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Demystifying Federal Authorities

State Considerations for Addressing Health-Related Social Needs in Medicaid

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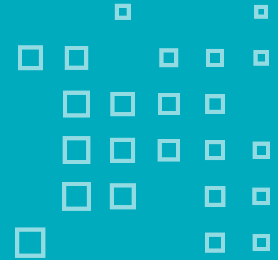

Table of Contents

Introduction....4
State Considerations for Choosing an HRSN Authority....7
Services....7
Target Populations....10
Scope and Reach of Coverage....12
Financing....14
Infrastructure and Capacity Building....17
Timing and Implementation....18
Conclusion....20
Appendix....21
Summary of Key HRSN Design Questions and Medicaid Authority Considerations....21

Introduction

Over the past several years, a growing body of literature has indicated that up to 50% of an individual's health can be driven by the underlying social and economic factors affecting their lives, such as access to safe housing, healthy food, and transportation; education and employment status; and exposure to interpersonal violence.[1] These factors are often collectively known as Health-Related Social Needs (HRSN).

States are increasingly pursuing interventions to address HRSN in their Medicaid programs to improve health outcomes for members and maximize the value of their Medicaid expenditures. The Centers for Medicare and Medicaid Services (CMS) has issued multiple guidance documents and regulations outlining the various authorities under which state Medicaid agencies can fund initiatives to address their members' HRSN and encouraging states to take advantage of these opportunities. The requirements for these authorities vary but generally afford states discretion to address HRSN if the proposed interventions can be supported by an evidence base illustrating their value in improving health. As a result, state Medicaid programs now have a range of options, which can be used in combination, for covering HRSN services in alignment with their programmatic goals. However, with this assortment of options comes a variety of authority-specific opportunities and constraints described in a patchwork of federal guidance, and determining the best approach to integrating HRSN services into a state Medicaid program can be challenging. This calculus is further complicated by the fact that federal HRSN approval policies are still evolving, in part due to evolving state requests.

Recent CMS Guidance on HRSN

- 2021 State Health Official letter on the Social Determinants of Health
- 2023 Informational Bulletin and accompanying framework on HRSN
- 2023 State Medicaid Director Letter on In-Lieu of Services and Settings (ILOS)
- 2024 Final Rule on Managed Care, including updated ILOS provisions
- 2024 State Medicaid Director Letter on 1115 budget neutrality policies, including for HRSN services

This issue brief aims to provide states with an actionable and comprehensive roadmap to evaluate the most suitable authority (or combination of authorities) to meet their HRSN-related goals, based on available guidance to date. The brief is organized by key design questions, which, when combined, shape the scope and scale of state HRSN initiatives. For each design question, the brief describes potential considerations to help guide states' selection of appropriate federal authority (or authorities) to support program goals and operations. There is no "right" or "wrong" path to authorize HRSN interventions—states with different goals, delivery systems, timelines and operational capacities will want to consider which path or paths are best suited to their circumstances.

Design Questions to Inform HRSN Authority Selection

Key HRSN design questions for states are:

- **Services**: Which domains will be addressed (e.g., housing, nutrition, interpersonal safety, etc.), and what services will be covered to address HRSN within those domains?
- **Target Populations**: Which populations (defined by clinical condition, social risk factor, age, eligibility group, geography, etc.) will receive HRSN services?
- **Scope and Reach of Coverage**: How broad will HRSN service coverage be in terms of delivery system (fee-for-service and/or managed care) and geography? Will the state extend the services to all those who meet state-defined eligibility criteria, or will there be caps or other limits on availability? Is there a desire to phase in services or populations over time?
- **Financing**: How will the state fund the cost of HRSN services (e.g., through new investments or via managed care rate setting)?
- **Infrastructure and Capacity Building**: Will the state seek to invest in infrastructure and capacity building to support HRSN initiative implementation?
- **Timing**: What is the desired launch date for HRSN services?

Answers to these questions may evolve over time as states and their partners gather more experience with planning and delivering HRSN services.

Medicaid Authorities to Consider for HRSN Services

Generally, states[i] can cover HRSN services through one or more of the authorities below, which are described in more depth throughout this issue brief:

- **1115 demonstrations**: Flexible authority that allows states to test policies otherwise not permissible under federal rules, as long as CMS determines the policies further the objectives of Medicaid.[2]
- **In-lieu of services and settings (ILOS)**: An option under managed care to cover alternative services or settings that substitute for traditional Medicaid services or settings. ILOS can either be a "real time" alternative to a service (for example, when a state authorizes home-delivered meals instead of a home health aide) or a preventive substitute service (such as asthma home remediation to avoid frequent emergency room visits). States implement ILOS through their managed care contracts, which are reviewed by CMS. Under federal regulation, coverage of ILOS must be optional for managed care plans.[3]
- **1915(b)(3) authority**: An option allowing states to offer "additional services" in managed care delivery systems authorized under 1915(b) waiver authority, when cost savings from services provided under the 1915(b) waiver can cover the cost of the additional services.[4] Little CMS guidance exists on this option.
- **1905(a) state plan authority**: The basic authority under which states administer their Medicaid programs, including defining the benefits and populations a state will cover. Like all services authorized under state plan authority, HRSN services under 1905(a) authority must be offered statewide, must be comparable

i. The Medicaid/CHIP authorities outlined in this paper also apply to US territories, but territories have unique Medicaid financing constraints that could impact their ability to offer HRSN services.

across eligibility groups and cannot be capped.[5] Select other state plan services authorized outside of 1905(a) can be limited to a more targeted population, such as those authorized under 1915(i) (addressed below), Targeted Case Management, and Health Homes state plan amendments (SPAs).

