SOCIETY OF ACTUARIES®

Health

2025 SOA MEETING

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In Lieu of Services:
Addressing Health-Related Social Needs in Medicaid

June 25, 2025

Moderator:
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Presenters:
Kevin Mitby-Manning, ASA, MAAA
Caroline Scott, MA, FSA, MAAA

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Agenda

- Introductions/Audience Poll
- What are Health-Related Social Needs and In Lieu of Services?
- Overview of 2016 CMS Final Rule and Subsequent Guidance
- State Approaches to Addressing Health-Related Social Needs in Medicaid
- Regulatory Authorities Supporting Health-Related Social Needs
- Actuarial Considerations
- Current Regulatory Landscape
- Questions and Discussion

Kevin Mitby-Manning, ASA, MAAA

Kevin is a Medicaid actuary at Centene. He joined Centene in July 2017 and has provided actuarial support to health plans operating in Arizona, California, Hawaii, Kansas, Nevada, New Mexico, and Oregon in addition to working on federal policy and other analyses across all markets.

In his prior role, Kevin worked as a Health and Welfare actuary at a consulting firm. His clients included large corporations, municipalities, and union and retiree benefit funds. He worked on benchmarking, plan design modeling and pricing, benefit fund projections, trend and reserve analysis, retiree medical valuations, union negotiations, and health care reform analysis.

Caroline Scott, MA, FSA, MAAA

Caroline Scott is a government health actuary at Mercer. She joined Mercer in January 2025 and provides actuarial support to multiple state Medicaid agencies.

In her prior role, Caroline led child welfare rate development projects in multiple states, including a comprehensive rate review of home and community-based services for the Indiana Department of Child Services.

Caroline has nearly 20 years of direct experience in public education: including Head Start, Title I, behavioral and academic intervention, alternative education, special education, and IEP/504 plan development.

Caroline previously served as a licensed foster parent for the State of Michigan, providing long-term, emergency, and special needs respite care to children and youth.

Q1: What is your primary role?

A. State Medicaid Program Actuary
B. Medicaid Managed Care Plan Actuary
C. Consulting Actuary
D. Other

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What is your primary role?

Q2: Rate your familiarity with health-related social needs

A. Expert: “Move over! I could lead this session!”
B. Intermediate: “I have worked on it a few times.”
C. Beginner: “I am familiar with the term.”
D. None: “What are health-related social needs?”

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Rate your familiarity with health-related social needs

Q3: Rate your familiarity with in lieu of service for Medicaid managed care

A. Expert: “Move over! I could lead this session!”
B. Intermediate: “I have worked on it a few times.”
C. Beginner: “I am familiar with the term.”
D. None: “What is in lieu of service?”

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: Rate your familiarity with in lieu of service for Medicaid managed care

What Are Health-Related Social Needs and in Lieu of Services?

Health-Related Social Needs

- CMS defines health-related social needs (HRSN) as an individual's unmet, adverse social conditions that contribute to poor health.
- These needs include food insecurity, housing instability, unemployment, and/or lack of reliable transportation, among others.
- An individual’s HRSN are a result of their community’s underlying Social Determinants of Health (SDOH).
- Extensive research has indicated that SDOH and associated HRSN can account for as much as 50% of health outcomes.

Medicaid/CHIP Managed Care In Lieu of Service or Setting (ILOS)

