[49] In states where eligibility for HRSN supports differ by service, outreach and education efforts will need to be carefully targeted.

Conclusion

Leveraging Medicaid to address families' health-related social needs has the potential to improve health outcomes for pregnant and postpartum parents who lack key social resources that are vital to accessing medical care and influencing long-term health both for parent and child. Unmet HRSNs can affect an individual's health and well-being during significant periods like pregnancy and early childhood. Now that most states have adopted the option to extend postpartum coverage to twelve months, there is an opportunity for states to explore policies that focus on the upstream factors that affect maternal mortality and morbidity and can support improved maternal and child health. In combination with other policies such as extended postpartum coverage and multi-year continuous eligibility for young children, services that target important social needs like housing and nutrition can help promote coverage and access to care in early childhood and throughout pregnancy and the postpartum period.

Recent actions by states to provide HRSN supports and services are a promising step to remove barriers to coverage and care to populations at greater risk of negative health outcomes. However, the impact of these new policies hinges on the extent to which states target these services to pregnant and postpartum individuals and young children as well as how successful states are in implementing the policies. States that broadly define eligibility to include postpartum/pregnant individuals or young children but do not explicitly call out those groups as eligible will need to do more outreach to ensure these individuals receive HRSN services. Outreach and cross-sectional partnerships will be critical to the success of states' HRSN approaches.

Lastly, the newly codified regulations on ILOS "In Lieu of Services" (ILOS) offer states an alternative pathway for using Medicaid to address HRSNs.[50] Moving forward, more states may begin to pursue providing HRSN supports through ILOS rather than through the time-limited and more arduous section 1115 demonstration project process. Providing HRSN services through Medicaid is not a comprehensive nor stand-alone fix to the unmet social needs of low-income pregnant and postpartum individuals or their children. However, states' pursuit of section 1115 demonstrations to cover HRSN services signifies positive, important progress in recognizing and addressing the many factors that contribute to families' success.

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The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high-quality, affordable health coverage for America's children and families. CCF is based at the McCourt School of Public Policy.

Appendix Tables

- Table 1 – Health-Related Social Need (HRSN) Housing Services for Which Pregnant/Postpartum Individuals or Young Children May Be Eligible
- Table 2 – Health-Related Social Need (HRSN) Nutrition Services for Which Pregnant/Postpartum Individuals or Young Children May Be Eligible
- Table 3 – Summary of Proposed or Approved State HRSN Supports for Pregnant/Postpartum Individuals or Young Children

Appendix Table 1. HRSN Housing Services for Which Pregnant/Postpartum Individuals or Young Children May Be Eligible

Health-Related Social Need Services Related to Housing								
State	Status	Health Needs-Based Eligibility[1] Criteria for Pregnant/ Postpartum Mothers or Young Child Population to Receive Services	Services				
			Rent/ temporary housing[2]	Utility Costs[3]	One-time Transition and Moving Costs/ Support[4]	Fees to Secure Housing[5]	Medically Necessary Home Goods and/or Home Modifications[6]
Arizona[7,8]	Approved	• Serious mental illness • High-cost high needs chronic condition or co-morbidities	X	X	X	X	X
Arkansas	Approved	• Individuals with high-risk pregnancies diagnosed by a physician and up to two years postpartum			X	X	
California[9,10,11]	Pending	• In development	X				
Connecticut	Pending	• Pregnant or postpartum individual released from justice-involved setting	X	X	X	X	X
Hawaii	Pending	• Individuals with an assessed mental health need requiring improvement, stabilization, or prevention of deterioration of functioning for SMI	X	X	X	X	
Illinois[10,12]	Pending	• Individual experiencing high-risk pregnancy or complications associated with pregnancy • Infants (up to one year old) born of high-risk pregnancy • Individuals assessed to have a mental health or substance use need requiring improvement, stabilization, or prevention of deterioration of functioning	X	X	X	X	X
Massachusetts[10,12,13]	Approved	• Individual experiencing high-risk pregnancy or complications associated with pregnancy up to 12 months postpartum • Infants up to one year of age of the pregnant individual, or infants born of high-risk pregnancy • For rent/temporary housing: Pregnant individuals and/ or families who demonstrate clinical need eligible for temporary housing assistance under the Massachusetts Emergency Assistance (EA) Family Shelter Program	X	X	X	X	X
New Jersey[11]	Approved	• In development					X
New York[14]	Approved	• Pregnant persons, up to 12 months postpartum • Children under the age of 6			X		X

Appendix Table 1 cont'd.