- **1915(c) Home and Community-Based Services (HCBS) waivers**: Commonly used waiver authority that enables states to provide a wide array of targeted long-term services and supports (LTSS) within the community for individuals who otherwise would require institutional levels of care. Services and expenditures can be capped under this authority.[6]
- **1915(i) Home and Community-Based Services (HCBS) state plan authority**: A state plan option to provide LTSS within the community, rather than in institutional settings, for individuals who meet state-defined criteria based on individual needs. Unlike 1915(c) authority, 1915(i) services do not need to be limited to individuals who would otherwise require institutional levels of care, but like other state plan services, they must be offered statewide and cannot be capped.[7]
- **CHIP Health Services Initiatives (HSIs)**: A flexible CHIP state plan authority allowing states to use a portion of their CHIP allotment funds to cover services that improve the health of low-income children, subject to certain administrative requirements and expenditure caps.[8]

Clarification on Terminology: This paper uses the industry's broad definition of "HRSN services," which includes any service addressing an individual's health-related social needs. However, CMS typically defines "HRSN services" narrowly as those housing and food-related services that are included in their 2023 HRSN framework guidance. CMS has approved some HRSN services beyond those included in the 2023 framework, such as diapers and non-medical transportation. Such services, sometimes referred to by CMS as "off framework," can vary by authority and state request, as discussed in more detail throughout this paper.

The goals and considerations that undergird state efforts to address HRSN are as unique as the state environments in which they operate and may change over time. This brief aims to serve as a reference point for states as they chart their course for coverage of HRSN services, enabling them to take full advantage of the opportunities HRSN authorities provide.

State Considerations for Choosing an HRSN Authority

Services

Key Design Question

Which domains will be addressed (e.g., housing, nutrition, interpersonal violence, etc.), and what services will be covered to address HRSN within those domains?

Key considerations include:

- Services considered to constitute “room and board,” including rent, recurring utility supports, and complete nutritional regimens, can only be authorized through 1115 demonstrations.
- Other common food and housing supports can be authorized under multiple authorities.
- Additional HRSN services that have been approved by CMS include care management, transportation, employment supports, diapers for children and services addressing interpersonal violence.

A gating issue for states exploring how to address HRSN is often deciding which HRSN services to provide. Most HRSN services covered by states to date fall under one of two domains—housing/utilities and food/nutrition. Many of these services have longstanding precedent under HCBS authorities but are now allowable for broader populations (see the “Target Populations” section below). A smaller cohort of states have implemented interventions related to other HRSN domains, including transportation, interpersonal violence, climate change and employment.

Service selection varies widely based on state goals. For example, one state seeking to improve maternal and child health outcomes has focused on housing, nutrition-related services, transportation and interpersonal violence. Other states have focused on services that can support individuals transitioning out of institutional care, including transitional housing-related case management, home modifications and pantry stocking. Further, multiple states addressing the poor health outcomes and high medical costs for adults and children experiencing homelessness have sought authority for a suite of housing-related services. States can also proceed in phases, beginning with certain high-priority or readily implementable services and adding others as experience and capacity deepens.

Most Food and Housing Services Can be Approved Under Multiple Authorities

Many housing- and food-related supports, as well as services that aim to support community-based living,[ii] have well-established approval precedents, are included in CMS's 2023 HRSN framework guidance, and present straightforward opportunities for states to address their members' HRSN. Specifically, the services in the call out box are all generally approvable under 1915(i) state plan authority, 1915(c) HCBS waivers, ILOS, and 1115 demonstration authority.[9] Additionally, some of these HRSN services could potentially be covered using 1915(b)(3) authority. For a recent example of approval documents for an HRSN 1115 demonstration, see Illinois, which has approval for a variety of housing and nutrition services.[10]

Room and Board Can Only Be Approved Under 1115 Authority

One key exception to this flexibility in authority is for coverage of "room and board" costs, which can only be authorized through 1115 demonstrations. While longstanding federal rules prohibit coverage of room and board costs in Medicaid (with the exceptions of hospital and nursing facility services), CMS's 2023 HRSN framework guidance allows the use of 1115 demonstration authority to cover certain room and board costs on a short-term basis (typically up to six months[iii]), including rent, recurring utility payments, costs associated with stays in transitional housing settings such as medical respite facilities, and full nutritional regimens constituting three meals/day (i.e., "board").[11] Housing security deposits, one-time utility payments/deposits, and nutrition supports of less than three meals/day are not considered room and board and can be approved through other authorities in addition to 1115 demonstrations.

