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The expanding use of in-lieu-of services and implications of CMS guidance

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On January 4, 2023, the Centers for Medicare and Medicaid Services (CMS) released guidance on the use of in-lieu-of services (ILOS) in Medicaid managed care service delivery systems.[1]

This sub-regulatory guidance issued in State Medicaid Director letter 23-001 provides additional clarification originally promulgated in the 2016 managed care rule that provided authority for ILOS. This guidance comes as states have sought to use the ILOS authority in innovative ways to address beneficiaries' health-related social needs (HRSNs). This paper:

- Provides a background on the ILOS authority
- Details the implications and potential approval requirements of ILOS
- Provides and discusses recent examples of ILOS
- Discusses considerations for states as they develop strategies to address HRSNs

Background on In-Lieu-of Services

2016 MANAGED CARE RULES

In-lieu-of services refers to services or settings that can be offered at the option of the managed care plan as a substitute for a state plan-covered service or setting. This authority to make the state plan benefit package more flexible was originally authorized as part of the 2016 Medicaid managed care final rule and codified under 42 CFR 438.3(e)(2), describing services that may be covered by a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP). The rule provides four basic criteria for ILOS.

1. The state determines that the alternative service or setting is a medically appropriate and cost-effective substitute for the covered service or setting under the state plan.
2. The enrollee is not required by the managed care plan to use the alternative service or setting.
3. The approved ILOS are authorized and identified in the managed care contract, and will be offered to enrollees at the option of the managed care plan.
4. The utilization and actual cost of ILOS is used in developing the component of the managed care capitation rates that represents the covered state plan services, unless a statute or regulation explicitly requires otherwise. This last exception primarily addresses institutions for mental disease (IMD). If the setting is an IMD, then the actuary must use the unit cost for the state plan inpatient psychiatric services.

ILOS are "triple-optional": The state does not have to approve them, the managed care plan is not required to offer them, and the member is not required to accept them as a substitute for state plan services.

Institutions for Mental Disease as an ILOS is the most common implementation of ILOS authority but the additional guidance issued by CMS is not applicable to IMD so we will not address it in this paper.[2]

It is helpful at this point to differentiate between ILOS and other enhanced services managed care plans offer to their members. Certain kinds of enhanced benefits may be included in the managed care plan's medical loss ratio (MLR) calculation and capitation rate development process, while others may not, as detailed in the table in Figure 1.

[1] CMS (January 4, 2023). SMD 23-001: Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care. Retrieved March 15, 2023, from https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf.

[2] For further background on IMD as an ILOS, please see https://us.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2016/2242hdp_20160526.ashx.

FIGURE 1: ENHANCED BENEFIT TABLE

ENHANCED BENEFIT	ILOS	VALUE-ADDED SERVICES	MARKETING/OTHER
Description	A medically appropriate and cost-effective substitute for a Medicaid state plan service.	Clinical services or settings that are reimbursed through a direct claims process that MCOs voluntarily agree to cover but that are not covered under the state plan or waiver or are in excess of the amount, duration, or scope of those listed in the contract.	Expenditures and/or activities that are not reimbursed through direct claims, do not meet the definition of Health Care Quality Indicator (HCQI) activities, or are intended to achieve a marketing objective.
Authorization	42 CFR 438.3(e)(2)	42 CFR 438.3(e)(1)(i)	▪ 42 CFR 438.104 Marketing Activities ▪ 45 CFR 158.150(c) Activities that improve health care quality
Capitation rate development treatment	Utilization and actual cost of the ILOS are included in the development of capitation rates.	Utilization and cost are excluded from the capitation rate development process.	Utilization and cost are excluded from the capitation rate development process.
MLR treatment	Calculated in the numerator of the MLR.	Calculated in the numerator of the MLR if they are a medical claim or as an activity that improves healthcare quality under 45 CFR 158.150(b).	Activities that fail to meet the federal definition of claims or HCQI cannot be included in the numerator of the MLR and should be reported as non-claims costs. Managed care plans cannot include the administrative costs of member incentive programs in healthcare quality improvement costs.
Examples	Home visits and parenting classes for pregnant mothers as a substitute for prenatal visits.	▪ Adult vision/eyeglasses ▪ Additional nonemergency transportation ▪ Sports physicals ▪ Shower grab bar	▪ Backpack and school supplies ▪ Boys & Girls Club membership ▪ GED test voucher