State	Status	Health Needs-Based Eligibility[1] Criteria for Pregnant/ Postpartum Mothers or Young Child Population to Receive Services	Services				
			Rent/ temporary housing[2]	Utility Costs[3]	One-time Transition and Moving Costs/ Support[4]	Fees to Secure Housing[5]	Medically Necessary Home Goods and/or Home Modifications[6]

North Carolina[12,15]	Approved	• All pregnant people enrolled in Medicaid
		• Children ages 0 to 3 who meet certain criteria including:
		  • Low birth weight
		  • Positive maternal depression screen at infant well-visit
		• Individuals "at risk" of a chronic condition across all eligibility categories
			X	X	X	X	X

Oregon[16,17]	Approved	• Individual who is pregnant, up to 12 months postpartum, who is experiencing or at risk of certain conditions including:
		  • High-risk pregnancy
		  • Abuse or interpersonal violence
		  • A mental health condition (including postpartum condition) or substance use disorder
		• Children under six experiencing or at risk of certain social or health-related conditions
		• Youth in the child welfare system
		• Individuals experiencing or has experienced interpersonal violence
			X	X	X	X	X

Pennsylvania	Pending	• Individuals who are pregnant or in the postpartum period	X		X	X	
Rhode Island	Pending	• Individuals assessed to have a mental health need requiring improvement, stabilization, or prevention of deterioration of functioning • Individuals experiencing or with a history of interpersonal violence	X	X	X		X
Vermont	Pending	• Individuals with an assessed mental health need requiring improvement, stabilization, or prevention of deterioration of functioning for SMI	x				
Washington[8,11]	Approved	• In development	X	X	X		X

Source: Georgetown University Center for Children and Families analysis of state section 1115 demonstration applications, approved standard terms and conditions, and other approval documents available on Medicaid.gov as of May 23, 2024.

Appendix Table 1 Endnotes

[1] All states establish homelessness, being at risk of homelessness, or transitioning out of an emergency shelter as a required risk-based criteria to be eligible for housing services and supports. CMS approvals have defined this eligibility criteria using the Housing and Urban Development (HUD) definition of homeless or at risk of homelessness at 24 CFR § 91.5. Individuals must meet an additional health or clinical needs-based criteria to be eligible to receive these services.

[2] Rent or temporary housing services may only be provided for up to a six-month period.

[3] Utility costs may include activation expenses and back payments to secure housing.

[4] The monetary or physical supports covered through this service may include: security deposit, first month's rent, utilities activation fee, movers, relocation expenses, pest eradication, pantry stocking, and the purchase of household goods and furniture.

[5] Fees states may provide to secure housing, which CMS defines as "housing deposits," include application and inspection fees as well as fees to secure needed identification.

[6] States may choose to provide medically necessary home goods, home accessibility modifications, or both/neither. Medically necessary home goods can include air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units, if needed for medical treatment. Medically necessary home modifications may include accessibility modifications like ramps, handrails as well as remediation services to include ventilation system repairs/improvements and mold/pest remediation.

[7] To be eligible for available housing services in Arizona, individuals must have an identified need for a housing-related goal included within their medical record. Arizona's clinical eligibility criteria is not limited to the categories explicitly identified in the state's approval; additional details on eligible populations will be provided in the state's protocol document for housing services once approved by CMS.