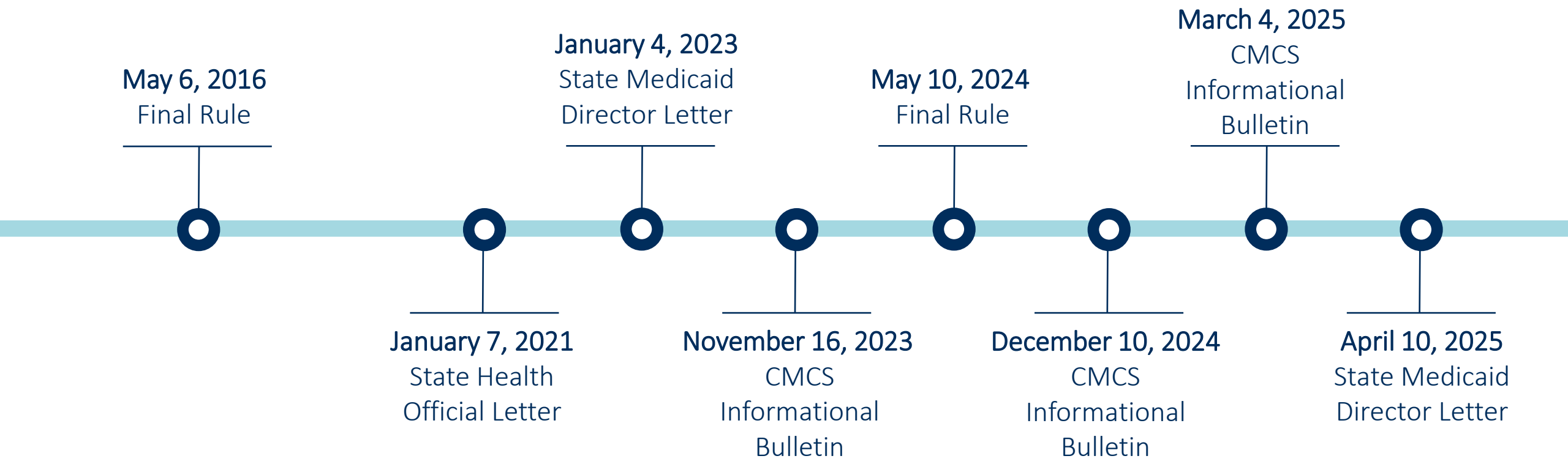
- Managed care plans may cover services or settings that are **substitutes** for services/settings covered under the state plan as "in lieu of services and settings" in accordance with 42 CFR § 438.3(e)(2) and 438.16.
- CMS finalized four requirements for the use of in lieu of service or setting (ILOS) at 42 CFR § 438.3(e)(2):
  1. States must determine that the ILOS is a medically appropriate and cost-effective substitute for covered services or settings under the state plan;
  2. Enrollees cannot be required to use the ILOS;
  3. An approved ILOS must be authorized and identified in the managed care plan contract and must be offered to enrollees at the option of the managed care plan; and
  4. The utilization and actual cost of the ILOS is taken into account in developing the component of the capitation rates that represents the covered state plan services, unless a federal statute or regulation explicitly requires otherwise.

Medicaid/CHIP Managed Care In Lieu of Service or Setting (ILOS)

- To obtain CMS approval, ILOSs included in managed care contracts must:
  1. Advance the objectives of the Medicaid program;
  2. Be cost effective;
  3. Be medically appropriate;
  4. Be provided in a manner that preserves enrollee rights and protections;
  5. Be subject to appropriate monitoring and oversight; and
  6. Be subject to retrospective evaluation, when applicable.

Overview of 2016 CMS Final Rule and Subsequent Guidance

Timeline of CMS Activity and Guidance



*There remains ongoing uncertainty in the current political environment and current regulation and guidance may change.

May 6, 2016 Final Rule

- Codified ILOS in 42 CFR § 438.3(e)(2)
- Four ILOS Criteria:
  - State Determination: The state must determine that the ILOS is a medically appropriate and cost-effective substitute for the covered state-plan service or setting.
  - Voluntary Use: An enrollee cannot be required to use the ILOS; it must be offered at the plan's discretion.
  - Contract Identification: All approved ILOS must be explicitly listed in the managed care contract.
  - Rate Development: The utilization and cost of each ILOS must be taken into account in the capitation rate development.

January 7, 2021 State Health Official Letter

- “Opportunities in Medicaid and CHIP to Address [SDOH]”
- Describes how states can leverage existing Medicaid and CHIP authorities to better address SDOH and to support states in designing programs, benefits, and services that improve population health, reduce disability, and lower overall costs by tackling upstream social needs.
  - It did not create any new flexibilities – just clarified existing federal authorities
- Aimed to give states a clear roadmap for embedding social care into Medicaid without requiring new legislation.
- Important to note that this was released during the first Trump administration.

January 4, 2023 State Medicaid Director Letter

- "Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care"
- Clarified how states may leverage their existing ILOS authority to address HRSN such as housing instability and nutrition insecurity.
- Introduced six principles that include advancing Medicaid objectives, cost-effectiveness, medical appropriateness, voluntary use and enrollee protections, monitoring and oversight, and retrospective evaluation.
- CMS sets financial guardrails by requiring states to calculate an "ILOS Cost Percentage"
  - Streamlined or enhanced requirements depending if % is more or less than 1.5%
  - Capping expenditures at 5% to ensure fiscal accountability

November 16, 2023 CMCS Informational Bulletin

- "Coverage of Services and Supports to Address Health-Related Social Needs in Medicaid and [CHIP]"
- Discussed opportunities available to address HRSN:
  - State plan authorities
  - Section 1915 HCBS waivers and state plan programs
  - Managed Care ILOS
  - Section 1115 demonstrations
  - CHIP Health Service Initiatives
- CMS published an HRSN Framework with the CIB detailing which HRSN services and supports are allowable under each authority.

