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Client Alert

CMS Issues "In Lieu of" Services Guidance to Address Health-Related Social Needs in Medicaid Managed Care

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On January 4, in its most recent effort to expand federal support for addressing health-related social needs (HRSNs), the Centers for Medicare & Medicaid Services (CMS) issued guidance to clarify an existing option for states to address HRSNs through the use of "in lieu of" services and settings policies in Medicaid managed care. This option is designed to help states offer alternative benefits that take aim at a range of unmet HRSNs, such as housing instability and food insecurity, and to help enrollees maintain their coverage and improve health outcomes.

Background

"In lieu of" services can be used as immediate or longer-term substitutes for state-covered services or settings to offset potential future acute or institutional care and improve the quality and health outcomes for the enrollee. The recent guidance builds on the 2016 Medicaid and Children's Health Insurance Program (CHIP) managed care final rule, which formally recognized states' and managed care plans' abilities to cover "in lieu of" services and significantly expanded its flexibility by permitting coverage of services in an institution for mental disease (IMD) with certain limitations. The final rule required that states' "in lieu of" services must be medically appropriate and cost-effective, prevents managed care plans from requiring services for enrollees as a substitute for a state plan covered service or setting, and factors services' utilization and actual costs into capitation rates.

States and CMS are using 1115 waiver authority to pursue "in lieu of" services and other HRSN-related services and supports. In recent months, CMS approved 1115 waivers in Arizona, Arkansas, Massachusetts, and Oregon that include "in lieu of" services proposals to address HRSNs. While several states currently use "in lieu of" services to cover mental health and substance use disorder treatment in IMD settings, CMS explains that additional guidance is necessary at this time for non-IMD and other types of services, including those to reduce the need for future costly state plan-covered services.

Guidance: CMS' Six Principles on Appropriate and Efficient Use of "In Lieu Of" Services

In guidance addressed to state Medicaid directors, CMS clarifies its expectations for the use of "in lieu of" services and settings and provides a policy framework for states in order to qualify for a Section 1115 waiver. The guidance also establishes the following six principles to guide states in this area: (i) Medicaid program alignment, (ii) cost-effectiveness, (iii) medical appropriateness, (iv) enrollee rights and protections, (v) monitoring and oversight, and (vi) retrospective evaluation (when applicable).

CMS has developed these clarifying parameters to ensure adequate assessment of the alternative services and settings prior to use, ongoing monitoring for appropriate utilization and enrollee protections, and financial guardrails to ensure accountability and prevent inappropriate use of Medicaid resources. States must fulfill each of the below requirements to obtain CMS approval of states' managed care plan contracts that include "in lieu of" services in accordance with 42 CFR § 438.3(a).

1. **"In lieu of" services must advance the objectives of the Medicaid program**

   CMS explains that it will review states' applications to ensure that they advance the objectives of the Medicaid program and make this determination as part of its review of the state's contracts and associated capitation rates. "In lieu of" services must not violate any applicable federal requirements and must be approvable through a state plan amendment authorized through the Social Security Act, including sections 1905(a), 1915(i), or 1915(k) of the Social Security Act, or a waiver under section 1915(c) of the Social Security Act.

2. **"In lieu of" services must be cost effective**

   According to the guidance, states must demonstrate to CMS that the "in lieu of" services are cost effective substitutes in order for CMS to consider the managed care plan contract. To ensure "in lieu of" services are used effectively to achieve their intended purpose to advance access to health care while still ensuring fiscal safeguards, CMS believes that the "in lieu of" services cost percentage per program should not exceed 5 percent. As part of rate certifications, actuaries must estimate and certify the projected services cost percentage annually. CMS outlines the below documentation requirements that states must provide in rate certifications:

   - A brief description of each "in lieu of" services in the Medicaid managed care program, and whether the service was provided as a benefit during the base data period;
   - The projected "in lieu of" services cost percentage, which is calculated by dividing the portion of the total capitation rates that would be attributable to a service, excluding short term stays in an IMD, for a specific managed care program by the projected total capitation payments for that program;
   - A description of how the "in lieu of" services (both material and non-material impact) were taken into account in the development of the projected benefit costs, and if this approach was different than that for any of the other services in the categories of service; and
   - An actuarial report that includes the final "in lieu of" services cost percentage, the actual plan costs for services for the specific managed care program, the portion of the total capitation payments that is attributable to services (excluding a short term stay in an IMD), and a summary of the actual managed care plan costs for delivering services based on claims and encounter data. The report should be submitted to CMS no later than 2 years after the completion of the contract year that includes services.