[8] In Arizona and Washington, only medically necessary home accessibility modifications and remediation services are covered through their respective demonstrations. Neither state covers medically necessary home goods, as defined above.

[9] California has also requested separate section 1115 demonstration authority, entitled "California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment," to provide transitional rent services to ensure "no wrong door" for individuals experiencing or at risk of homelessness are able to access available housing services.

[10] California, Illinois, and Massachusetts all require individuals to be enrolled in a managed care plan to be eligible for HRSN services.

[11] New Jersey and Washington have both received CMS approval to cover housing supports. However, the clinical or health needs-based criteria for an individual to be eligible for services is not specified in these approvals and will instead be defined in protocol documents to be approved and included at a later date (Attachment F and Attachment U, respectively). California similarly has a pending request to provide temporary rent services that does not stipulate the health needs-based eligibility criteria.

[12] In Illinois, North Carolina, and Massachusetts, the risk-based eligibility to qualify for housing supports includes individuals experiencing interpersonal violence or other violence-related circumstances.

[13] Massachusetts provides rent/ short-term post transition temporary housing for up to six months to pregnant individuals and families participating in the Massachusetts Emergency Assistance (EA) Family Shelter Program. Individuals in the EA Family Shelter Program must meet the HUD definition of homelessness or at risk of homelessness. The state defines any pregnant or postpartum individual experiencing homelessness or nutrition insecurity as a high-risk pregnancy.

Massachusetts has operated the "Flexible Services Program (FSP)" that has targeted some health-related social needs; the state has received approval to continue and expand the services offered through its "MassHealth" demonstration to address HRSN. The demonstration's standard terms and conditions define the eligibility criteria for services currently offered through the FSP, which is used for Table XX. Eligibility criteria may change upon approval of the "Protocol for Assessing Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications which will be found in Attachment P.

[14] New York limits eligibility for rent/temporary housing and utility costs/payments to individuals who are high utilizers of Medicaid services. Given the narrow scope of this eligibility, the state is not included in Table XXX as providing those services to pregnant/postpartum people and young children.

[15] North Carolina has existing approval through its "Medicaid Reform Demonstration" to operate a program to provide HRSN services, known as "Healthy Opportunities Pilot (HOP)." In the state's request to extend the demonstration pending with CMS, the state is seeking to expand the eligibility criteria for the HRSN services provided through HOP. We have included the proposed expanded eligibility criteria in Table XXX in addition to the existing qualifying criteria for young children which remains unchanged in the state's request.

[16] The full list of clinical risk eligibility criteria in Oregon can be found in the state's approved Health Related Social Needs Protocol, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-hrsn-srvs-prtcl-aprvl.pdf - page=23.

[17] In Oregon, cribs are covered under the one-time transition and moving costs service under basic household goods.

Appendix Table 2. HRSN Nutrition Services for Which Pregnant/Postpartum Individuals or Young Children May Be Eligible

Health-Related Social Need Services Related to Nutrition					
State	Status	Pregnant/Postpartum Individuals or Young Child Population Eligible to Receive Services	Services		
			Medically Tailored Meals[1]	Meals or Pantry Stocking/ Groceries[2]	Fruit/Vegetable and/or Protein Prescription
Delaware[3]	Approved	• All postpartum Medicaid enrollees, up to 12 weeks postpartum		X	
Hawaii[4]	Pending	• Postpartum individuals within one year of labor and delivery • Individual experiencing housing, financial, or food insecurity, or interpersonal violence	X	X	X
Illinois[5]	Pending	• Individuals who are pregnant or up to 60 days postpartum, identified as being food insecure	X	X	X
Massachusetts[5, 6, 7, 8]	Approved	• Individual experiencing high-risk pregnancy or complications associated with pregnancy up to 12 months postpartum, at risk for nutritional deficiency or imbalance • Infants up to one year of age of the pregnant individual, or infants born of high-risk pregnancy, at risk for nutritional deficiency or imbalance	X		X
New Jersey[9]	Approved	• Pregnant individuals who are at risk of or diagnosed with diabetes	X		
New Mexico[10]	Pending	• Pregnant individuals with gestational diabetes		X	
New York[7, 8]	Approved	• High-risk pregnant individuals, including up to 12 months postpartum	X	X	X

