California Initiative for Health Equity & Action (Cal-IHEA)

HEALTH POLICY REPORT

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Coverage of Housing Services in Medi-Cal: Policy Recommendations for 'In Lieu of Services'

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EXECUTIVE SUMMARY

Prior to COVID-19, California was on the cusp of implementing CalAIM, an ambitious reform of the state's Medicaid program intended to continue Whole Person Care Pilot efforts to integrate physical health, mental health, and social services for high-risk beneficiaries.[1]

CalAIM contained an innovative proposal to pay for housing services in Medi-Cal as 'In Lieu of Services' – a new funding pathway that aligns incentives between the State and the Managed Care Plans that currently deliver care to 85% of Medi-Cal beneficiaries to invest in services that address social risk factors.[2]

This policy analysis describes the legal authority that governs 'In Lieu of Services' at the federal and state level and examines how this funding pathway overcomes three challenges that have previously hindered the provision of housing services, specifically, through Medicaid:

- **Legal Requirements**
- **Medical Loss Ratio Requirements**
- **Rate-Setting Requirements**

Under federal regulations, 'In Lieu of Services' (ILOS) can substitute traditional medical services covered under the Medi-Cal State Plan, are designated as incurred claims on the 'medical' side of a plan's medical loss ratio, and their cost is built into the medical load for a plan's rate-setting.

While CalAIM has been delayed due to budgetary restrictions following COVID-19[3], the original ILOS policy merits critical analyses given the potential the initiative has to sustain Medicaid funding for housing supports, with California being one of the first states in the country to propose this large-scale policy change to tackle housing instability[4]. Proposed ILOS services including housing navigation and medical respite aim to prevent ED admissions and ED discharge delays, and ultimately improve health outcomes for homeless Medi-Cal beneficiaries that face complex physical and/or mental health conditions. ILOS leverages Medi-Cal funding to help alleviate the homelessness crisis on a statewide level.[5]

Ensuring the sustainability of ILOS as a policy solution will necessitate further action from the Legislature, the Department of Health Care Services (DHCS) and other health care stakeholders. Key informant interviews of California health care stakeholders informed policy recommendations focused on how to effectively implement 'In Lieu of Services' for housing across the state, guided by a data-driven strategy, community engagement and a focus on reducing health disparities:

1. **Conduct a Homelessness Services Statewide Needs & Gaps Analysis (AB 2329)**
2. **Implement Regional Learning Collaboratives for ILOS Stakeholders**
3. **Finalize Standardized Housing Metrics with Collaborative Stakeholder Input**
4. **Include an ILOS Evaluation for Benchmarking & Accountability**

IN LIEU OF SERVICES (ILOS)

BACKGROUND

While research has established that social risk factors related to social determinants of health (SDOH) (food insecurity, housing instability, etc.) have a strong impact in shaping health outcomes, stakeholders have faced regulatory barriers in diverting Medicaid funds to services that address these risk factors.[6-7]

As a way to align incentives and overcome regulatory barriers to addressing the flow of Medi-Cal funds to housing services for the highest risk homeless Medi-Cal members, the Department of Health Care Services (DHCS) proposed embracing the provision of 'In Lieu of Services' (ILOS) as part of its original multi-year California Advancing and Innovating Medi-Cal Initiative (CalAIM). Through federal regulation 42 C.F.R. § 438.3(e), states are granted the ability to approve 'In Lieu of Services' that are provided by managed care plans as a substitute to (hence, 'in lieu of') traditional medical benefits, as long as the State has determined these services to be medically appropriate and cost-effective.[8]

Accordingly, ILOS are provided in different settings and by different providers than traditional medical benefits; Thus, ILOS can be leveraged with the intention of diverting Medicaid funds to more appropriate services that can address social risk factors related to SDOH, improve patient outcomes and avoid costly care settings (e.g. ED admissions, inpatient hospital services, skilled nursing facility institutionalization). Under CalAIM, DHCS designed a 'menu' of ILOS including housing services for individuals experiencing/at risk for homelessness with services aimed at addressing both long-term housing stability and acute housing needs (Figure 1).[9]