New guidance: 2023 State Medicaid Director letter

In January 2023, CMS released a State Medicaid Director letter (SMDL 23-001) outlining new requirements for states that elect to use ILOS. As discussed above, CMS previously finalized guidance on ILOS in the 2016 Medicaid and Children's Health Insurance Program (CHIP) managed care final rule. The 2023 SMDL does not supersede any of this existing guidance. The four basic requirements listed above for the use of ILOS still apply.

CONTEXT

The SMDL characterizes ILOS as an opportunity for states to reduce health disparities and address unmet HRSNs. The letter states that through the use of ILOS states may be able to (1) offset future costs, and (2) improve quality, health outcomes, and enrollee experience. Despite the letter's health equity focus, the new guardrails it enacts do not relate solely to HRSNs. The new requirements apply to all ILOS, regardless of whether they are targeted at an HRSN.

NEW RATE-SETTING REQUIREMENT: ILOS COST PERCENTAGE

States will be required to calculate the cost of ILOS included in the managed care capitation rates relative to the overall capitation rates, defined as the "ILOS Cost Percentage." SMDL 23-001 defines the ILOS Cost Percentage as "a calculation of the portion of the total capitation payments attributable to all ILOS(s), excluding short term stays in an IMD,[3] for the specific managed care program (numerator) divided by the total costs for the specific managed care program (denominator), which must include all capitation payments, including all state directed payments in accordance with 42 CFR § 438.6(c) and pass-through payments in accordance with 42 CFR § 438.6(d)."

The ILOS Cost Percentage may not exceed 5% for each individual managed care program. Based on this guidance, it appears that the ILOS Cost Percentage may exceed 5% for a given rate cell, but must be less than or equal to 5% in aggregate for the managed care program included in the rate certification.

All states must submit a projected and final (after the contract period) aggregate ILOS Cost Percentage annually to CMS. These calculations may differ for a number of reasons, including different rate cell mixes from those projected with different lLOS Cost Percentages. Further, along with each final aggregate ILOS Cost Percentage, states must report actual managed care plan ILOS costs during the contract period. Finally, the actuarial rate certification for each managed care program must document the ILOS Cost Percentage for each individual ILOS that has a "material impact on the rates." It is noteworthy that "materiality" is not defined in the guidance. For ILOS that are projected to have a nonmaterial impact, the certifying actuary may group these ILOS together for purposes of calculating the ILOS Cost Percentage. The state's actuary must develop and certify both the projected and final ILOS Cost Percentage as well as actual managed care plan ILOS costs.

To the extent the projected ILOS Cost Percentage is greater than 1.5% for a managed care program, states are required to submit documentation demonstrating that the ILOS are projected to be cost-effective, including key factors and data used to conclude that the ILOS were cost-effective. Additionally, while all states are encouraged to complete a retrospective evaluation of the ILOS regarding its impact on the Medicaid program, states are required to complete a retrospective evaluation when the ILOS Cost Percentage is greater than 1.5% for a managed care program.

CONSIDERATIONS IN PROJECTING THE ILOS COST PERCENTAGE

Actuarial Standard of Practice (ASOP) 49 states that actuaries developing Medicaid managed care capitation rates should reflect covered services under the managed care contract between the state and MCOs, which may include cost-effective ILOS.[4] However, given the optional nature of ILOS for both the MCO and beneficiaries, there may be greater uncertainty with the utilization of ILOS, particularly for services that are preventive in nature or for a provider network that is in an immature state. It may also be possible that significant disparities exist in provider network maturity across different areas of a state (e.g., urban vs. rural areas). The state's actuary, working with state personnel and other key stakeholders, should evaluate the provider network's capacity to extend specific ILOS to the targeted populations for which the ILOS is both cost-effective and medically appropriate.