3. **“In lieu of” services must be medically appropriate**

States must demonstrate to CMS that “in lieu of” services are medically appropriate substitutes for state plan-covered services or settings to be considered for approval. CMS directs states to submit the following within their managed care contracts:

- The name and definition of each “in lieu of” services and the services or settings which they substitute, including the relevant coding;
- Clinically oriented definitions for the target population;
- A contractual requirement for the managed care plans to utilize a consistent process to ensure that a provider using professional judgement determines the medical appropriateness of the service for each enrollee; and
- If the projected cost percentage is higher than 1.5 percent, states must provide a description of the process to determine medical appropriateness.

CMS will review the state’s determination to ensure it is reasonable and reserves the authority to deny approval for any “in lieu of” service that it determines is not a medically appropriate substitute.

4. **“In lieu of” services must be provided in a manner that preserves enrollee rights and protections**

CMS states that the provision of “in lieu of” services is also dependent on the enrollees’ willingness to receive the service and that managed care plans are strictly prohibited from requiring enrollees to utilize the service or from mandating replacement of a state plan covered service. Medicaid managed care plans are not permitted to deny an enrollee a medically appropriate Medicaid covered state plan service or setting on the basis that an enrollee has been offered an “in lieu of” service, is currently receiving an “in lieu of” service, or has received an “in lieu of” service in the past. CMS also clarifies the requirements of managed care plans’ grievance and appeal systems.

5. **“In lieu of” services must be subject to appropriate monitoring and oversight**

CMS requires states to conduct ongoing and robust monitoring and oversight activities to evaluate compliance with federal requirements. To demonstrate appropriate state monitoring and oversight of “in lieu of” services, CMS directs states to submit the following:

- An actuarial report provided by the state’s actuary certifying the final “in lieu of” service cost percentage specific to each managed care program as outlined above;
- Written notification within 30 days of determining that an “in lieu of” service is no longer a medically appropriate or cost-effective substitute, or for any other areas of non-compliance;

- An attestation to audit encounter, grievances, appeals, and state fair hearing data to ensure accuracy, completeness, and timeliness, including data to stratify utilization by demographics when possible; and
- Documentation necessary for CMS to understand how the utilization, cost, and savings for an "in lieu of" service was considered in the development of actuarially sound capitation rates.

6. **"In lieu of" services must be subject to retrospective evaluation (when applicable)**

CMS will require states with final "in lieu of" services cost percentages greater than 1.5 percent to submit a retrospective evaluation for each managed care program that includes "in lieu of" services. At a minimum, evaluations should include the following information:

- The impact each service had on utilization of state plan-covered services or settings, including associated cost savings, trends in managed care plan and enrollee use of each service, and impact of each service on quality of care;
- An assessment of whether encounter data supports the state's determination that each service is a medically appropriate and cost-effective substitute;
- The final "in lieu of" services cost percentage consistent with the actuarial report;
- Appeals, grievances, and state fair hearings data separately for each service including volume, reason, resolution status, and trends; and
- The impact each service had on health equity initiatives and efforts undertaken by the state to mitigate health disparities.

Evaluations must be submitted to CMS no later than 24 months after the completion of the first five contract years that include "in lieu of" services. If the retrospective evaluation identifies substantive issues, CMS may determine whether to permit the state to take corrective action to remedy the deficiency or terminate the service.

Next Steps

States that use "in lieu of" services for their Medicaid managed care contracting will have until the contract rating period beginning on or after January 1, 2024, to conform with this guidance for existing services. Effective January 4, 2023, any state managed care plan contract that includes new "in lieu of" services must conform to the guidance.

The guidance demonstrates the Administration's interest and commitment to bolster federal support for reimbursement of "in lieu of" services to address HRSNs. States can leverage existing federal policy flexibilities to offer expanded benefits to Medicaid beneficiaries and improve population health. In addition, the guidance may offer opportunities for plans, providers, health technology companies, and others to improve access to health-related social care services for vulnerable populations.

For more information on how the guidance could impact your organization, please contact the professionals listed below, or your regular Crowell & Moring contact.

For more information, please contact the professional(s) listed below, or your regular Crowell & Moring contact.

Troy A. Barsky
Partner & CHS Managing Director – Washington, D.C.
Phone: +1.202.624.2890
Email: tbarsky@crowell.com

Janet C. Walker
Senior Counsel & CHS Managing Director – Washington, D.C.
Phone: +1.202.624.2593
Email: jawalker@crowell.com

Allison Kwon
Healthcare Policy Consultant – Washington, D.C.
Phone: +1.202.508.8899
Email: akwon@crowell.com