Figure 1. Cal-AIM's 'Menu' of Proposed In Lieu of Services

Category	Services
Housing Related Services	Housing Transition Navigation Services
	Housing Deposits
	Housing Tenancy & Sustaining Services
	Short-Term Post-Hospitalization Housing
	Recuperative Care/Medical Respite
Long-Term Care Related Services	Respite Services
	Day Habilitation Programs
	Nursing Facility Transition/Diversion to Assisted Living Facilities
	Community Transition Services/Nursing Facility Transition to a Home
	Personal Care and Homemaker Services
	Environmental Accessibility Adaptations/ Home Modifications
	Meals/Medically Tailored Meals
Diversion Related Service	Sobering Centers

LEVERAGING ILOS TO ADDRESS HOUSING AS A SOCIAL RISK FACTOR

California is one of the first states to take a targeted approach to ILOS and leverage it as a tool to provide coverage for housing services after a 2016 Final Rule from CMS on Medicaid Managed Care Regulations provided legal guidance on conditions under which ILOS can be implemented (Figure 2)[10]. As Medi-Cal primarily employs a managed care delivery system, with 85% of all 13 million Medi-Cal members receiving services through Managed Care Plans (MCPs), the CMS Final Rule opened up the possibilities for care delivery reform through ILOS. The Final Rule does not dictate what type of services can be designated as ILOS or whether services must be directed at a certain population, but rather grants the state the power to make this decision, allowing for a flexibility that "gives states and plans the ability to negotiate innovative, evidence-based delivery alternatives to covered services".[11]

The focus on housing services through ILOS merits closer analysis given that it addresses three challenges that have previously hindered the provision of housing services through Medicaid:

- Legal Requirements
- Medical Loss Ratio Requirements
- Rate-Setting Requirements

Figure 2. Federal Regulations Governing In Lieu of Services 42 CFR § 438.3(e)

1. The State must determine the **In Lieu of Service is a medically appropriate and cost-effective substitute** for a service or setting covered under the State Plan
2. **Receiving an In Lieu of Service is optional for beneficiaries**; they cannot be required to use these services
3. **Providing an In Lieu of Service is optional for Managed Care Plans**; services must be authorized and identified in Plan's contract with the State
4. The **utilization and cost of In Lieu of Services are taken into account for capitation rates** that represent the covered State Plan service

LEGAL REQUIREMENTS

Housing services have historically suffered from legal ambiguity over what specific services federal Medicaid funds are allowed to pay for. One crucial housing service, paying directly for rent, is prohibited by federal Medicaid law, and any potential changes to this statute would have to occur at the federal level.[12] Building on a patchwork of guidance from CMS, states have gone ahead and implemented some innovative housing-related services with Medicaid funds: Instead of paying for rent, paying for one-time housing deposits and transition services such as housing assessments and support plans.[13] States typically provide these housing services with Medicaid funds using the flexibility permitted by 1115 waivers, demonstration projects submitted by states to CMS and approved for a limited period of time, typically five years.[14] California has taken this approach with its Whole Person Care Pilots (WPC), authorized by an 1115 waiver from 2015 to 2020, whereby the housing-related services in Figure 1 were originally piloted in select counties.[15]

Prior to COVID-19, DHCS had proposed funding an expansion of these housing support services by funding them as 'In Lieu of Services' rather than through 1115 waiver funds. DHCS has indicated expanding these services through an 1115 waiver renewal is not viable due to strict budget neutrality requirements from CMS. Thus, to ensure continued provision and expansion of these services, which have thus far served nearly 70,000 homeless WPC[16] enrollees and showed some promising health outcomes[17], DHCS proposed classifying and funding housing services as ILOS, which operates under a *cost-effective* determination made by the State, as opposed to a *budget neutral* determination made by CMS.[18]

Ultimately, the different federal regulations governing ILOS allow them to be a new funding pathway for housing services that have already been piloted under WPC, not barred by a budget neutral requirement, and with the ability to target services at specific high-risk populations, including the homeless.