May 10, 2024 Final Rule

- Formalizes and expands ILOS authority in managed care by specifying that ILOS may be used as either short-term or longer-term substitutes for covered state-plan services or settings to address HRSN, subject to:
  - Contract documentation
  - Fiscal guardrails (1.5% documentation trigger; 5% aggregate cap)
  - Ongoing monitoring
  - Five-year retrospective evaluation requirement
- ILOS may be deployed either as an immediate substitute (e.g., covering a sobering center instead of an ED visit) or as a longer-term alternative (e.g., supportive housing in lieu of repeated hospitalizations).

May 10, 2024 Final Rule

- Each ILOS must be approvable via a Medicaid state-plan amendment or a 1915(c) waiver, and must be explicitly documented in managed care plan contracts, including definitions, eligible populations, service codes, and clinical criteria.
- In the detailed economic analysis section, CMS clarifies that while guidance requires ILOS to be cost effective, the rule does not require cost effectiveness to be “budget neutral”.

December 10, 2024 CMCS Informational Bulletin

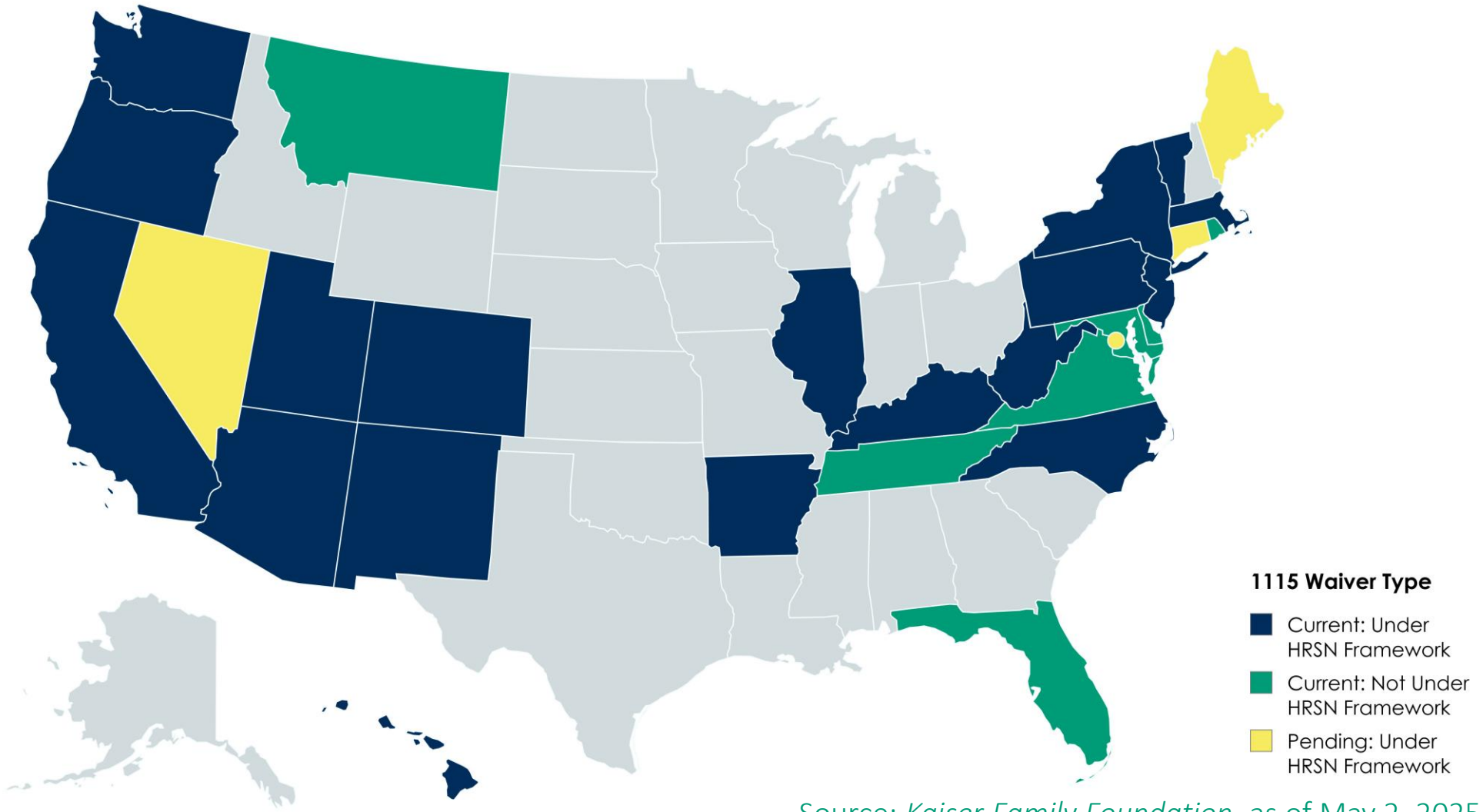
- The December 10, 2024 CIB clarifies and supersedes the November 16, 2023 guidance.
- Refined parameters around allowable HRSN interventions, distinguished room-and-board housing supports more clearly, and provided explicit programmatic guidelines for each category.
- Provided detailed technical clarifications, explicit cross-references to statutory citations, and provided guidance on how infrastructure costs may be treated under Section 1115 demonstrations.