Common HRSN Services Allowed Under Multiple Medicaid Authorities

- Housing transition and navigation services, including housing-related case management
- Tenancy sustaining services
- One time move-in costs, deposits, and fees, including utility activation fees
- Caregiver respite
- Day habilitation programs
- Sobering centers <24 hours
- Home remediations
- Home accessibility and safety modifications
- Nutrition-related case management services
- Nutrition counseling and education
- Home delivered meals, if less than three meals/day
- Pantry stocking and groceries, if constituting less than three meals/day
- Nutrition prescriptions, if constituting less than three meals/day
- Linkages to HRSN-related legal supports, not to include direct coverage of legal services

ii. Under 1915(i) state plan and 1915(c) HCBS waiver authorities, states have broad flexibility to cover HRSN services that help prevent institutionalization or enable transitions from institutional settings to the community.
iii. Nutritional services that provide the equivalent of three meals per day can only be authorized for six months at a time; housing services with clinical supports (e.g., medical respite/recuperative care, short-term pre-hospitalization housing, and short-term post-hospitalization housing) can only be authorized for six months per year; and housing without clinical supports (i.e., rent) can only be authorized for six months per demonstration period. CMS has not typically applied duration limits to HRSN services beyond 1115-authorized room and board.

Examples of Other Authorized HRSN Services

While CMS's recent HRSN framework guidance focuses on housing and nutrition services, states have covered other HRSN services in Medicaid as well. Examples include:

- **Interpersonal violence case management**: North Carolina covers specialized interpersonal violence case management under 1115 authority,[12] which aims to support individuals in addressing the effects of an abusive relationship.
- **Community violence prevention**: Connecticut covers community violence prevention services (including individualized counseling, conflict mediation, crisis intervention, mentorship and education) through 1905(a) state plan authority.[13]
- **Transportation**: New York covers public and private transportation to covered HRSN services and case management activities through their 1115 demonstration.[14]
- **Employment Supports**: Alabama covers employment supports for individuals with intellectual disabilities via 1915(c) waiver authority.[15]
- **Diapers**: Tennessee recently received 1115 demonstration authority to cover diapers for children up to age 2.[16]
- **Climate-Related Devices**: Oregon's 1115 demonstration covers climate-related devices and services, such as air conditioners, heaters, and air filtration devices, when clinically appropriate.[17]

CMS's willingness to approve HRSN services not addressed by the 2023 HRSN framework guidance has varied by states' specific service and authority requests. Notably, CMS has yet to approve state requests for authority to cover childcare-related services, regardless of pathway.[18]

Finally, states can combine authorities to cover HRSN services; for example, California uses managed care ILOS to cover a wide range of housing and nutrition services,[19] while using 1115 authority to cover post-hospitalization housing and recuperative care.[iv,20]

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iv. California also has a pending 1115 request to include rent as an HRSN service under 1115 authority.

Target Populations

Key Design Question

Which populations (defined by clinical condition, social risk factor, age, eligibility group, geography, etc.) will receive HRSN services?

Key considerations include:

- Across authorities, CMS requires states to define eligibility for HRSN services by both the social needs of the population and the clinical needs the HRSN services are expected to improve.
- Clinical criteria that align with a diagnosis (e.g., a chronic disease or behavioral health condition) or a disability are the most clear-cut for CMS approval.
- States can further refine the eligible population for a particular service or an array of services; for example, by targeting services by age or eligibility group.
- Some authorities must be targeted to certain classes of individuals, such as CHIP HSIs that must target low-income children, 1915(c) waivers that are limited to individuals who meet institutional level of care criteria, or ILOS that are limited to those enrolled in managed care.

HRSN services are meant to address social needs that affect the health of Medicaid members. CMS requires states to identify both clinical and social needs criteria as they define the population(s) they will serve. For example, a state might target housing navigation services to individuals with chronic conditions (clinical need) who are homeless (social need), because these individuals are at high risk of poor health outcomes due to their homelessness. While CMS generally allows states flexibility to propose the clinically focused, needs-based criteria they will use to define the eligible population, ultimately, CMS must approve these state-defined eligibility factors.[21] To supplement clinical and social needs criteria, states may further narrow eligibility by age, Medicaid eligibility group or other population-based targeting criteria. 1115 demonstrations can authorize services for any approved population, while other authorities apply to narrower populations of focus. For example, services authorized through 1915(c) waivers are limited to individuals who meet institutional level of care criteria, CHIP HSIs are limited to low-income children and ILOS are limited to those enrolled in managed care.

