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CMS New Guidance on Use of ILOS

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CMS announces a new policy framework for managed care in-lieu-of services

On January 4, 2023, CMS issued the State Medicaid Director (SMD) letter #23-001, providing new guidance on the use of in-lieu-of-services (ILOS) in Medicaid managed care. ILOS are cost-effective and medically-appropriate services or settings substituted for a Medicaid-covered service in managed care.

According to CMS, this guidance clarifies an existing option that states may consider when leveraging Medicaid managed care programs to reduce health disparities and address unmet health-related social needs (HRSNs). In reality, while CMS has opened up new opportunities to use ILOS, they are also placing new rules and restrictions that will impact new and long-standing ILOS initiatives, regardless of whether or not the ILOS is related to HRSNs. This will require additional actuarial documentation, clinical and coding support, contract changes, monitoring and evaluation, and review of existing ILOS to ensure compliance with the new program parameters.

Background

CMS regulations on ILOS are found at 42 CFR 438.3(e)(2). States currently have to meet four requirements:

1. States, typically in partnership with their actuary, must determine that the ILOS is a cost-effective and medically-appropriate substitute for covered services or settings under the state plan.

2. Enrollees cannot be required to use the ILOS.

3. An approved ILOS must be authorized and identified in the managed care plan contract and must be offered to enrollees at the option of the managed care plan.

4. The utilization and actual cost of the ILOS is taken into account in developing the component of the capitation rates that represent the covered state plan services, unless a federal statute or regulation explicitly requires otherwise.

On January 7, 2021, CMS published a State Health Official (SHO) letter #21-001 that described opportunities states have to better address social determinants of health, more currently known as HRSNs. This latest guidance from CMS builds upon the policies described in the 2021 SHO letter and emerging 1115 Waiver negotiations and ILOS approvals, such as the CalAIM initiative approvals in California.

New Policy Framework for ILOS

In the SMD letter #23-001, CMS announced six new principles for ILOS that states must address in order to obtain CMS' approval of a state's managed care contract:

1. **ILOS must advance the objectives of the Medicaid program**. ILOS cannot violate federal prohibitions (e.g., coverage of room and board) and must be approved under a state plan or home and community based services (HCBS) waiver authority. CMS does not address Section 1115 authority. However, in one example so far, CMS indicated they would deny an ILOS proposal for a service only coverable under Section 1115 authority.

2. **ILOS must be cost-effective**. Actuaries will need to calculate and certify a new ILOS Cost Percentage by program, and ILOS will generally be limited to a Cost Percentage that does not exceed 5%. We expect CMS to approach this limit as a hard cap, but it may be challenging to enforce. While CMS has signaled some flexibility in how the 5% can be calculated, this limit may become an issue, for example, for programs that deliver higher amounts of HCBS through ILOS (versus state plan or waiver) authority. If your state is unsure of where your programs fall within this expectation, please reach out to the Mercer consultants. We will keep you informed as we learn more about CMS' position on the Cost Percentage and flexibility.

3. **ILOS must be medically appropriate**. States will need to provide additional documentation of the clinical basis for the substitution if the ILOS Cost Percentage is above 1.5% and provide additional documentation of the appropriateness for targeted populations. HCBS services that are intended to avoid institutionalization and are approvable under 1915 HCBS authorities will be considered medically appropriate. States may also need to justify the target populations for HCBS-like ILOS services.

4. **ILOS must be provided in a manner preserving enrollee rights and protections**. Even though ILOS are made available at a Managed Care Organization's (MCO's) option, members have grievances and can appeal rights (including State fair hearings) with the respect to the authorizations and denial decisions of an MCO to make an ILOS available.

5. **ILOS must be subject to appropriate monitoring and oversight**. This includes the use of appropriate quantitative and qualitative measures, at least annually. This activity includes a new actuarial reporting requirement on the ILOS Cost Percentage, advance written notification if an ILOS is no longer available, an attestation to audit certain data, including encounter data, and documentation necessary for CMS to understand how the utilization and cost of ILOS (as well as any savings resulting from the use of ILOS) were considered in the development of the actuarially sound capitation rate. It is expected that CMS will include further guidance on the documentation standards in actuarial rate certifications in the next rate guide for rating periods starting on or after July 1, 2023.

6. **ILOS must be subject to retrospective evaluation, when applicable**. States will be required to perform a retrospective evaluation of ILOS in all programs with an ILOS Cost Percentage greater than 1.5%. Much like 1115 Demonstration Waiver requirements, evaluations must be submitted to CMS no later than 24 months after the completion of the first five contract years that include ILOS and further evaluations may be needed after the first five years based on CMS discretion.

Expenditures associated with Institutions for Mental Diseases as an ILOS are excluded from this guidance and should continue to follow current Medicaid managed care rules.

Effective Dates

For new ILOS, including those in managed care contracts currently pending CMS review but not yet approved, CMS has said states will need to comply **immediately**. States that currently use ILOS, as documented in an approved managed care contract as of January 4, 2023, will have until the contract rating period beginning on or after January 1, 2024 to comply with this guidance for existing ILOS. These deadlines create particular challenges for programs with ILOS expenditures that currently exceed the 5% limit and program launching new ILOS.

Next Steps for State Medicaid Programs

We understand the use of ILOS can be a powerful tool in how states leverage Medicaid managed care programs to achieve access, quality and financial goals. For some states, this new guidance will require a significant amount of preparation and Mercer is here to assist. We will continue to share updates and guidance on this topic as new information becomes available. We are working diligently to help navigate any client-specific challenges and strategize on next steps.

Please contact your Mercer client leader to talk through the potential impact for your state. You may also email us at **mercer.government@mercer.com.**

View more information at **www.mercer-government.mercer.com**