March 4, 2025 CMCS Informational Bulletin and April 10, 2025 State Medicaid Director Letter

- The March 4, 2025 CIB rescinded CMS' prior HRSN guidance — including the HRSN Frameworks included in the November 2023 and December 2024 CIBs.
  - Directed that any state proposals to cover HRSN will be evaluated on a case-by-case basis, without reliance on those bulletins or the HRSN Framework.
- The April 10, 2025 letter does not directly reference ILOS authority or HRSN.
  - Designated State Health Programs and Designated State Investment Programs will no longer be approved or renewed under Section 1115 demonstrations.

State Approaches to Addressing Health-Related Social Needs in Medicaid

Approved & Pending 1115 Waivers Addressing HRSN



Source: *Kaiser Family Foundation*, as of May 2, 2025.

Summary of 8 States Approved Under the HRSN Framework as of March 2024 with 1115 Waivers

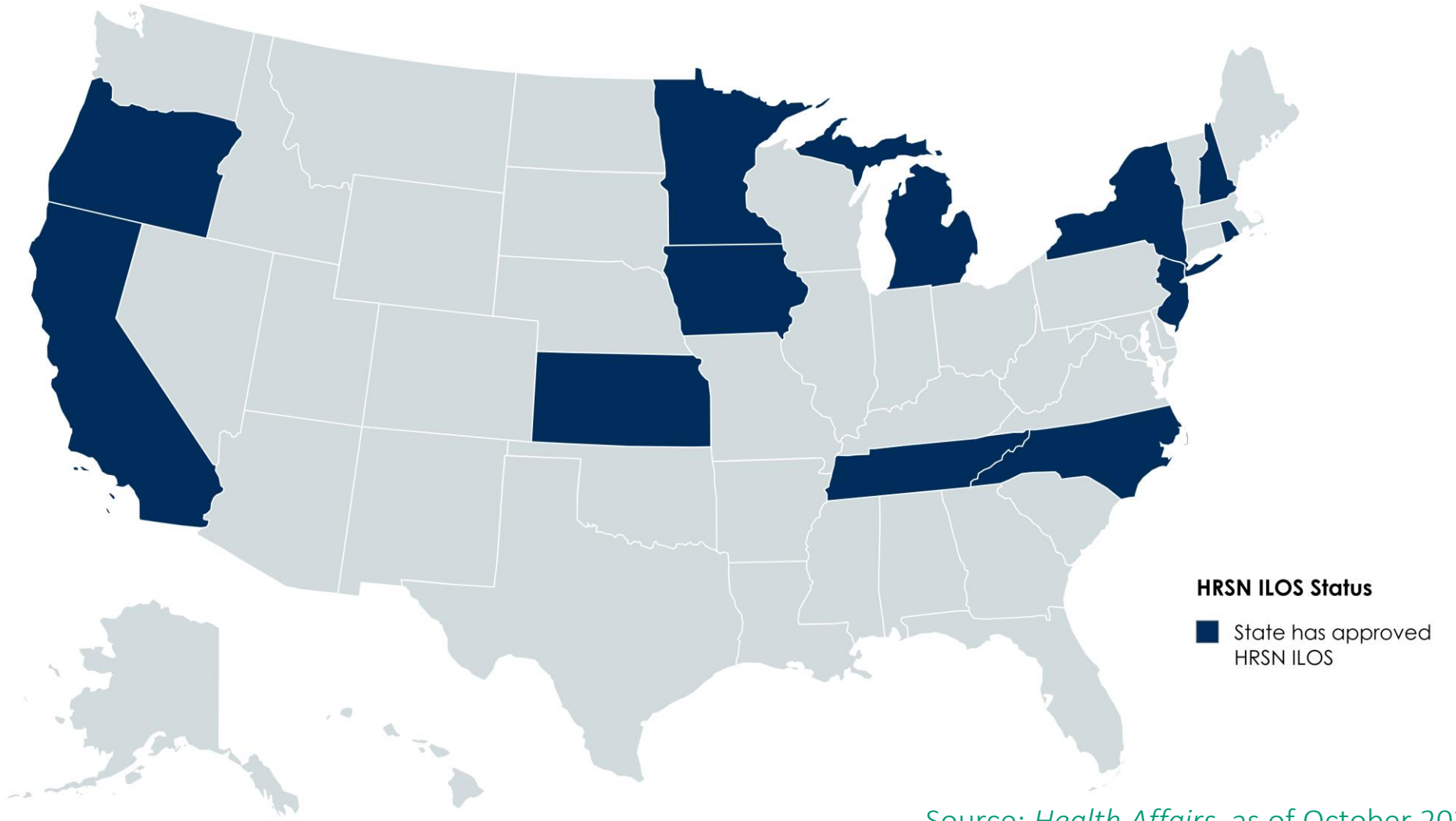
State	Without Room and Board				With Room and Board	
	Housing transition navigation services	Pre-tenancy and tenancy sustaining services	One-time transition and moving costs and housing deposits	Medically necessary home modifications and remediation services	Recuperative care (up to 90 days) and short-term post-hospitalization housing (up to 6 months)	Rent/temporary housing, including utility costs (up to 6 months)
Arizona	X	X	X	X	-	X
Arkansas	X	X	X	-	-	-
California	-	-	-	-	X	-
Massachusetts	X	X	X	X	-	-
New Jersey	X	X	-	X	-	-
New York	X	X	X	X	X	X
Oregon	X	X	X	X	-	X
Washington	X	X	X	X	X	X