MEDICAL LOSS RATIO REQUIREMENTS

Apart from providing flexibility with legal Medicaid requirements to provide housing services, ILOS also aligns incentives regarding requirements faced by MCPs to report their medical loss ratio (MLR) annually and target a minimum 85% MLR. While this minimum MLR requirement already existed in the commercial insurance market as a result of the ACA, it was not until 2019 that Medicaid Managed Care plans had to abide by the same standard.[19]

The MLR is measured as a ratio that places a plan's incurred claims, expenses on quality improvement and fraud prevention in the numerator and plan revenue (capitation payments, premiums, etc.) in the denominator.[20] The MLR percentage is subsequently interpreted to reflect the amount of revenue plans spend on services that directly benefit members as opposed to administrative expenses, including profit margin. While the MLR serves as an oversight tool to ensure a minimum 85% of capitation revenue is spent on member services, incurred claims have typically been defined as claims for medical services, which posed a challenge to how SDOH-related services are labeled in the MLR: as medical or administrative. However, the same 2016 CMS Final Rule on Medicaid Managed Care Regulations that provided legal clarity on ILOS also codified that non-medical services may be counted in the numerator of the MLR as well.[21] This broadened definition for incurred claims is crucial given that it can incentivize plans to engage in non-medical SDOH-related investments towards meeting their minimum 85% MLR. On the contrary, if SDOH-related investments are counted as administrative expenses, this would contribute to a lower MLR for plans and disincentivize large investments from MCPs.[22]

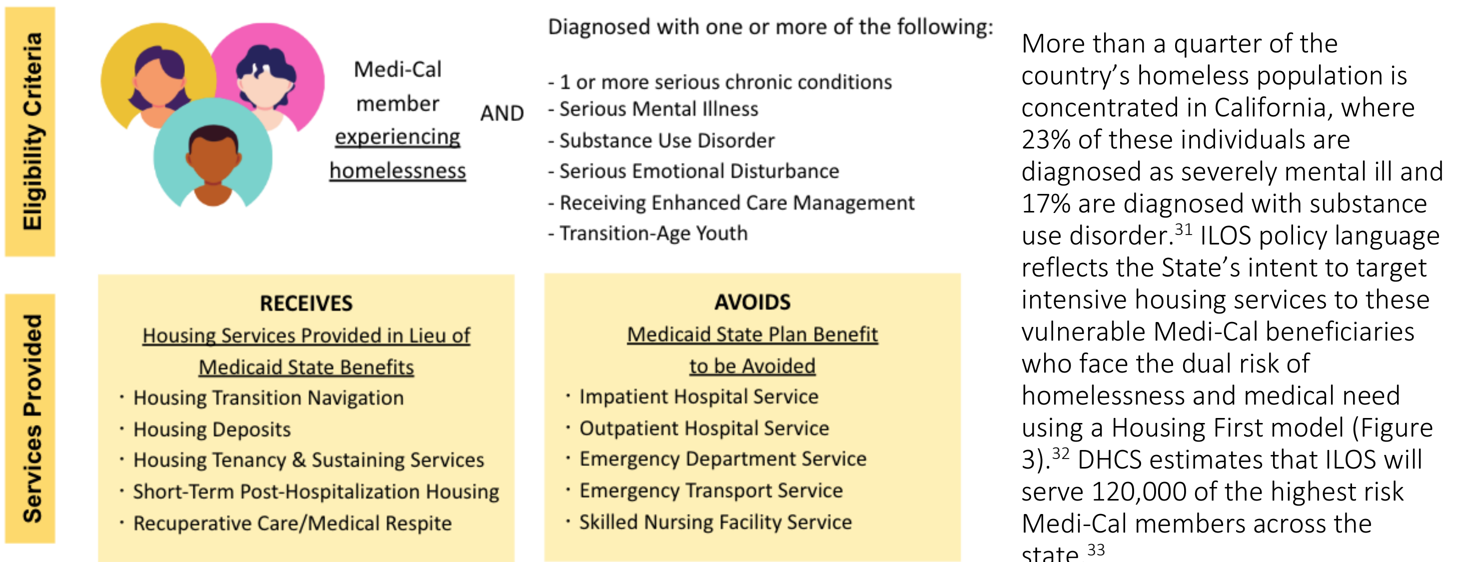
Federal regulations specify that any service provided as an ILOS will be counted in the numerator of the medical loss ratio calculation.[23-24] Thus, the housing services proposed by DHCS under ILOS, including housing deposits and tenancy services, will clearly be labeled as incurred claims for MCPs and count towards their target 85% MLR, eliminating any ambiguity over their inclusion in the calculation.