Defining and Documenting Clinical Need

The clinical needs that define an HRSN intervention's target population may vary by service. For example, a state may offer individuals with asthma a home remediation service, while offering high-risk pregnant women a medically tailored meal delivery service. CMS guidance to date is relatively high-level on what constitutes an appropriate clinical risk factor for the purpose of HRSN eligibility, and federal policy on this question appears to be evolving, particularly in recent 1115 demonstration approvals and ILOS guidance. Under 1115 demonstrations, clinical criteria that align with a diagnosis (e.g., a chronic disease or behavioral

health condition) or a disability are the most clear-cut for CMS approval. Conversely, CMS has recently declined to approve clinical criteria for HRSN services that are based on undiagnosed/suspected conditions or populations who are at high risk of poor clinical outcomes (such as foster care children or individuals who are justice-involved). However, some exceptions have been made for broader population-based eligibility in 1115 demonstrations, such as the recent approval to provide diapers to all Medicaid- and CHIP-enrolled children under 2 years of age in Tennessee.[22] For ILOS, in addition to requiring clinically defined target populations, regulations require that services be determined to be medically appropriate for an individual by a provider and be documented in a member's medical record or care plan.[23] Clinical risk in the context of HCBS populations is focused on those who meet institutional levels of care (under 1915(c) waivers)[24] or other "needs-based criteria" (under 1915(i) SPAs), such as adaptive, personal/social, communication, motor or cognitive needs.[25]

Defining Social Risk for HRSN Target Populations

In addition to defining a clinical need, states need to define the social need that a service is addressing when proposing eligibility for HRSN interventions. Social needs under 1115 demonstrations or ILOS might include individuals experiencing homelessness or at risk of homelessness, food insecurity, interpersonal violence, certain life events (e.g., experiencing an extreme climate event, as was approved in Oregon,[26] or justice-involvement, as was approved in Arkansas[27]), or transitions (e.g., leaving a nursing home or other institution) whose health outcomes and health care utilization would be improved if those social needs were met. Note, in cases when a social need has an existing federal definition, CMS typically asks states to adopt the federal definition. For example, "homelessness" has been formally defined by the U.S. Department of Housing and Urban Development (HUD)[28] and "food insecurity" has been defined by the U.S. Department of Agriculture (USDA).[29] CMS often requires these definitions to be integrated into states' eligibility criteria within HRSN initiative approval documents.

Other State-Designed Eligibility Criteria

After defining the clinical and social risks to be addressed by the HRSN services, a state may layer on additional eligibility criteria to further define the target population. The ability to target HRSN services to specific target populations will vary depending on the authority used. For example, under an 1115 demonstration or ILOS authority, a state could limit a population by age (e.g., to limit asthma remediation services to children) or by certain eligibility categories (e.g., to limit home-delivered meals to current/former foster care youth, pregnant women or aged/blind/disabled members). CHIP HSI authority, notably, is limited to low-income children.[30] As noted above, state plan authority generally must be provided statewide across all eligibility groups. Further, as discussed below, targeting by delivery system and geography is also possible under certain authorities.

Scope and Reach of Coverage

Key Design Question

How broad will HRSN service coverage be in terms of delivery system (fee-for-service and/or managed care) and geography? Will the state extend the services to all those it defines as eligible, or will there be caps or other limits on availability? Is there a desire to phase in services or populations over time?

Key considerations include:

- 1115 authority can cover services across any delivery system(s) and allows states to target services by geography and to phase in/ramp up services and/or populations, if desired.
- ILOS authority is limited to managed care. Services must be optional for plans to provide and therefore cannot be mandated statewide. ILOS authority can be combined with other authorities to extend services in fee-for-service.
- 1915(c) waivers can apply to any delivery system(s) and can be geographically targeted and capped, effectively allowing for geographic or population-based phase-in of a service over time.
- 1905(a) and 1915(i) state plan authority must cover services for all eligible individuals across all delivery systems and geographies without a ramp-up period.

It is critical that a state use an HRSN authority (or multiple authorities) that aligns with the state's vision for the scope and reach of HRSN services, as the authority pathway can dictate the mandatory or optional nature of service provision, the delivery system(s) in which coverage is offered, and the geographic reach of services. Generally, 1905(a) and 1915(i) state plan authorities require the widest scope and reach for HRSN services (i.e., a service must be offered to all eligible individuals across all delivery systems, statewide), while other authorities allow more state flexibility to phase in or ramp up a service over time by population, delivery system, or geography.

Mandatory versus Optional or Limited Provision of an HRSN Service

A basic question a state must consider is whether the state is interested in making HRSN services mandatory, meaning they must be offered and provided to all eligible individuals as defined by the state. 1905(a) and 1915(i) state plan authorities generally require HRSN services be offered as mandatory Medicaid benefits for the eligible population, with no phase-in.

By contrast, under the regulations governing ILOS, states cannot require their managed care plans to cover HRSN services, as ILOS services must be optional for plans to provide. Because ILOS are optional for plans, ILOS authority does not ensure that services will be available to all eligible individuals in the state; it allows

interested plans to move forward with others potentially joining over time. States can encourage plans to take up ILOS, including by providing incentive payments to plans that decide to offer the services, as California has done.[31]

As with many other aspects of HRSN policy, 1115 demonstration approvals to date provide states with the most flexibility, allowing them to decide whether to make HRSN coverage available to all eligible individuals. Oregon has made the HRSN services authorized under its 1115 demonstration mandatory,[32] meaning all eligible individuals must be offered HRSN services, while California is allowing managed care plans to opt in or out of providing 1115-authorized recuperative care and short-term post-hospitalization housing services, to align with the state's housing-related ILOS.[33]

In all cases, like all other services in Medicaid, CMS has required HRSN services be optional for the member. There can be no requirement that an eligible individual accept an HRSN service, and states, plans, and providers may not withhold or condition other Medicaid services on whether the individual utilizes an HRSN service. Similarly, CMS has required that other member protections—such as rights to notices, grievances, appeals, and state fair hearings—are applied to all HRSN services consistent with the Medicaid rules for the delivery system in which the services are offered, regardless of the authority under which the services are approved.