Summary of 8 States Approved Under the HRSN Framework as of March 2024 with 1115 Waivers

State	Nutrition Supports				Other Supports	
	Nutrition counseling and education	Home-delivered meals or pantry stocking (up to 3 meals a day, up to 6 months)	Nutrition prescriptions (up to 6 months)	Grocery provision (up to 6 months)	Case management, outreach, and education	Transportation to HRSN services
Arizona	-	-	-	-	X	-
Arkansas	X	-	-	-	X	-
California	-	-	-	-	-	-
Massachusetts	X	X	X	-	X	X
New Jersey	X	X	-	X	X	-
New York	X	X	X	X	X	X
Oregon	X	X	X	-	X	-
Washington	X	X	X	X	X	X

Note: All states have approval for HRSN infrastructure expenditures to support the implementation and delivery of HRSN services.

Approved Managed Care ILOS Addressing HRSN



Source: *Health Affairs,* as of October 2024.

Summary of Approved HRSN Services via ILOS

State	Approved ILOS Category				
	Nutrition	Housing	Transportation	Environment	Employment
California	X	X	-	X	-
Iowa	X	X	X	-	X
Kansas	X	X	X	-	-
Michigan	X	-	-	-	-
Minnesota	X	-	-	-	-
New Hampshire	X	-	-	-	-
New Jersey	-	X	-	-	-
New York	X	-	-	-	-
North Carolina	-	X	-	-	-
Oregon	X	-	-	-	-
Rhode Island	X	-	-	-	-
Tennessee	X	X	X	X	-
Total States:	10	6	3	2	1

Note: As of October 2024.

Types of ILOS Services Approved

Approved ILOS Category				
Nutrition	Housing	Transportation	Environment	Employment
10 states, 13 types of services ranging from nutrition therapy to medically tailored meals.	6 states, 6 types of services ranging from home modifications to housing deposits.	3 states, 6 types of services ranging from vehicle modification to non-medical transportation.	2 states, 2 types of services including asthma remediation and bed bug treatment.	1 state, 1 type of service including supported employment services.

California — Example of Using Multiple Avenues

ILOS Authority

Respite services, assisting living facility transitions, community or home transition services, personal care and homemaker services, home modifications, medically tailored meals, sobering centers, asthma remediation, housing transition navigation services, housing deposits, housing tenancy and sustaining services, day habilitation programs

State Plan Amendment

Enhanced Care Management

Section 1115 Demonstration Waiver

Short-term post-hospitalization housing, recuperative care (medical respite) and transitional rent

Target Populations for HRSN Services

- States have both **Social Criteria** and **Clinical Criteria**
  - The broad definition of **Social Criteria** is standard across states and is captured during an HRSN screening, but the specific details might differ. For example, for Housing Supports the Social Criteria is experiencing or at risk of experiencing homelessness. For Nutrition Supports, the Social Criteria is experiencing food or nutrition insecurity.
  - The **Clinical Criteria** varies by state
    - The Clinical Criteria may include high-risk pregnancies (including postpartum), transitioning out of the foster care system, transitioning from institutional care, transitioning from correctional facilities, receiving HCBS services, having specific physical or behavioral health conditions, or repeat hospitalization or ED use.