North Carolina	Approved	• All pregnant people enrolled in Medicaid
		• Children ages 0 to 3 who meet certain criteria including:
		  • Low birth weight
		  • Positive maternal depression screen at infant well-visit
		• Individuals "at risk" of a chronic condition across all eligibility categories
			X	X	X

Oregon[7, 11]	Approved	Individuals who are homeless or at risk of homelessness and experiencing food insecurity that also meet a clinical risk factor including: Pregnant/postpartum person or child under six experiencing or at risk of certain social or health-related conditions Youth in the child welfare system who meet one of the above clinical risk factors	X	X	X

Appendix Table 2 cont'd.

State	Status	Pregnant/Postpartum Individuals or Young Child Population Eligible to Receive Services	Services		
			Medically Tailored Meals[1]	Meals or Pantry Stocking/ Groceries[2]	Fruit/Vegetable and/or Protein Prescription
Pennsylvania	Pending	• Pregnant individuals and their households who are experiencing or have a history of food insecurity, up to two months postpartum		X	
Washington[7]	Approved	• Individuals with chronic conditions who screen positive housing, financial, or food insecurity	X	X	X

Source: Georgetown University Center for Children and Families analysis of state section 1115 demonstration applications, approved standard terms and conditions, and other approval documents available on Medicaid.gov as of May 23, 2024.

Appendix Table 2 Endnotes

[1] The definition and requirements for medically tailored meals (MTM) may vary across states. In Oregon, the only state to have an approved HRSN services protocol, medically tailored meals include the preparation, provision, and delivery of prescribed meals that are consistent with an individual's previously developed nutrition care plan. Several states have outlined in their pending HRSN plans, or approved in the case of Oregon, that individuals must undergo a nutritional assessment by a registered nutritionists or provider to develop a medically appropriate nutrition care plan prior to receiving any MTM supports.

[2] Pantry stocking or grocery provisions allow individuals to purchase food from a retailer or have food delivered if delivery is available. Pantry or grocery items may include fresh items (e.g., fruits, meats, dairy) or shelf-staple items. States may provide prepared meals or meal kits as an alternative to grocery provisions supports. Both services are available for up to three meals per day, for the allowable time period defined by CMS and can be administered through a variety of ways including a voucher or prepaid card limited to food retailers.

[3] Delaware currently operates a "Food Box Initiative" pilot program using state-only funds that provides postpartum members one shelf-stable food box per week for up to eight weeks postpartum. The state's pending request would allow the state to receive federal funding for its pilot program and would expand the period food boxes would be available to twelve weeks postpartum.

[4] Hawaii proposes that individuals would have to be recommended for nutrition supports by a healthcare provider and assessed for eligibility by a qualified Medicaid provider "with knowledge of the principles, methods and procedures" of the proposed services prior to receiving any of the nutrition supports. Meal or pantry restocking for individuals with a HRSN (individual experiencing housing, financial, or food insecurity, or interpersonal violence) would be limited to children under 21 or pregnant people; all postpartum persons within one year of delivery would be eligible for this service.

[5] Illinois and Massachusetts require individuals to be enrolled in a managed care plan to be eligible for HRSN services.

[6] Massachusetts defines nutritional deficiency or imbalance as "having limited or uncertain availability of nutritionally adequate, medically appropriate, and/or safe foods, or limited or uncertain ability to acquire or prepare acceptable foods in socially acceptable ways." Massachusetts has operated the "Flexible Services Program (FSP)" that has targeted some health-related social needs; the state has received approval to continue and expand the services offered through its "MassHealth" demonstration to address HRSN. The demonstration's standard terms and conditions define the eligibility criteria for services currently offered through the FSP, which is used for Table XX. Eligibility criteria may change upon approval of the "Protocol for Assessing Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications which will be found in Attachment P.