Geographic Targeting and Phase-In

A state's interest in targeting HRSN services to members in specific geographic areas will also have implications for which authority pathway they pursue. Services authorized in the state plan (either through 1905(a) or 1915(i) authority) must be offered statewide (although some targeting is possible under Targeted Case Management or Health Homes SPAs), while HRSN services authorized through 1115 demonstrations or 1915(c) waivers can be targeted to specific regions. As noted above, plans may choose whether to offer ILOS, and some states have allowed plans to limit ILOS to a subset of their geographic service areas. As such, under ILOS authority geographic variation is likely and effectively allows plans to ramp up or discontinue HRSN services over time.

Targeting HRSN Services by Delivery System

A state that wants to target an HRSN service to a specific delivery system can do so under some but not all authorities. 1115 demonstrations provide states with the most flexibility to target HRSN service coverage to their delivery system(s) of choice (e.g., fee-for-service and/or managed care), while ILOS authority can only be used in managed care. Conversely, in the absence of a modifying waiver, coverage of HRSN services via 1905(a) and 1915(i) state plan authorities must apply to all eligible populations, both in fee-for-service and managed care. Once states choose a delivery system, they must abide by the rules of that delivery system.

Again, 1115 demonstrations provide states with the most flexibility to define where, how, and when services are phased in or ramped up. Under all circumstances, states may choose to phase in HRSN initiatives by starting with certain services or populations and requesting additional authority over time.

Financing

Key Design Question

How will the state fund the cost of HRSN services (e.g., through new investments or via managed care rate setting)?

Key considerations include:

- HRSN services, like other Medicaid costs, require states to fund their share of costs. There are some special considerations on financing HRSN services under 1115 authority. Under ILOS, HRSN services are financed through managed care capitation rates, like medical services.
- Under 1115 authority, state spending may be affected by maintenance of effort and payment rate threshold requirements.
- 1115 and ILOS authority both come with different, CMS-directed caps on federal HRSN spending.

Financing can be a primary factor for states in determining whether and how to cover HRSN services. State plan HRSN services are financed like any other state plan services, while ILOS and 1115 authority have specific policies and financial guardrails that states must consider.

State Financing for HRSN Services

A state's ability to fund the state share of HRSN services is a key factor in determining which HRSN authority to pursue. If a state lacks upfront funding for its share of the cost of HRSN services but has a robust managed care program, ILOS may be the best authority pathway to pursue, mindful of the constraints on ILOS discussed above. Under ILOS authority, the cost of the ILOS services provided by a plan, like medical service costs, must be accounted for in rate setting.[34] In many cases, states may not ultimately need to increase their managed care capitation rates overall to cover HRSN-related ILOS, as these services are intended to offset other medical costs for which they are a substitute. If costs for hospitalizations, for example, decline at the same time as ILOS are implemented, the net effect on rates from authorizing ILOS may not be material. This may be helpful for states with limited upfront funding to invest in HRSN service provision. However, the timing of offsetting savings may not always align with the timing of managed care expenditures, as many HRSN-related ILOS aim to reduce reliance on medical services over time, rather than immediately (e.g., investments in home remediation to reduce asthma-triggered emergency room visits).[35] Early investments in ILOS made through higher capitation rates or incentive payments (discussed below) can address the time lag and help encourage plan uptake of HRSN services.

While it is possible to embed HRSN into risk-based managed care capitation rates under 1115 authority, most 1115 demonstrations approved to-date have sought increases in state spending to support direct payment for HRSN services outside of capitation rates, while anticipating lower medical service costs and incorporation into managed care capitation rates over time. Additionally, 1115 demonstrations can offer opportunities

for reducing the state cost of new initiatives through the use of Designated State Health Program (DSHP) payments. Under this 1115 funding mechanism, CMS approves federal match for certain state-funded health programs related to but outside of Medicaid, freeing up state dollars which can then be repurposed to support new CMS-approved demonstration initiatives such as HRSN service coverage.[v,36]

Other HRSN-Related Requirements for 1115 Demonstrations That Affect State Spending

States should also note that 1115-authorized HRSN services, per current Administration policy, come with additional requirements that may impact state spending. First, CMS has required that states not substitute new 1115 funding for current state investments; states must maintain current levels of state spending (i.e., a “maintenance of effort,” or MOE) on ongoing social service programs outside of Medicaid that are related to the state’s Medicaid HRSN services (e.g., other state-financed food or housing programs). For example, states covering tenancy support services under an 1115 demonstration cannot decrease state funding for previously state-funded tenancy support services. The intent of CMS’s MOE policy is to ensure states are not replacing existing state investments with federal dollars but are instead growing the overall pool of HRSN resources. CMS has allowed states to exclude certain state investments from their MOE benchmark, including brick-and-mortar investments in housing or explicit one-time state investments.