The state and its actuary should also have a clearly defined plan to collect and monitor the utilization and cost of ILOS and their associated impacts on state plan services. While the initial development of the ILOS Cost Percentage will need to be developed based on observed experience in other managed care programs, third-party research, target population criteria, maturity of the provider network, and actuarial judgment.

CONTRACT REQUIREMENTS

In addition to the new rate-setting requirements, the SMDL also requires the state to include details about the ILOS that will be offered in the managed care contract. Prior to this requirement, state approaches to including ILOS in their contracts were not standardized and could contain varying amounts of detail. According to the SMDL, managed care contracts must now contain at least:

1. The name and definition of each ILOS and the covered Medicaid state plan services or settings for which they substitute, as well as the coding to be used on claims and encounter data.
2. The clinically oriented definitions for the target populations for which the state has determined each ILOS to be a medically appropriate and cost-effective substitute.
3. A contractual requirement for the managed care plans to utilize a consistent process to ensure that a provider using their professional judgment determines and documents that the ILOS is medically appropriate for the specific enrollee.

[3] The costs of short-term IMD stays that are ILOS are not included in the ILOS Cost Percentage as these costs must reflect the unit cost of providers delivering equivalent state plan services.

[4] Actuarial Standards Board (March 2015). ASOP 49: Medicaid Managed Care Capitation Rate Development and Certification. Retrieved March 15, 2023, from https://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

States will submit this information to CMS as part of the managed care contract approval process. Much of the new required contract elements, such as the requirement to include the applicable procedure codes or other identifying logic that should be used for ILOS claims, are not commonly included in most states' managed care contracts. As such states should consider building time into their managed care contracting processes to refine their ILOS definitions, coding, and eligible populations.

ILOS: Service considerations

Notably, the SMDL does not provide many detailed parameters for the ILOS themselves. However, the letter frames the guidance in a strategic context, in recognition of ILOS as one strategy to improve access to care to address HRSNs,[5] and in alignment with prior guidance from CMS on opportunities to address social determinants of health (SDOH).[6] While the SMDL provides additional structure for reporting and monitoring ILOS and provides some broad regulatory parameters, the guidance allows states to innovate in this space and to consider approaches that can make broader arrays of ILOS available in more consistent ways across contracted managed care entities.

The strategic framing of ILOS as a tool to address HRSNs leads CMS to offer states the ability to cover ILOS, not only as pure substitutes for state plan services, but also as preventive services, or those that "can be expected to reduce or obviate the future need to utilize state plan-covered services or settings."[7] This explicit clarification gives states more flexibility to test interventions directed at addressing HRSNs that are expected to reduce healthcare utilization in the future through ILOS.

That said, states will have to remain compliant with federal rules. In particular, ILOS are subject to prohibitions on payment for room and board,[8] meaning that ILOS can be used to pay for housing transitions, security deposits, and housing support services, but not for an individual's rent. Additionally, ILOS must be approvable under a state plan amendment or a 1915(c) waiver.[9] Many states have used 1915(i) and (c) home- and community-based services authorities to cover services related to HRSNs as a strategy to prevent future institutional-level care,[10] which may serve as useful references for states exploring ILOS strategies to address HRSNs.