Aligning incentives for MCPs in Medi-Cal is even more critical after the approval of Senate Bill (SB) 171, whereby California will mandate that MCPs who fail to meet the minimum 85% MLR be required to remit payment to the State, effective July 1, 2023.[25]

RATE-SETTING REQUIREMENTS

In addition to being counted as incurred claims under the MLR, federal regulations also allow ILOS' cost and utilization to be taken into account when developing the capitation rates for Medicaid MCPs.[26] Medi-Cal plans had

Figure 3. In Lieu of Services Provide Cost-Effective Services that Substitute Current Medicaid Plan Benefits



Source: Department of Health Care Services (2020). California Advancing & Innovating Medi-Cal (CalAIM) Revised February 2020 Proposal.

previously reported that without addressing rate-setting, they were disincentivized from long-term funding for SDOH-related services, as there was uncertainty over whether they would recoup their investments.[27] This provision thus overcomes a major financing hurdle for Medi-Cal plans by creating an avenue for "sustained funding" towards the proposed ILOS housing services.[28] Similar to how ILOS are counted as incurred claims for purposes of the MLR, the costs of ILOS are built into the medical load for a plan's rate-setting.[29]

Leveraging ILOS in Medi-Cal was also a core recommendation from the 2018 California Health Care Foundation Report "Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs," intended to enhance financing in SDOH investments and help align incentives between the State and MCPs.[30]

IMPLICATIONS FOR CALIFORNIA

More than a quarter of the country's homeless population is concentrated in California, where 23% of these individuals are diagnosed as severely mental ill and 17% are diagnosed with substance use disorder.[31] ILOS policy language reflects the State's intent to target intensive housing services to these vulnerable Medi-Cal beneficiaries who face the dual risk of homelessness and medical need using a Housing First model (Figure 3).[32] DHCS estimates that ILOS will serve 120,000 of the highest risk Medi-Cal members across the state.[33]

Figure 4 provides a deep dive into the specific assistance Medi-Cal members can receive under each housing service, including:

- Housing assessment and support plans to *find* housing
- Coverage of security deposits to *secure* housing, and
- Linkage to community resources to *sustain* housing

ILOS are intended to be integrated with either care or case management and thereby "fill gaps in state plan benefits to address medical or social determinants of health needs."[34] The rationale for providing these intensive ILOS services is that following a Housing-First model will lead to both better health outcomes for beneficiaries by addressing unmet social needs and cost-savings to the state by avoiding costly and inappropriately high levels of care (e.g. inpatient hospital admission).

Figure 4. Specific Housing Services Provided as In Lieu of Services

Housing Transition & Navigation Services	Housing Deposits	Housing Tenancy & Sustaining Services	Short Term Post-Hospitalization Housing	Medical Respite
• Housing assessment • Housing support plan • Completion of housing applications • Benefits Advocacy (Section 8, etc.) • Landlord engagement and advocacy	• Security Deposits • Utilities set-up fees/deposits • First month coverage of utilities • First month's/last month's rent (as required by landlord for occupancy)	• Intervention for behaviors that may jeopardize housing (e.g. poor follow-up w/ physical health, SUD treatment needs) • Assistance in resolving disputes w/ landlord to reduce risk of eviction • Advocacy and linkage w/ community resources to prevent eviction • Assistance w/ annual housing recertification process	• Individual/shared interim housing setting • Ongoing support necessary for recuperation & recovery • Assistance receiving medical/ psychiatric/SUD care	• Interim housing w/ bed, meals, & ongoing monitoring of medical/behavioral health condition • Coordination of transportation to post-discharge appointments • Support in accessing benefits & housing

Source: California Department of Health Care Services. (2020). California Advancing & Innovating Medi-Cal (CalAIM) Revised February 2020 Proposal.
**Example of select services, full list of services available under CalAIM ILOS Proposal. Individuals may require and access only a subset of the services listed above.*

POLICY RECOMMENDATIONS FOR ILOS IMPLEMENTATION

Drawing on key informant interviews conducted with California health care stakeholders in April 2020 and public notes of CalAIM stakeholder engagement workgroup meetings[35], the following policy recommendations are proposed for maximizing the efficacy of ILOS implementation across the State.