[7] In accordance with CMS guidance on HRSN, approved nutrition supports services are limited to six months (MA, NY, OR, WA). In some cases, like in New York, individual may be able to continue to receive services if a follow-up assessment determines they still meet eligibility criteria.

[8] In Massachusetts and New York, additional supports are permitted when provided to the household of a pregnant person or a child identified as high risk (to be defined in Attachment P and Attachment J, respectively, at a later date). Individuals who receive delivered meals are not allowed to receive the other nutrition services (e.g., nutrition prescriptions), and vice versa.

[9] New Jersey limits eligibility for medically indicated meals to 300 pregnant individuals who meet dietary risk factors per year.

[10] New Mexico would have managed care plans be responsible for providing two meals per day to eligible populations.

[11] Oregon limits eligibility for nutrition services to individuals meeting the USDA definition of food insecurity and meet an additional clinical risk factor; an individual must also be part of one of the covered populations (e.g., youth in the child welfare system or individual experiencing or at risk of homelessness). The full list of clinical risk eligibility criteria for nutrition support services Oregon can be found in the state's approved Health Related Social Needs Protocol, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-hrsn-srvs-prtcl-aprvl.pdf - page=23. Meal or pantry restocking is limited to children under 21, youth with special health care needs, or pregnant individuals who meet the other eligibility criteria described above.

Appendix Table 3. Summary of Proposed or Approved State HRSN Supports for Pregnant/Postpartum Mothers or Young Children

State	Housing Services	Nutrition Services	Other HRSN Services[1]
Arizona	X		
Arkansas	X		
California	X		
Connecticut	X		
Delaware		X	Diapers
Hawaii	X	X	
Illinois	X	X	IPV; Transportation
Massachusetts	X	X	Transportation
New Jersey	X	X	
New Mexico		X	
New York	X	X	Transportation
North Carolina	X	X	IPV; Transportation
Oregon	X	X	
Pennsylvania	X	X	
Tennessee			Diapers
Rhode Island	X		
Washington	X	X	
Vermont	X		

Source: Georgetown University Center for Children and Families analysis of state section 1115 demonstration applications, approved standard terms and conditions, and other approval documents available on Medicaid.gov as of May 23, 2024.

[1] All states except Delaware and California (both of which have pending proposals) include case management services related to HRSN supports offered through the state's demonstrations. Hawaii currently uses section 1115 authority to provide its HRSN-related case management services, but plans to transition those services to other Medicaid authorities.

Endnotes

[1] In October 2018, the Trump Administration approved Massachusetts's "Flexible Services Program" protocol and North Carolina's "Medicaid Reform Demonstration" which allowed both states to provide more direct housing and nutrition supports to certain high-risk populations. See the MassHealth "Flexible Services Protocol" Approval, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-flex-srvcs-prtcl-appvl-20181004.pdf and the North Carolina 1115 demonstration approval, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf#page=76.

[2] With focus nationally and in states on "maternal" health, this paper uses the term "mother" to distinguish covered individuals following their pregnancy. We aim to use more inclusive terms when able in recognition that not all individuals who become pregnant and give birth identify as women. Georgetown CCF also uses the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth; 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/health-related-social-needs/downloads/hrsn-coverage-table.pdf.

[3] CMS, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," November 2023, available at https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf. With focus nationally and in states on "maternal" health, this paper uses the term "mother" to distinguish covered individuals following their pregnancy. We aim to use more inclusive terms when able in recognition that not all individuals who become pregnant and give birth identify as women. Georgetown CCF also uses the term "women" when referencing statute, regulations, research, or other data sources that use the term "women" to define or count people who are pregnant or give birth.