These broad parameters give states and their contracted managed care entities the ability to test novel approaches in addressing HRSNs. Along with that flexibility, the SMDL places an emphasis on documentation, monitoring, and evaluation. CMS expects states to have clear documentation to demonstrate cost-effectiveness and medical appropriateness, though states have the ability to pull from a range of resources, such as peer-reviewed research, program evaluations, and clinical engagement. The requirements for this documentation are more prescriptive if the ILOS Cost Percentage exceeds 1.5%. Similarly, states are encouraged to conduct a retrospective evaluation of ILOS, and required to do so if the ILOS Cost Percentage is higher than 1.5%.[11]

California's approach to implementing ILOS to address HRSNs is a useful example of how ILOS can be used in this more expansive context. In many ways, the SMDL codifies for all states the expectations that were previously set by precedent in CMS' approval of California's 1915(b) managed care waiver in 2021. Below, we present a case study of California's approach.

[5] CMS, SMD 23-001, op cit.

[6] CMS (January 7, 2021). SHO 21-001: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH). Retrieved March 15, 2023, from https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

[7] CMS, SMD 23-001, op cit.

[8] Ibid.

[9] Ibid.

[10] MACPAC (May 2022). Financing Strategies to Address the Social Determinants of Health in Medicaid. Issue Brief. Retrieved March 15, 2023, from https://www.macpac.gov/wp-content/uploads/2022/05/SDOH-Issue-Brief_May-2022.pdf.

[11] CMS, SMD 23-001, op cit.

Case study: California's implementation of ILOS

California's recently approved 1915(b) managed care waiver and accompanying ILOS form a useful case study that illustrates the innovative use of ILOS that are preventive in nature and provides a glimpse into more detail regarding the approval hurdles with CMS.

TRANSFORMING MEDICAID: CALIFORNIA'S APPROACH

On December 29, 2021, CMS approved California's renewal of its 1915(b) waiver California Advancing and Innovating Medi-Cal (CalAIM).[12] CalAIM transitioned California's Medi-Cal managed care program from an 1115 demonstration authority to a 1915(b) managed care waiver. In the approval of CalAIM, CMS took the unusual step of requiring special terms and conditions (STCs), a process typically not used for 1915(b) waivers. The services were implemented by California to help alleviate complex members' health-related social needs in the community. Fourteen services were submitted by the state, and twelve were approved as ILOS. The approved services include:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facility
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptions (home modifications)
- Asthma Remediation
- Medically Tailored Meals
- Sobering Centers

In its approval letter, CMS found that two services violated the long-standing room and board prohibition. These two services, Short-Term Post-Hospitalization Housing and Medical Respite were approved in a companion 1115 demonstration project under CalAIM.

ILOS as preventive measures vs. real-time substitutes

Traditionally, ILOS have been used as a real-time substitute for a state plan service. This has been common with intermediate levels of care for behavioral health services. For example, in some states, if a person has a behavioral health need that warrants an inpatient psychiatric stay, the managed care plan could offer partial hospitalization as an ILOS. The partial hospitalization could very well be a cost-effective real-time substitute for the inpatient stay.

What we see with CalAIM is an innovative interpretation of the ILOS authority where the ILOS is more preventive in nature and not a real-time substitute. Asthma Remediation offers a good example of a CalAIM ILOS that is more preventive in nature. This service includes physical modifications to the home environment to mitigate asthma triggers. In the Medi-Cal Community Supports or In Lieu of Services (ILOS) Policy Guide, the potential state plan service or setting substitutes listed for Asthma Remediation are emergency department services, home health aide, home health agency, inpatient stay, outpatient hospital services, and personal care services. The intent of the Asthma Remediation ILOS is to prevent acute events requiring the state plan services utilized to treat an asthma event. SMDL 23-001 further clarifies ILOS "as immediate or longer-term substitutes for state plan-covered services or settings." Additionally, the guidance states that "*ILOS can be utilized by states and their managed care plans to strengthen access to care by expanding settings options and address certain Medicaid enrollees' HRSNs in order to reduce the need for future costly state plan covered services.*"

[12] CMS. California Advancing and Innovating Medi-Cal (CalAIM) Waiver: Special Terms and Conditions. Waiver Control # CA 17.R10: January 1, 2022, through December 31, 2026. Retrieved March 15, 2023, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf.