1 SUPPORT FOR HOMELESSNESS SERVICES STATEWIDE NEEDS & GAP ANALYSIS (AB 2329) TO INFORM DATA-DRIVEN ILOS SERVICE PROVISION

Under federal regulations, ILOS are optional for MCPs to provide[36] and in the absence of state guidelines on contracting, there could be significant variation in how MCPs determine which ILOS services to roll out across the counties they serve; in turn, this could contribute to further fragmentation in State efforts to address homelessness.[37] Assembly Bill 2329 proposes conducting an analysis that comprehensively identifies all current funding streams for homelessness services in California and assesses what further investments across geographic regions are needed to be able to move individuals experiencing homelessness into permanent housing.[38] This data could identify and prioritize which counties need further investment for housing services and where to incentivize plan participation in ILOS, ensuring a coordinated distribution of resources backed by a data-driven strategy. A data informed approach on where to direct ILOS funding can also ensure that Medi-Cal funded housing services are integrated into existing homelessness initiatives across the state and avoid becoming siloed.

2 IMPLEMENT REGIONAL LEARNING COLLABORATIVES FOR ILOS

Original policy language for ILOS emphasized that MCPs should contract ILOS services to community providers who have "demonstrated experience" providing housing-related services and supports and working with individuals experiencing homelessness. To proactively address questions of contracting and resources in place to provide ILOS, DHCS should require regional learning collaboratives be put into place at the local level that include the diverse stakeholders key to ILOS, such as MCPs, community-based organizations (CBOs), and county officials. Formalizing collaborations with local entities will be key in order to effectively engage and provide ILOS services to homeless individuals, who may require more intensive outreach efforts.

3 GATHER COLLABORATIVE INPUT FOR FINAL STANDARDIZED HOUSING METRICS

DHCS should seek further collaborative input from local housing service providers (e.g. CBOs, counties) to inform the final metrics for ILOS. Input is needed to assess the feasibility of what process and outcome measures these providers are able to track and report, considering their current infrastructure and the fact that new local providers may not have historically worked with Medi-Cal. Given the variability of metrics used by WPC pilot entities across counties (e.g. percent in housing after 6 months, new housing placements),[39] DHCS can also analyze and present any best practices around housing metrics that have been learned from these pilots.

4 ILOS EVALUATION FOR BENCHMARKING AND ACCOUNTABILITY

California saw homelessness increase by 16% in 2019[40] despite continued state investment, emphasizing the need for a robust evaluation into the effectiveness of future ILOS services and whether they can lead to attributable changes in homelessness measures. Evaluation of ILOS effectiveness will also be necessary for benchmarking of future target metrics by housing providers and accountability of whether these significant investments are proving successful, especially with a focus on reducing inequities and measuring whether ILOS is driving improvements in communities of color that are disproportionately affected by homelessness. There is no evidence that other states have used ILOS to fund housing services on the scale that California has proposed, and thereby California's approach to ILOS could serve as a blueprint for innovative housing policies in other states.

CONCLUSION

In Lieu of Services present an avenue for innovation in the Medicaid Managed Care delivery system, especially as stakeholders acknowledge the need to address social risk factors that impact health outcomes. Under the original CalAIM initiative, California's Department of Health Care Services proposed covering housing services in Medi-Cal by designating them as ILOS, building on the state's progress providing a whole person care approach for homeless and other high-risk populations led by the WPC program. ILOS grants the State significant legal flexibility to provide innovative services helping homeless beneficiaries find, secure, and sustain housing in an effort to improve their health outcomes and prevent hospitalizations, thereby driving down use of high cost ED settings. As services that will newly count as incurred claims in a Managed Care Plan's MLR and for rate-settings purposes, ILOS helps align incentives between the State and plans to invest in services that mitigate the social risk factor of housing instability and contribute to curbing California's homelessness crisis.

SUGGESTED CITATION

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https://healthequity.berkeley.edu/sites/default/files/in_lieu_of_services.pdf

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