Overview of Regulatory Authorities Supporting Federal Financial Participation for Health-Related Social Needs

State Plan Authority (Social Security Act §1902)

- To be included in a Medicaid state plan the service must comply with federal regulations outlined in the Social Security Act and other relevant legislation.
  - State plan services must be deemed **medically necessary** for the treatment of a condition or to maintain health.
- Key requirements under Medicaid state plan authority include:
  - **1902(a)(10)(B) — Comparability:** A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees.
  - **1902(a)(23) — Freedom of choice:** All beneficiaries must be permitted to choose a health care provider from among any of those participating in Medicaid.
  - **1902(a)(1) — Statewideness:** Statute dictates that a state Medicaid program cannot exclude enrollees or providers because of where they live or work in the state.

State Plan Authority (Social Security Act §1902)

- To alter state plan services, states must file a state plan amendment (SPA) and receive CMS approval prior to implementation.
  - CMS has 90 days from the filing date to approve or deny the SPA, otherwise the proposed changes go into effect.
- SPA approvals are not contingent on meeting any budgetary target, but states are required to indicate the expected federal financial impact.
- Common HRSN services included in Medicaid state plans include:
  - Targeted case management
  - Peer recovery support services
  - Community health worker services
  - Non-emergency medical transportation
  - Early and Periodic Screening, Diagnostic, and Treatment services

Children's Health Insurance Program Health Services Initiatives

- The State Children's Health Insurance Program (CHIP) allows states to use up to 10% of CHIP funding to implement health services initiatives (HSIs) focused on improving the health of eligible children under §2105(a)(1)(D)(ii) of the Social Security Act.
  - HSI funding is included in the 10% CHIP administrative cap.
- States seeking to implement HSIs must:
  - Submit a state plan amendment specifying the population(s) served,
  - Show the HSI will improve children's health,
  - Submit an updated CHIP program budget, and
  - Provide assurances that they will not supplant or match CHIP federal funds with other federal funds.

Children's Health Insurance Program Health Services Initiatives

- States implementing HSIs have flexibility to determine the type and scope of HSIs.
- Common HSIs include:
  - Poison control centers
  - Lead testing, prevention, and abatement services
  - Behavioral health and SUD services
  - Parenting education and supports
  - Violence prevention services
  - Nutrition services
  - School-based health services and supports

Types of Medicaid Waiver Authority

- Medicaid waivers can be classified broadly as research and demonstration waivers (Section 1115 waivers) or program waivers (Section 1915 waivers).
- Waivers are commonly utilized to "waive" the following state plan requirements:
  - **Comparability:** Waivers of comparability allow states to limit an enhanced benefit package to a targeted group of persons identified as needing it most and to limit the number of participants to implement a demonstration on a smaller scale.
  - **Freedom of choice:** Freedom of choice waivers are typically used to allow implementation of managed care programs or better management of service delivery.
  - **Statewideness:** A waiver of statewideness can limit the geographic area in which a state is testing a new program, facilitate a phased-in implementation of a program, or reduce state expenditures by limiting eligible participants.

Section 1115 Demonstration Authority

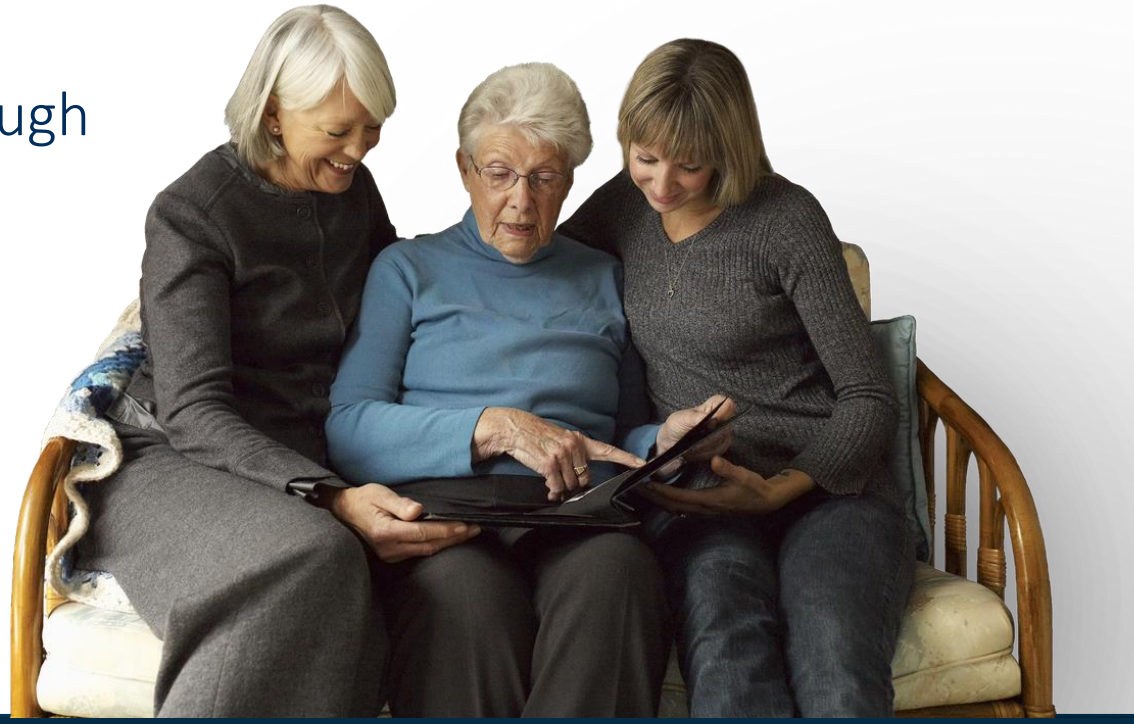
- Under Section 1115, the HHS Secretary can waive almost any Medicaid state plan requirement under §1902 to the extent necessary to carry out a demonstration or experimental project furthering the goals of the program.
  - Section 1115 predates the enactment of Medicaid as a vehicle for testing new approaches in a variety of federally funded programs.
  - The Secretary can also permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the Medicaid state plan.