Cost-effectiveness

In the CalAIM approval as well as the recent SMDL, cost-effectiveness was not defined in a prescriptive or formulaic manner that would be similar to a 1915(b) waiver or other programmatic analysis. What we can see from CalAIM and the SMDL is that CMS is approaching and managing cost-effectiveness from two perspectives.

For "real-time" substitutes this can be a simple exercise that factors in unit cost differences from the state plan service and anticipated utilization to determine cost-effectiveness. For a preventive service, there can be more uncertainty regarding the outcome and timing. California's approach to evaluating the cost-effectiveness of ILOS included the development of a thorough evidence library based on stakeholder engagement, previous experience with the services, and a literature review.[13] The CalAIM evidence library summary cites three evidence-based studies detailing emergency department and inpatient savings for three different populations that receive home modifications for asthma remediation.

Typically, STCs are attached to section 1115 demonstration projects but not 1915(b) waivers. In the CMS approval of the 1915(b), there are 28 STCs. STCs 17 to 21 are specifically related to ILOS. A review of the STCs is useful in understanding how CMS will review future ILOS submitted for approval. It is worth mentioning at this point that ILOS are not required to be approved as part of the waiver submission process, as demonstrated by ILOS implementation in states such as New York and Florida, which added the services to managed care delivery systems through the plan contract and accompanying rate certification.[14,15]

More than half of the STCs specific to ILOS addressed monitoring and evaluation requirements, highlighting the importance of retrospective review. In particular, STCs 19 and 20 are very similar to the guidance in the SMDL. STC 21 requires a thorough independent evaluation of the ILOS, which was ultimately not included in the guidance letter.

OTHER SPECIAL TERMS AND CONDITIONS

As part of the CalAIM STCs, managed care plans are not allowed to extend any ILOS to individuals beyond those for whom the state has determined the ILOS will be cost-effective. Additionally, cost-effectiveness is not simply measured by substituting an ILOS for a state plan service but also by assessing the downstream impact of ILOS on the utilization of state plan services.

The STCs require California to provide documentation to ensure appropriate clinical support for the medical appropriateness and cost-effectiveness of an ILOS, including:

- Well defined, clinically oriented definitions for the targeted populations for which the ILOS has been determined to be a medically appropriate and cost-effective substitute.
- Definitions within the plan contract must outline the population(s) that each ILOS is clearly linked to improve overall health outcomes, reduce cost, and reduce or prevent utilization of other state plan services (e.g., acute care).
- A documented process to authorize an ILOS for beneficiaries for whom there is an assessed risk of incurring other Medicaid state plan services, such as inpatient hospitalizations, a skilled nursing facility stay, or emergency department visits.
- A provider must document that, in their professional judgment, the ILOS is likely to reduce or prevent the need for acute care or other Medicaid services.
- Any data determined by the state or CMS to monitor and oversee the ILOS as a medically appropriate substitute.
  - Specifically, timely and accurate encounter data must be submitted to CMS related to ILOS.
  - Documentation must also be submitted for CMS to evaluate whether the ILOS is a cost-effective, reasonable, and appropriate component of the overall Medicaid program costs, and to understand how the ILOS were incorporated into the actuarially sound capitation rates consistent with statutory and regulatory requirements.
  - The state must submit an annual report on ILOS that includes utilization data for ILOS and any other data related to the cost-effectiveness of ILOS.

[13] California Department of Health Care Services. CalAIM In Lieu of Services: Cost-Effectiveness and Medical Appropriateness of ILOS. Retrieved March 15, 2023, from https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf.

[14] New York State Department of Health. New York State Medicaid Managed Care Alternative Services and Settings – In Lieu of Services (ILS). Retrieved March 15, 2023, from https://www.health.ny.gov/health_care/managed_care/app_in_lieu_of_svs_mmc.htm.

[15] Florida DOH (January 4, 2022). Statewide Medicaid Managed Care (SMMC) In Lieu of Services (ILOS). Retrieved March 15, 2023, from https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/ILOS_Chart.pdf.