Additionally, to ensure that states with 1115-authorized HRSN services preserve or improve access to quality care for all Medicaid members, CMS has required that states seeking HRSN-related 1115 authority demonstrate that their Medicaid payment rates for primary care, behavioral health, and obstetrical/gynecological services meet a minimum threshold defined by CMS. States that do not meet this threshold must increase those rates in line with CMS policy.[vi,37,38]

Expenditure Limits for HRSN Services

Finally, states should consider their total expected spending on HRSN services when evaluating potential authority pathways, as some authorities have expenditure limits. Under 1115 demonstrations, CMS currently caps federal HRSN-related expenditure authority at 3% of total Medicaid spending. States can spend more of their own funds on their HRSN initiatives, but federal matching payments authorized under the demonstration are limited by this cap. Additionally as noted below, CMS further caps total HRSN infrastructure spending at 15% of total HRSN-related expenditure authority. States cannot receive federal match on spending above these caps.[39]

States must also meet budget neutrality requirements for 1115 demonstrations, though this does not require budget neutrality savings offsets for most housing- and nutrition-related services. See the call out box for more detail on 1115 budget neutrality policy for HRSN services.

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v. Under current CMS DSHP policy, states must still fund at least 15% of the state share of a given demonstration initiative using state funds. For more information about how DSHP funding works, see this 2023 Commonwealth Fund blog and pages 5–7 of CMS’s 9/28/22 approval letter for the Oregon Health Plan 1115 demonstration.

vi. Under the CMS provider payment rate increase requirements, if a state’s annual HRSN-related expenditures are greater than $50 million or 0.5% of the state’s total annual Medicaid spend (whichever is less), the state is required to demonstrate that its rates for primary care, behavioral health, and OB/GYN services are equal to at least 80% of Medicare-comparable rates in FFS and managed care, or commit to increasing the rates in the lowest category by at least 2 percentage points and sustaining that increase over the course of the demonstration.

1115 Demonstration Budget Neutrality Policy for HRSN Services[40,41,42]

1115 demonstrations must be budget neutral to the federal government, meaning spending under the demonstration cannot exceed the projected spending without the demonstration. New spending in a demonstration must generally be offset by savings produced by the new demonstration or by accrued savings from prior demonstrations, so that demonstration spending in total does not exceed the expected amount without the demonstration.

Housing and nutrition services included in CMS's 2023 HRSN framework guidance, however, do not require offsetting savings to be considered budget neutral because CMS has determined that the services could otherwise be covered under Medicaid for other populations, and/or because evidence indicates that the services improve quality and effectiveness of other Medicaid services, improve member outcomes, and reduce costs. Budget neutrality policy for other HRSN services varies by specific service; some services may require a state to have and use offsetting budget neutrality savings, as is the case in New York for housing-related brokerage fees and cooking supplies,[43] while others may not require offsetting savings if the services could otherwise be covered under Medicaid for other populations.

Under ILOS authority, CMS will not approve ILOS with total costs (including all HRSN- and non-HRSN-related ILOS) that are expected to exceed 5% of total capitation payments to the applicable managed care plans, not accounting for any offsets in expenditures for state plan services that the ILOS might generate.[44] For comprehensive managed care programs, this can be a relatively permissive cap, but for very targeted managed care programs (e.g., managed care plans that offer only limited benefits, such as behavioral health), this can be constraining, especially if those plans are already offering other, non-HRSN-related ILOS. Conversely, state plan and HCBS authorities do not have federally imposed expenditure limits for HRSN services, though 1915(c) waiver services must be cost-neutral on a per capita basis when compared to institutional spending. Under the 1915(b)(3) option, costs for an HRSN service are limited to the amount of savings created by implementing the managed care services authorized under the 1915(b) waiver (for example, by moving services into managed care, creating utilization savings relative to the cost of implementing the same services under fee-for-service). In states with mature managed care delivery systems, where the state is no longer implementing new managed care services and is not creating savings relative to fee-for-service, such savings may be more difficult to identify.

Infrastructure and Capacity Building

Key Design Question

Will the state seek to invest in infrastructure and capacity building to support HRSN initiative implementation?

Key considerations include:

- 1115 authority is the most direct pathway to fund infrastructure and capacity building for HRSN service delivery, allowing for investments in community-based organizations that provide HRSN services, in training and technical assistance to plans and providers, and in system development (e.g., data exchange platforms).
- More limited options to support HRSN-related capacity building outside of 1115 authority include certain managed care strategies and regular Medicaid administrative matching.

