NEW YORK STATE OF OPPORTUNITY. Department of Health

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To: Mainstream Medicaid Managed Care Plans (MMC), Health and Recovery Plans (HARP), and HIV Special Needs Plans (HIV SNP).

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Subject: Updates to In Lieu of Services or Settings (ILS) Application Process and Guidance

On January 4, 2023, the Centers for Medicare and Medicaid Services (CMS) issued State Medicaid Directors (SMD) letter # 23-001 "*Additional Guidance on Use of In Lieu of Services and Settings in Medicaid Managed Care.*" The letter describes six principles for the appropriate and efficient use of ILS that reflect the goal of improving health outcomes and advancing health equity:

- ILS must advance the objective of the Medicaid program;
- ILS must be cost effective;
- ILS must be medically appropriate;
- ILS must be provided in a manner that preserves enrollees right and protections;
- ILS must be subject to appropriate monitoring and oversight; and
- ILS must be subject to retrospective evaluation, when applicable.

As a result of this directive, the New York State Department of Health (the Department) must modify the current ILS application process. Outlined below are conditions that are new or not previously addressed in Department guidance. MMC, HARP, and HIV SNPs (collectively referred to as MMCPs herein) with existing Department approved ILS will have until the contract rating period beginning on or after January 1, 2024, to conform with this guidance.

ILS Must Advance the Objective of the Medicaid Program

1) Prior to submitting an ILS application, MMCPs must ensure that the alternative service or setting is approvable through a State Plan Amendment (State Plan) authorized through the Social Security Act, including sections 1905(a), 1915(i), or 1915(k), or a waiver under section 1915(c) of the Social Security Act. As part of their review, MMCPs may find it helpful to review the mandatory and optional benefits as well as those outlined in the section 1915(c) technical guidance.
2) In addition, an ILS must not violate any applicable federal requirements, including 42 CFR § 438.3(e)(2), general prohibitions on payment for room and board costs under title XIX of the Social Security Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Emergency Medical Treatment and Labor Act.

ILS Must be Medically Appropriate

1) When submitting an ILS application, MMCPs must include a clinically oriented definition of the target population for which it has been determined that the ILS is a medically

appropriate and cost-effective substitute. This information must be inserted in question two of the "*Cost Effective Alternative Services (In Lieu of)*" application.

2) The MMCPs must utilize a consistent process to ensure that a Provider (either the Contractor's licensed clinical staff or Participating Provider), using their professional judgment, and assessing the enrollee's presenting medical condition, preferred course of treatment, and current or past medical treatment, determines and documents that the cost-effective alternative service is medically appropriate for the specific enrollee, based on the target population. This documentation could be included, for example, in an enrollee's care plan or medical record.

ILS Must be Provided in a Manner that Preserves Enrollees Rights and Protections

1) Per section 10.43.b of the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract, "*The MMCP shall not require an Enrollee to utilize a cost-effective alternative Service as a substitute for a service covered under the Benefit Package. Upon approval of a cost-effective alternative service, the Contractor shall provide notice to Enrollees of the availability of the cost-effective alternative services, in a form and format as determined by SDOH, in consultation with OMH and OASAS."* In addition to the above,
    i. An enrollee who is offered or utilizes a cost-effective alternative service offered as a substitute for a covered service or setting under the State Plan retains all rights and protections afforded under 42 CFR 438 Subpart C. If an enrollee chooses not to receive a cost-effective alternative service, they retain their right to receive the service or setting covered under the State Plan on the same terms as would apply if an ILS was not an option; and
    ii. A cost-effective alternative service may not be used to reduce, discourage, or jeopardize an enrollee's access to services and settings covered under the State plan. The MMCP may not deny access to a service or setting covered under the State plan on the basis that:
        - the enrollee has been offered a cost-effective alternative service as an optional substitute for a service or setting covered under the State plan;
        - the enrollee is currently receiving a cost-effective alternative service as a substitute for a service or setting covered under the State plan; or
        - the enrollee has utilized a cost-effective alternative service in the past.

ILS Approval Process

As of January 4, 2023, each ILS, whether state-initiated or MMCP-initiated, will need to be reviewed and approved by CMS, in addition to the Department, prior to implementation. The ILS application will be submitted to CMS as part of the Department's submission of Medicaid Managed Care contract actions. Approval of the ILS will be obtained with the approval of the Medicaid Managed Care contract action. Please note, this new CMS requirement will significantly affect the approval process timeline.

If you have any questions regarding these changes, please contact ILS@health.ny.gov.