Returning to the previously discussed Asthma Remediation ILOS, California intends to meet the above cost-effectiveness requirements for this ILOS by the following criteria, processes, and payment criteria:[16]

- Evidence-based savings: The cost-effectiveness of Asthma Remediation is well documented, with the Centers for Disease Control and Prevention (CDC) stating, "Home-based multi-trigger, multi-component, interventions with an environmental focus with mild and moderate environmental remediation are a good value for the money invested."
- Targeted population: Eligible populations for Asthma Remediation include individuals with poorly controlled asthma as determined by different criteria, including an emergency department visit or hospitalization or too sick or urgent care visits in the past 12 months or a score of 19 or lower on the asthma control test.
- Professional authorization: A licensed healthcare provider must have documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.
- Ensuring cost-effectiveness:
  - If another state plan service is available and would accomplish the same goals of
  - preventing asthma emergencies or hospitalizations that service should be used.
  - Remediations must follow applicable state and local building codes.
  - Payments for Asthma Remediation have a lifetime maximum per beneficiary of $7,500.

Ultimately, the cost-effectiveness of the Asthma Remediation—which may include environmental remediation in homes such as mattress and pillow dust covers, high-efficiency particulate air (HEPA)-filtered vacuums, dehumidifiers, or air cleaners, minor mold removal and remediation services, ventilation improvements, or pest management[17]—must be assessed by evaluating the change in state plan service utilization for acute asthma-related events relative to the cost of the ILOS provided.

Using ILOS to pilot new services addressing HRSNs

The January 2023 SMDL guidance strengthens the documentation, monitoring, and evaluation requirements governing ILOS and highlights an opportunity for states to consider ILOS within the context of their overall strategies to address the HRSNs of Medicaid beneficiaries. States can review the continuum of services currently authorized, identify the extent to which gaps exist to meet beneficiary needs, and evaluate which regulatory pathways may be the most appropriate when developing new benefits to address HRSNs. The new ILOS reporting requirements support this opportunity for states to "test" new services before providing them more broadly and (potentially permanently) through the state plan or waiver pathway. Understanding utilization patterns, cost-effectiveness, medical appropriateness, and how ILOS act as substitutes for other services are critical components of evaluating a new benefit. Furthermore, these evaluation components can serve as important inputs into the subsequent development of the service definition, clinical coverage policies, and rate setting if the state decides to add an ILOS to its Medicaid benefit package. Recognizing that each federal authority through which states can offer services—the state plan and section 1915(b), section 1915(c), or section 1115 demonstration waivers—has different federal budget requirements, any advance data estimating financial costs is extremely valuable when evaluating options for implementation and securing the necessary budgetary authority at the state level. States can also require managed care plans to monitor the quality outcomes of members who use ILOS and study the extent to which ILOS advance their quality improvement initiatives.

Additionally, many services addressing HRSNs are delivered by community-based providers or nontraditional vendors who may not have experience with Medicaid reimbursement methodologies, either through fee-for-service (FFS) or managed care delivery systems. New Medicaid provider types will need time to build capacity and familiarity with a different reimbursement paradigm before expanding the availability of services. Piloting services addressing HRSNs as ILOS permits providers and managed care plans the opportunity to explore innovative solutions on a smaller scale before they are dictated into rules and regulations across all populations. States can leverage lessons learned from the development of home and community-based services (HCBS) and consider providing resources and training support on enrollment, certification, and credentialing requirements, as well as reviewing other operational processes to reduce administrative burden as part of a thoughtful implementation approach.

[16] California Department of Health Care Services (July 20, 2022). CalAIM Community Supports Spotlight: Asthma Remediation and Environmental Accessibility Adaptations. Retrieved March 15, 2023, from https://www.dhcs.ca.gov/Documents/MCQMD/20220721-CS-Asthma-and-Home-Mods-Transcript.pdf.

[17] Ibid.