When developing an HRSN proposal, states should consider whether they want to invest in infrastructure and capacity building for HRSN-related providers, care managers, and data systems, in addition to paying for HRSN services themselves. States can receive federal match for many types of infrastructure investments through regular Medicaid administrative match, including ongoing training and education programs for providers, investments in screening tools and other technology, and quality oversight activities. Technology investments may also be supported through Advanced Planning Document (APD) processes, often at an enhanced federal matching rate. However, some types of more intensive, upfront infrastructure investments that may be needed for HRSN initiatives would not qualify for regular administrative or systems funding. For example, states may want to offer additional supports to community-based organizations (CBOs) that provide HRSN services, such as investments to help CBOs prepare their workflows, augment and train their workforce, or purchase service-related equipment and technology.

Capacity Building Under 1115 Demonstrations

States seeking to invest in HRSN infrastructure and capacity building beyond what is available through administrative match will want to consider 1115 authority, which is the most straightforward mechanism for those types of investments. Capacity building investments can be extremely helpful to support CBOs providing the HRSN services, who are often smaller, nonprofit providers with no previous experience with Medicaid or Medicaid billing structure, and who may lack systems capacity to share data with health plans or the state. Under 1115 authority, CMS has recently approved four categories of allowable infrastructure investments for HRSN providers and other implementing partners—development of business operations, workforce training, technology investments, and stakeholder engagement and member education activities. Capacity building under 1115 demonstrations is limited to 15% of the total approved HRSN expenditures.[45]

Alternative Authorities for Capacity Building

States seeking to support HRSN infrastructure without pursuing 1115 authority have alternative, if less direct, options to do so. States can incorporate requirements into their managed care contracts to incentivize or mandate managed care plan investments in HRSN-related capacity building, including through managed care plan quality incentives[vii] and community reinvestment programs.[viii] In the context of fee-for-service programs, 1915(c) waiver authority can include investments in provider workforce, including recruitment and retention activities for providers of 1915(c) services.[46]

Timing and Implementation

Key Design Question

What is the desired launch date for HRSN services?

Key considerations include:

- 1115 authority can require years of lead time prior to implementation, accounting for application development, submission processes, and federal negotiations.
- State plan and HCBS authorities are quicker for states to submit and often for CMS to approve.
- ILOS timelines are contingent on CMS's standard review of state managed care contracts.

Depending on a state's policy and financial goals, as well as any underlying political considerations, timing may be a critical factor in determining an appropriate pathway for HRSN authority. States may choose to start with one HRSN authority and then add or transition to other authorities over time.

1115 Demonstration Approval Timeframe

1115 authority, while the most flexible in many ways, has the longest submission process and approval timelines. 1115 demonstrations typically require 18–24 months from application development to CMS approval, which includes two public comment periods of at least 30 days each. Even after CMS approval of a demonstration, states may be required to develop and submit additional documentation or protocols for

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vii. States can incorporate incentive payments into their managed care contracts with health plans, equal to up to a 5% increase in capitation payments, per 42 CFR 438.6(b)(2). These incentive payments must be tied to the state's quality strategy, as defined by 42 CFR 438.340. States can tie these payments to quality goals aligned with HRSN-related infrastructure and capacity building.

viii. Through their managed care contracts, states can implement community reinvestment programs that require managed care plans to invest a portion of their Medicaid-based revenue back into their members' communities. States have discretion to define the types of investments that plans are required to make, which can include infrastructure and capacity building for HRSN service providers. For more information on community reinvestment programs, see Manatt's 2024 Community Reinvestments newsletter.

approval by CMS before implementing their HRSN initiatives.[ix] Given these requirements, implementing HRSN services through 1115 authority can take years, which may not align with states' policy goals, budget allocations or legislative mandates. CMS is currently evaluating potential strategies, including 1115 template approvals, for states that agree to align closely with demonstration terms that have already been approved in other states, which may help expedite this process for some states.

State Plan and HCBS Waiver Authority Approval Timeframe

State plan and HCBS authorities have shorter approval timeframes than 1115 demonstrations and may be better options for Medicaid agencies seeking to cover HRSN services quickly. CMS is subject to a 90-day approval deadline for SPAs and 1915(c) waiver applications, resulting in expedited negotiations. Notably, the 90-day deadline does not include any days during which CMS is waiting for additional information from the state, so states interested in rapidly advancing their applications should be prepared to provide prompt responses to CMS questions. The negotiation processes for 1905(a) SPAs and 1915(c) waivers also tend to be more streamlined compared to the process for 1915(i) SPAs, which often entails multiple rounds of questions and answers between CMS and states.

ILOS Authority Approval Timeframe

Unlike with other HRSN authorities, ILOS has no separate application process. ILOS services must be specified by the state in their managed care contracts and submitted to CMS prior to implementation as part of CMS's standard review of managed care contracts and rate certifications.[47] Aligning proposed HRSN policies with ILOS that have been approved in other states (e.g., California) could help facilitate a faster approval process.