[4] Guillermia Girardi, et al., "Social Determinants of health in pregnant individuals from underrepresented, understudied, and underreported populations in the United States," *International Journal for Equity in Health* September 2023, Vol. 22 (186), available at https://doi.org/10.1186%2Fs12939-023-01963-x; Jessica M. Green, et al., "Trends, Characteristics, and Maternal Morbidity Associated With Unhoused Status in Pregnancy," *JAMA Network Open*, 2023, Vol. 6(7), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807786.

[5] The American Academy of Pediatrics and The American College of Obstetricians and Gynecologists, "Guidelines for Perinatal Care: Eighth Edition," 2017, pg. 151, available at https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx.

[6] Ashlyn K. Lafferty, et al., "A Prospective Study of Social Needs Associated with Mental Health among Postpartum Patients Living in Underserved Communities," *American Journal of Perinatology* 2023, available at https://doi.org/10.1055/a-2113-2739; Laura J. Chavez, "Social Needs as a Risk Factor for Positive Postpartum Depression Screens in Pediatric Primary Care," *Academic Pediatrics*, 2023, Vol. 23 (7), available at https://doi.org/10.1016/j.acap.2023.03.007.

[7] Vida Sandoval, et al., "Unmet Social Needs in the Prenatal Period: Effects on Birth Outcomes and Child Health," *Obstetrics & Gynecology*, May 2020, Vol. 135, available at https://journals.lww.com/greenjournal/abstract/2020/05001/unmet_social_needs_in_the_prenatal_period__effects.590.aspx.

[8] Chidiogo Anyigbo, et al., "Household Health-Related Social Needs in Newborns and Infant Behavioral Functioning at 6 Months," *JAMA Pediatrics*, 2024, Vol. 178(2), available at https://jamanetwork.com/journals/jamapediatrics/article-abstract/2812811.

[9] Sarah Gordon, et al, "Medicaid After Pregnancy: State-Implications of Extending Postpartum Coverage (2023 Update)," HHS Assistant Secretary for Planning and Evaluation Office of Health Policy, April 7, 2023, available at https://aspe.hhs.gov/sites/default/files/documents/168cd047bebc0725da3128104ec8fdde/Postpartum-Coverage-Issue-Brief.pdf.

[10] CMCS Informational Bulletin, "Coverage of Services and Supports to Address Health-Related Social Needs I Medicaid and the Children's Health Insurance Program," November 16, 2023, https://www.medicaid.gov/media/166286.

[11] CMS, "Home and Community-Based Services 1915(c)," available at https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html.

[12] For more information about CHIP HSIs, see MACPAC, "CHIP Health Services Initiatives: What They Are and How States Use Them," July 2019, available at https://www.macpac.gov/publication/chip-health-services-initiatives-what-they-are-and-how-states-use-them/.

[13] Wisconsin Children's Health Insurance Program State Plan Amendment, October 27, 2022, available at https://www.medicaid.gov/CHIP/Downloads/WI-21-0022.pdf.

[14] CMS, State Medicaid Director Letter, "Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care," January 4, 2023, available at https://www.medicaid.gov/sites/default/files/2023-01/smd23001.pdf.

[15] Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, 89 FR 41002 (to be codified at 42 CFR parts 430, 438, and 457), available at https://www.federalregister.gov/public-inspection/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and.

[16] States submit applications for section 1115 demonstrations to CMS for approval, which must include a research hypothesis the state plans to test and a proposed evaluation. Applications are considered "pending" until CMS takes action to approve or deny a proposal.

[17] CMS, Slide Deck, "Addressing Health-Related Social Needs in Section 1115 Demonstrations," December 6, 2022, available at https://www.medicaid.gov/sites/default/files/2023-01/addrss-hlth-soc-needs-1115-demo-all-st-call-12062022.pdf.

[18] Jessica M. Green, et al. "Trends, Characteristics, and Maternal Morbidity Associated With Unhoused Status in Pregnancy," *JAMA Network Open*, 2023, Vol. 6(7), available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2807786.

[19] SchoolHouse Connection, "Infant & Toddler Homelessness Across 50 States: 2021-2022," May 20, 2024, available at https://schoolhouseconnection.org/wp-content/uploads/2024/03/Infant-and-Toddler-Homelessness-Across-50-States-2021-2022.pdf.