Encouraging managed care plans to offer ILOS

As noted above, states cannot require managed care plans to offer ILOS, either generally or certain ILOS specifically. However, there are ways states can encourage managed care plans to offer ILOS.

PROCUREMENT STRATEGY

States can incentivize managed care plans to offer ILOS by evaluating benefit proposals through the competitive procurement for the managed care contract. Under this approach, states request respondents to identify the ILOS they propose to offer and award evaluation points to those respondents that submit ILOS in alignment with the state's criteria. Florida's Department of Health (DOH) required respondents to complete an attachment selecting the benefits they would offer from a pre-populated list of state-suggested ILOS in the 2018 procurement for their specialty managed care programs for medically complex children. DOH awarded points for each ILOS a respondent proposed as part of the procurement's overall evaluation criteria and scoring.[18] States can also request respondents to propose innovative ILOS outside of a state-curated list and award points similar to how many states evaluate the enhanced benefits proposed by bidders during procurements.

PUBLISH LISTS OF ILOS AS COMPETITIVE DIFFERENTIATORS

Another tactic is for states to include ILOS alongside other value-added services and enhanced benefits in state-published plan comparison materials and member plan-selection guides. Managed care plans may be encouraged to offer ILOS as a competitive differentiator, especially when presented in member-facing materials.

DEVELOP STATE IDENTIFIED PICK-LISTS

Several states[19] have developed curated lists of ILOS from which managed care plans can select individual services to offer, as in the Florida DOH example. Rather than leave the proposal of ILOS open-ended on the part of managed care plans, under this approach states can identify the ILOS they prefer plans to offer, particularly the services that support members' HRSNs in alignment with the state's broader strategic and financial objectives. States would determine the ILOS that are medically appropriate and cost-effective substitutes for covered services or settings under the state plan in advance of their approvals of plan proposals. For example, Florida's Agency for Health Care Administration (AHCA) requires its Medicaid managed care plans to complete an ILOS submission form to request the agency's approval to provide members an ILOS. AHCA differentiates between "state-identified" and "state-approved" ILOS on the form, and the agency does not require managed care plans to submit the same level of detailed information if the managed care plan is requesting approval to offer one of the state-identified ILOS.[20]

VBP STRATEGIES

Incentive and withhold arrangements are two common value-based payment (VBP) models states employ with managed care plans to reward quality outcomes. As states increasingly use these payment strategies to address HRSNs, managed care plans may seek levers beyond traditional medical interventions to drive behavior changes. States can design their VBP programs to incentivize the outcomes that may be more easily realized through creative and innovative solutions, thereby indirectly encouraging managed care plans to offer ILOS.

Additionally, many states have implemented strategies to require managed care plans to implement VBP contracts with provider entities.[21] These efforts can create financial incentives for providers to improve the quality of care, population health outcomes, and cost-efficiency. Because HRSNs have profound impacts on healthcare costs and outcomes,[22] VBP arrangements can create an imperative for providers to screen for and address these needs. Inclusion of ILOS in managed care contracts can give managed care plans additional tools to support their provider partners in offering reimbursement for HRSN services that can help them succeed under VBP. States and managed care plans can work together to make sure ILOS and VBP strategies are aligned within the managed care contract.

[18] Florida DOH (May 4, 2018). Invitation to Negotiate CMS Managed Care Plan. Retrieved March 15, 2023, from https://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?dept_ad_number_str=DOH17-026&pui_code_str=6400.

[19] California, Florida, Kansas, New Jersey, New York, and Oregon are examples of states that either include in the managed care contract, or publish separately, lists of state-approved ILOS.

[20] AHCA. SMMC 2018-24: Agency-Approved Contract Materials. Retrieved March 15, 2023, from https://ahca.myflorida.com/medicaid/statewide_mc/app_contract_materials.shtml.

[21] Hinton, E. et al. (January 12, 2022). State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid. Kaiser Family Foundation. Retrieved March 15, 2023, from https://www.kff.org/edicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/.