Post-Approval Requirements for HRSN Services

State engagement with CMS does not end with HRSN service approval. Many authorities require states to provide CMS with ongoing monitoring or implementation planning reports and/or to conduct independent evaluations to determine whether the HRSN services are fulfilling their intended goals. These requirements vary by authority. For example, for ILOS, evaluations are required after five years of implementation for states with overall ILOS spending exceeding 1.5% of managed care capitation payments (and encouraged for all states implementing ILOS),[48] while 1115 demonstrations typically require annual monitoring reports and independent evaluations once per demonstration approval period (e.g., every five years).[49] CMS has also required in recent 1115 demonstration approvals that states submit implementation plans for their HRSN programs, which must include, among other elements, a description of efforts to coordinate HRSN services with other federal programs such as SNAP, WIC, and HUD housing assistance.[x] States should keep these ongoing administrative requirements in mind when planning for HRSN program implementation.

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ix. For most 1115 documentation requirements, states can begin implementing their HRSN programs prior to CMS approval of these protocols, and retrospectively claim federal match for HRSN program costs after documentation has been approved. However, any infrastructure or service costs that are not included in final CMS-approved documents cannot receive federal match, leaving states at financial risk for these costs if not approved.

x. SNAP: Supplemental Nutrition Assistance Program, operated by USDA.
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children, also operated by USDA.
HUD: US Department of Housing and Urban Development.

Conclusion

States are increasingly looking to integrate HRSN initiatives into their Medicaid programs and they now have many options to receive federal matching funds for initiatives designed to meet their unique priorities and circumstances. Authorities can be staged, combined, and/or amended over time. Although selecting the right authority or authorities requires nuance, and no single authority may meet every state goal, careful consideration of the various authority options can help states address their highest priorities (and constraints) in operating an HRSN program, whether that be funding, timing, or coverage of specific services or populations. CMS policy on HRSN continues to evolve as more states submit and negotiate authority requests. While this paper captures the current state of regulations, guidance, and approvals, states will need to be attentive to CMS policy changes on HRSN going forward and seek out clarification and flexibility from CMS when they are looking to explore new innovations for improving the health of people enrolled in Medicaid.

Appendix

Summary of Key HRSN Design Questions and Medicaid Authority Considerations

Key Question	Key Considerations
Which domains will be addressed (e.g., housing, nutrition, interpersonal violence, etc.), and what services will be covered to address HRSN within those domains?	• Services considered to constitute "room and board," including rent, recurring utility supports, and complete nutritional regimens, can only be authorized through 1115 demonstrations. • Other common food and housing supports can be authorized under multiple authorities. • Additional HRSN services that have been approved by CMS include care management, transportation, employment supports, diapers for children and services addressing interpersonal violence.
Which populations (defined by clinical condition, social risk factor, age, eligibility group, geography, etc.) will receive HRSN services?	• Across authorities, CMS requires states to define eligibility for HRSN services by both the social needs of the population and the clinical needs the HRSN services are expected to improve. • Clinical criteria that align with a diagnosis (e.g., a chronic disease or behavioral health condition) or a disability are the most clear-cut for CMS approval. • States can further refine the eligible population for a particular service or an array of services; for example, by targeting services by age or eligibility group. • Some authorities must be targeted to certain classes of individuals, such as CHIP HSIs, which must target low-income children; 1915(c) waivers, which are limited to individuals who meet institutional level of care criteria; or ILOS, which are limited to those enrolled in managed care.

Key Question	Key Considerations
How broad will HRSN service coverage be in terms of delivery system (fee-for-service and/or managed care) and geography? Will the state extend the services to all those it defines as eligible, or will there be caps or other limits on availability? Is there a desire to phase in services or populations over time?	• 1115 authority can cover services across any delivery system(s) and allows states to target services by geography and to phase in/ramp up services and/or populations, if desired. • ILOS authority is limited to managed care. Services must be optional for plans to provide and therefore cannot be mandated statewide. ILOS authority can be combined with other authorities to extend services in fee-for-service. • 1915(c) waivers can apply to any delivery system(s) and can be geographically targeted and capped, effectively allowing for geographic or population-based phase-in of a service over time. • 1905(a) and 1915(i) state plan authority must cover services for all eligible individuals across all delivery systems and geographies without a ramp-up period.
How will the state fund the cost of HRSN services (e.g., through new investments or via managed care rate setting)?	• HRSN services, like other Medicaid costs, require states to fund their share of costs. There are some special considerations on financing HRSN services under 1115 authority. Under ILOS, HRSN services are financed through managed care capitation rates, like medical services. • Under 1115 authority, state spending may be affected by maintenance of effort and payment rate threshold requirements. • 1115 and ILOS authority both come with different, CMS-directed caps on federal HRSN spending.
Will the state seek to invest in infrastructure and capacity building to support HRSN initiative implementation?	• 1115 authority is the most direct pathway to fund infrastructure and capacity building for HRSN service delivery, allowing for investments in community-based organizations that provide HRSN services, in training and technical assistance to plans and providers, and in system development (e.g., data exchange platforms). • More limited options to support HRSN-related capacity building outside of 1115 authority include certain managed care strategies and regular Medicaid administrative matching.
What is the desired launch date for HRSN services?	• 1115 authority can require years of lead time prior to implementation, accounting for application development, submission processes, and federal negotiations. • State plan and HCBS authorities are quicker for states to submit and often for CMS to approve. • ILOS timelines are contingent on CMS's standard review of state managed care contracts.

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