Center for Health Care Strategies

Using In Lieu of Services to Address Health-Related Social Needs: Upshots from the Recent Federal Rule

By Diana Crumley, Center for Health Care Strategies

Over the past decade, Medicaid managed care organizations (MCOs) have increasingly chosen to provide services that address their members' health-related social needs (HRSN), such as medically tailored meals, home remediation to reduce asthma triggers, and housing navigation services. However, because MCO capitation rates have not traditionally reflected these HRSN services, many MCO activities to address HRSN have remained in pilot phases.

New Centers for Medicare & Medicaid Services (CMS) guidance on *in lieu of* services (ILOS) is changing this dynamic. ILOS are defined as medically appropriate and cost-effective substitutes for state Medicaid benefits, with special treatment in managed care rates (discussed below). ILOS authority is particularly valuable for states aiming to avoid a Section 1115 demonstration, which involves lengthier planning and negotiation, and may face delays in federal review and approval. States with 1115 demonstrations that address HRSN may also use ILOS as part of their overall HRSN strategy — for example, California, New York, North Carolina, Oregon, and Washington State.

CMS' May 2024 final rule builds on the agency's prior guidance on using ILOS to address HRSN. Below are five upshots from the recent rule and guidance. The takeaways also reflect questions and concerns we have heard from state Medicaid agencies, MCOs, providers, and community-based organizations about ILOS.

1. ILOS can be more preventive, and not a direct substitute.

The 2016 federal managed care rules defined ILOS as a medically appropriate and cost-effective substitute for a state plan service or setting. But confusion remained: *Could a service linked to reductions in emergency department visits or nursing facility admissions qualify as an ILOS? Would a Medicaid member have to forego a service like personal care services to receive a home-delivered meal as an ILOS?*

CMS provides clarifications in the 2024 final rule preamble, as well as earlier guidance. ILOS can be "immediate or longer-term substitutes" for Medicaid services and settings, or when "the ILOS can be expected to reduce or prevent the future need" for services and settings. In other words, MCOs and states did not need to demonstrate "an immediate offset or reduction in the State plan-covered service or setting." States could use previous experience and academic studies to determine if a service is medically appropriate or cost-effective.

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2. ILOS must be approvable as a Medicaid state plan or home and community-based service, and not include "room and board."

MCOs can use ILOS to provide more preventive care, but there are guardrails.

Notably, "an ILOS must be approvable as a service or setting through a waiver under section 1915(c) of the Act or a State plan amendment, including section 1905(a), 1915(i), or 1915(k) of the Act." CMS has provided a non-exclusive list of 12 nutrition and housing services that meet this criteria, including caregiver respite, medically tailored meals, pantry stocking, nutrition prescriptions, home remediations, and support with SNAP, WIC, and housing applications. Other non-traditional services, like yoga, cannot be ILOS. Services that do not meet ILOS criteria may still qualify as value-added services or activities that improve health care quality.

ILOS authority cannot relax traditional "room and board" restrictions for Medicaid funding. For example, nutrition-related ILOS must be fewer than three meals a day or an equivalent. And ILOS authority is not appropriate for the following housing services: short-term pre-procedure and/or post-hospitalization housing, including medical respite and post-hospitalization recuperative care; short-term post-transition housing, including transitional rent; and utility assistance. These services, however, are approvable via a Section 1115 demonstration.

3. ILOS can have a budget impact.

If states approve HRSN services as ILOS, MCOs have more confidence to expand their community partnerships. MCOs receive capitation rates that include the projected costs of both the ILOS they elect to provide and Medicaid covered services.

ILOS should be, by definition, cost-effective. But as CMS makes clear in its 2023 proposed rule and again in the final 2024 rule, cost-effectiveness does not require budget neutrality. Additionally, cost-effectiveness can be measured over years.

States can develop MCO capitation rates that reflect ILOS utilization and cost in the projected benefits portion of the rate. However, ILOS costs cannot exceed five percent of total capitation payments. ILOS cost percentages less than one and a half percent require less reporting and evaluation activities.

A number of comments on the proposed rule highlighted potential negative impacts to some managed care products as a result of the five percent cap on ILOS cost percentages. For example, North Carolina commented that the five percent cap has a "significant disadvantage to states that have smaller, limited benefit managed care programs such as a behavioral health carve out." Nonetheless, CMS maintained the five percent cap as an appropriate guardrail.

4. States must identify specific codes and modifiers for ILOS.

MCOs will need to report ILOS costs annually and provide relevant encounter data. This task may be complex. Some services may not be easily identifiable through existing CPT and HCPCS codes. For services with established codes, modifiers may be needed to distinguish an ILOS from state plan or waiver service (see an example from California) CMS will not require standardization of codes, but encouraged states to

work collaboratively toward the development of CPT and HCPCS codes and modifiers for ILOS, including in partnership with other interested organizations. For example, the Gravity Project has done work identifying relevant codes for HRSN interventions.

5. Rates should only reflect ILOS and not other infrastructure costs.

Even with CPT and HCPCS codes in place, community-based organizations providing HRSN services may have limited experience billing and coding for services. CMS agrees that states should provide necessary resources, training, and technical assistance to these providers to enable successful implementation of ILOS. But CMS suggested it was inappropriate to include ILOS infrastructure costs and activities into the non-benefit portion of managed care rates, stating that agency does not "believe it is appropriate to include costs associated with third party management, operational costs, or infrastructure of ILOSs within any portion of ILOS costs … or any portion of Medicaid managed care capitation rates."

There may be other vehicles for covering these costs, however. In another section of the rule preamble, CMS reminds states of the role of MCO incentive arrangements for HRSN activities. For example, California has used incentive arrangements for similar infrastructure-building activities, including the Incentive Payment Program and the Housing and Homelessness Incentive Program. In addition, HRSN infrastructure funding is available through CMS' recent Section 1115 demonstration opportunity.

Looking Ahead

CMS notes in this new rule that using ILOS to address HRSN in Medicaid has the potential to improve quality, health outcomes, and member experience. Although some worry that CMS' new guidance could increase state and MCO burden and have detrimental effect on innovative use of ILOS, states and MCOs appear to be moving forward. In a 2023 Association of Community Affiliated Plans benchmark assessment, 26 percent of MCOs were already using ILOS to address HRSN. With this new federal rule on ILOS finalized, that number will likely grow in years to come.

Initial implementation may be rocky and — as expected for optional services — variable across MCOs and regions. Nonetheless, early signals from similar HRSN programs are promising.