[22] ASPE Office of Health Policy (April 1, 2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Retrieved March 15, 2023, from https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAMS

Similar to the VBP strategy above, states can encourage managed care plans to offer ILOS through their managed care quality assessment and performance improvement programs. States can integrate social determinants of health into their performance improvement projects and require plans to include interventions that address HRSNs.

Capitation rate development approach

While managed care plans are not required to offer ILOS, the managed care rate development process provides the necessary flexibility to properly incorporate cost-effective ILOS into capitation rates.

ACCOUNTING FOR ILOS AS A COVERED SERVICE

First, actuaries are required to account for covered services under the contract between the state and managed care plans. The inclusion of cost-effective ILOS as a covered service is specifically called out in Section 3.2.5 of ASOP 49, where it states the "actuary should reflect covered services for Medicaid beneficiaries, as defined in the contract between the state and the managed care plans, which may *include cost effective services provided in lieu of state plan services."*[23]

MODELING COST IMPACTS FOR VOLUNTARY ILOS

Second, CFR 438.4(a) defines actuarially sound capitation rates as rates that "are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract."[24] To the extent that the cost-effective ILOS could reasonably be provided by a managed care plan, as authorized in the managed care plan contract with the state, it seems logical that the cost-effective ILOS could be included in managed care development, *even if an individual managed care plan elected not to provide the ILOS*.

CAPITATION RATES ARE NOT CERTIFIED AS ACTUARIALLY SOUND FOR INDIVIDUAL MCOS

Third, Section 3.1 of ASOP 49 indicates "the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual MCO." The certifying actuary does not develop rates in a manner specific to each MCO operating in a state; rather the capitation rates reflect reasonable, appropriate, and attainable costs for a MCO doing business in the state. Consistent with the second consideration in this section, this provision of ASOP 49 supports the inclusion of cost-effective ILOS in the rate development even if a contracted MCO elects not to offer ILOS. However, in this assessment, the actuary would also need to understand why the MCO did not offer cost-effective ILOS—was the provider network limited or was there some other barrier that made it unreasonable for the MCO to offer the ILOS? If a legitimate implementation barrier exists, then the actuary may be constrained in making provision for a material cost-effective ILOS in the capitation rates, as this would not reflect an attainable cost. In making rate adjustments specific to ILOS, the actuary should also consider the adjustment in the context of broader service availability for beneficiaries.

MANAGED CARE ADJUSTMENT FOR ILOS

Finally, when developing prospective managed capitation rates, a state's actuary may incorporate the cost-effectiveness assumptions of ILOS into the rate development as a managed care adjustment, reflecting estimated changes in utilization or unit cost between the experience period and rate period attributable to the ILOS. As described in ASOP 49, the managed care adjustment should be attainable within the rating period by a managed care entity. For example, if the ILOS's aggregate impact on state plan services was anticipated to take three years to be achieved, then the managed care adjustment during the first year of the ILOS should only reflect incremental impacts achievable in the first year (rather than at the end of year 3). Additionally, the managed care adjustment should not overlap with trend assumptions (i.e. if trend assumptions are lower because of ILOS, it would be inappropriate to also apply a managed care adjustment attributable to ILOS).

[23] ASOP 49, op cit.

[24] 42 CFR § 438.4 – Actuarial soundness. Retrieved March 15, 2023, from https://www.law.cornell.edu/cfr/text/42/438.4.

Summary

Recent innovative interpretations of ILOS authority in California and other states have prompted CMS to issue sub-regulatory guidance that solidifies ILOS as a preventive service in addition to a real-time substitute for state plan services. This additional benefit flexibility can help states address HRSNs on an ongoing or temporary basis. There will still be a need for detailed analysis and thoughtful benefit design with robust clinical backing. Comparatively, ILOS will be easier and more flexible to implement than other waiver authorities. Stakeholder engagement and MCO buy-in will ultimately be necessary for a successful implementation.

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