[20] Green, et al. (17)

[21] Nikita Mharte, "Homelessness Hurts Moms and Babies," National Partnership for Women & Families and National Birth Equity Collaborative, 2021, available at https://nationalpartnership.org/wp-content/uploads/2023/02/homelessness-hurts-moms-and-babies.pdf?wpId=70931.

[22] SchoolHouse Connection, p. 4, https://schoolhouseconnection.org/wp-content/uploads/2024/03/Infant-and-Toddler-Homelessness-Across-50-States-2021-2022.pdf.

[23] Robin E. Clark, et al., "Infants Exposed to Homelessness: Health, Health Care Use, And Health Spending from Birth to Age Six," *Health Affairs*, Vol. 38(5), May 2019, available at https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00090.

[24] Joint Center for Housing Studies of Harvard University, "America's Rental Housing 2020," 2020, available at https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_Americas_Rental_Housing_2020.pdf.

[25] In addition to the services outlined in Appendix Table 1, states may provide other pre-tenancy and tenancy sustaining supports. Pre-tenancy services are defined as services that assist individuals with locating and obtaining housing options, and providing education about their tenancy rights and responsibilities. Tenancy sustaining services include connecting individuals with social services or services that can assist in applications to obtain sources of income, assisting with lease and housing subsidy renewals, and directing individuals to legal assistance as needed. States like Massachusetts and Hawaii were previously authorized to provide these services, which are still largely included in the states' approved demonstrations or pending proposals.

[26] Oregon Health Plan HRSN Infrastructure Protocol, January 5, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-dshp-claim-proto-appvl-ltr-01052024.pdf; North Carolina Medicaid Reform Demonstration "Healthy Opportunities Pilot Eligibility and Services," October 20, 2023, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nc-medicaid-reform-demo-attach-g-hop-eligibility-services-appvl-10202023.pdf.

[27] CMS guidance defines "room" as "hotel or shelter-type expenses including all property related costs" and defies "board" as "three meals a day or other full nutritional regimen." With its recent 1115 amendment approval in Massachusetts, CMS has broadened the definition of allowable "room and board" to include certain short-term post transition temporary housing.

[28] CMCS Informational Bulletin, pg. 2.

[29] Matthew P. Rabbit, et al., "Household Food Security in the United States in 2022," USDA Economic Research Service, October 2023, available at https://www.ers.usda.gov/webdocs/publications/107703/err-325.pdf?v=7539.3.

[30] Ricardo Ataide, et al., "Iron deficiency, pregnancy, and neonatal development," *International Journal of Gynecology & Obstretrics*, Vol. 162(S2), pg. 14-22, August 4, 2023, available at https://obgyn.onlinelibrary.wiley.com/doi/full/10.1002/ijgo.14944.

[31] National Scientific Council on the Developing Child, "Maternal Depression Can Undermine the Development of Young Children, Harvard University Center on the Developing Child, available at https://developingchild.harvard.edu/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf.

[32] Alana Rodgers, et al., "Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development – A Meta-analysis," *JAMA Pediatrics*, Vol. 174(11), September 14, 2020, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2770120.

[33] Chloe R. Drennen, et al., "Food Insecurity, Health, and Development in Children Under Age Four," *Pediatrics*, Vol. 144(4), October 2019, available at https://doi.org/10.1542%2Fpeds.2019-0824; Klébya Hellen Dantas de Oliveira, et al., "Household food insecurity and early childhood development: Systematic review and meta-analysis,' *Maternal & Child Nutrition*, Vol. 16 (3), February 12, 2020, available at https://doi.org/10.1111/mcn.12967.

[34] Kassandra Martinchek, et al., "As Inflation Squeezed Family Budgets, Food Insecurity Increased between 2021 and 2022," Urban Institute, March 2023, available at https://www.urban.org/sites/default/files/2023-03/As%20Inflation%20Squeezed%20Family%20Budgets%20Food%20Insecurity%20Increased%20between%202021%20and%202022.pdf.