Section 1115 Demonstration Authority

- Section 1115 waivers are required to be budget-neutral, meaning that federal spending under the waiver cannot exceed what it would have been in absence of the waiver.
  - Section 1115 waivers can be used to allow a state to use savings generated by one initiative to pay for other changes, such as eligibility expansions, as long as the waiver as a whole is budget neutral.
- Section 1115 waivers are initially approved for five years. They are renewed for up to three years at a time (or up to five years for duals).
  - In exchange for the flexibility provided under Section 1115 waivers, states must contract with independent evaluators to conduct periodic evaluations of the waiver's outcomes and provide quarterly and annual reports on elements specified in the special terms and conditions of the waiver, such as information on waiver enrollment and spending, and the state's implementation progress.

HCBS Authorities Section 1915(c), 1915(i), 1915(j), 1915(k)

- Home and community-based services waivers (HCBS Waivers) meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.
  - Nearly all states and DC offer services through HCBS Waivers.
  - States can operate as many HCBS Waivers as they want — currently, about 257 HCBS Waiver programs are active nationwide.



HCBS Authorities Section 1915(c), 1915(i), 1915(j), 1915(k)

Section 1915 HCBS waivers are classified in four broad categories:

- **1915(c):** waiver authority that allows for a broad array of services and design flexibilities, for individuals with an institutional level of care.
- **1915(i):** state plan option for people who need less than an institutional level of care.
- **1915(j):** state plan option for self-directed personal assistance services.
- **1915(k):** state plan option, also known as Community First Choice (CFC), that provides a 6% increase in the federal medical assistance percentage (FMAP) for attendant services.

Section 1915(b) Waiver Authority

- Section 1915(b) of the Social Security Act, enacted in 1981 as part of the Omnibus Budget Reconciliation Act (P.L. 97-35), provides states with the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice.
  - 1915(b) waivers must be cost effective.
- States typically use two provisions in the law to implement managed care delivery systems under the following authorities:
  - 1915(b)(1)—Primary care case management or specialty service arrangement.
  - 1915(b)(4)—Restriction to specified providers.

Housing Services and Supports	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 Health Services Initiatives
Housing supports without room and board	Yes	Yes	Yes	Yes
First month's rent	Yes	1915(k) only	Yes	Yes
Short-term pre-procedure/post-hospitalization housing with room and board	No	No	Yes (6 months, 1x/year)	Not previously approved
Caregiver respite	Yes	Yes	Yes	Yes
Utility assistance	No	No, unless MFP	Yes (6 months, 1x/demonstration)	Yes
Day habilitation services	Yes	Yes	Yes	Not previously approved
Sobering centers	Yes	Yes	Yes	Not previously approved
Medically necessary home remediations	Yes	Yes	Yes	Yes
Home accessibility modifications	Yes	Yes	Yes	Yes

Nutrition Services and Supports	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 Health Services Initiatives
Case management services	Yes	Yes	Yes	Not previously approved
Nutrition counseling	Yes	Yes	Yes	Yes
Home delivered meals or pantry stocking	Yes, less than 3 meals/day	Yes, less than 3 meals/day	Yes, up to 3 meals/day for 6 months	Not previously approved
Nutrition prescriptions	Yes, less than 3 meals/day	Yes, less than 3 meals/day	Yes, up to 3 meals/day for 6 months	Not previously approved
Grocery provisions	Yes, less than 3 meals/day	Yes, less than 3 meals/day	Yes, up to 3 meals/day for 6 months	Not previously approved

Actuarial Considerations for ILOS

Actuarial Considerations for ILOS

- As required in 42 CFR § 438.66(a) through (c), states must establish a system to monitor performance of their managed care programs.
  - When ILOSs are included in a managed care plan's contract, they too must be part of the state's monitoring activities.
- States are required to annually submit a projected ILOS Cost Percentage and retroactively a final ILOS Cost Percentage to CMS.
  - The projected ILOS Cost Percentage must be developed in a reasonable and appropriate manner, consistent with generally accepted actuarial principles and practices.

Actuarial Considerations for ILOS

- The ILOS Cost Percentage is a calculated as:
  - The portion of the total capitation payments attributable to all ILOS(s), excluding short term stays in an IMD, for the specific managed care program (numerator), **divided by**
  - The total costs for the specific managed care program, including state directed and pass-through payments (denominator).
- The ILOS Cost Percentage shall not exceed 5% of total costs per managed care program.
  - Documentation, monitoring, and evaluation requirements for states with an ILOS Cost Percentage that is de minimis (i.e., <= 1.5%) are streamlined, while states with higher ILOS Cost Percentages must adhere to additional requirements.

Actuarial Considerations for ILOS

States' actuaries must document the items below in each rate certification that includes ILOS(s):

1. A brief description of each ILOS in the Medicaid managed care program, and whether the ILOS was provided as a benefit during the base data period.
2. The projected ILOS Cost Percentage, as defined above.
3. A description of how the ILOS(s) (both material and non-material impact) were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service.

Actuarial Considerations for ILOS

- The final ILOS Cost Percentage must be certified by states' actuaries and provided to CMS in a separate actuarial report with the future rate certification(s) required in 42 CFR § 438.7(a) for the applicable programs that include the ILOS(s).
  - This actuarial report, including both the final ILOS Cost Percentage and the actual plan costs, must be submitted to CMS no later than two years after the completion of the contract year that includes ILOS(s).

Actuarial Considerations for ILOS

The final actuarial report must include, at a minimum, the information specified below:

1. The portion of the total capitation payments that is attributable to ILOS(s), excluding a short term stay in an IMD, for the specific managed care program that includes the ILOS(s) and a description of how this amount was calculated.
2. The total actual dollar amount of capitation payments specific to the Medicaid managed care program that includes the ILOS(s). This total capitation payment amount must include all state directed and pass-through payments.
3. The final ILOS Cost Percentage specific to the Medicaid managed care program. This percentage is calculated by dividing the amount from Step 1 by the amount from Step 2.
4. A summary of the actual managed care plan costs for delivering ILOSs based on claims and encounter data provided by the managed care plans to states.

Current Regulatory Landscape

CMS Rescinds Prior HRSN Guidance: March 2025

- On March 4, CMS rescinded prior HRSN guidance issued in November 2023/December 2024.
  - **The March 4 memo states:**
    "CMS will consider states' applications to cover these services and supports on a case-by-case basis to determine whether they satisfy federal requirements for approval under the applicable provisions of the Social Security Act and implementing federal regulations, without reference to the November 2023 and December 2024 CIBs or the HRSN Framework."
  - No additional guidance was provided.

CMS Suspends 1115 Authority: April 2025

- On April 10, CMS issued a memo suspending new/renewed authorizations for non-medical Designated State Health Programs (DSHPs) and Designated State Investment Programs (DSIPs) under Section 1115(a) authority.
  - **The April 10 memo states:**
    "CMS has determined these programs were funded entirely without federal Medicaid funds prior to those approvals, and the addition of federal Medicaid funding does not render these programs as integral components of section 1115 demonstration programs. As such, CMS has renewed concerns about the appropriateness of providing federal funding for these programs under section 1115 demonstration authority and does not anticipate approving new state proposals of section 1115 demonstration expenditure authority for federal DSHP or DSIP funding or renewing existing section 1115 demonstration expenditure authority for federal DSHP or DSIP funding, including when current DSHP or DSIP authority concludes before the expiration date of the demonstration."

CMS Suspends 1115 Authority: April 2025

- At present, no change in federal participation for 1115 waiver demonstrations already approved is planned.
  - **The April 10 memo states:**
    "The Center for Medicaid and CHIP Services (CMCS) will conduct direct outreach to states with existing DSHP and DSIP authority to emphasize that the time-limited authority for DSHP or DSIP will not be extended beyond the currently approved demonstration period or, when current DSHP or DSIP authority concludes before the end of the demonstration's approval period, the current end date for such authority."

Questions?

Provide Your Feedback

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