[35] CMS, "Coverage of Health-Related Social Needs (HRSN) Services in Medicaid and the Children's Health Insurance Program (CHIP)," November 2023, available at https://www.medicaid.gov/health-related-social-needs/downloads/hrsn-coverage-table.pdf.

[36] Cooking supplies are only allowed when not available to an individual through other programs.

[37] State of Hawaii Department of Human Services "QUEST Integration Section 1115 Demonstration, January 17, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/hi-quest-pa-01172024.pdf.

[38] In North Carolina, transportation needs must be documented in an individual's care plan in order to receive services.

[39] CMS, "Reentry Section 1115 Demonstration Opportunity," available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity/index.html.

[40] Sristy Agarwal, et al., "A Comprehensive Review of Intimate Partner Violence During Pregnancy and Its Adverse Effects on Maternal and Fetal Health," Cureus, Vol. 15(5), May 20, 2023, available at https://doi.org/10.7759/cureus.39262.

[41] "North Carolina Medicaid Reform Demonstration Healthy Opportunities Pilot Eligibility and Services," October 20, 2023, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nc-medicaid-reform-demo-attach-g-hop-eligibility-services-appvl-10202023.pdf.

[42] Any exceptions for children under age three to receive diapers are when determined to be medically necessary. Full details can be found at https://nationaldiaperbanknetwork.org/wp-content/uploads/2022/02/Medicaid-Chart-Diapers-Final.pdf.

[43] Diaper need occurs when a household is has an insufficient supply or is unable to afford enough diapers necessary to keep their child "clean, dry, and healthy." National Diaper Bank, "What is Diaper Need?," https://nationaldiaperbanknetwork.org/the-need/.

[44] National Diaper Bank, "The NDBN Diaper Check 2023: Diaper Insecurity among U.S. Children and Families," June 15, 2023, available at https://nationaldiaperbanknetwork.org/wp-content/uploads/2023/06/NDBN-Diaper-Check-2023_Executive-Summary-FINAL.pdf.

[45] Dara Lee Luca, et al, "Societal Costs of Untreated Perinatal Mood and Anxiety Disorders I the United States," April 2019, available at https://mathematica.org/publications/societal-costs-of-untreated-perinatal-mood-and-anxiety-disorders-in-the-united-states.

[46] Tennessee's proposal would provide 100 diapers per month per Medicaid-eligible child; CMS, "TennCare III Amendment Approval," May 17, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-demo-aprvl-amndmnt-5.pdf.

[47] CMS, "Delaware Diamond State Health Plan Demonstration Extension Approval," May 17, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-dmntn-appvl-05172024.pdf.

[48] Once CMS approves such infrastructure funding, states must seek subsequent CMS approval on a protocol document detailing use of funds and the providers eligible to receive funding (additional oversight and data on the infrastructure funding is required in other demonstration documents like the evaluation of the demonstration).

[49] Oregon Health Plan HRSN Infrastructure Protocol, January 5, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/or-health-plan-dshp-claim-proto-appvl-ltr-01052024.pdf; Washington Medicaid Transformation Project HRSN Infrastructure Protocol, May 27, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wa-medicaid-transformation-dmntrtn-aprvl-hrsn-infrtre-prtcl.pdf#page=527; New Jersey FamilyCare Comprehensive Demonstration, April 18, 2024, available at https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-familycare-comp-demo-appvl-04182024.pdf#page=204.

[50] Leonardo Cuello, "Strengthened Tool to Address Health-Related Social Needs: The New Medicaid Managed Care Regulation's 'In Lieu of Services' Explained," Georgetown University Center for Children and Families, May 23, 2024, available at https://ccf.georgetown.edu/2024/05/23/strengthened-tool-to-address-health-related-social-needs-the-new-medicaid-managed-care-regulations-in-lieu-of-services-explained.