Green & Healthy Homes Initiative

Authority for Services in Lieu

2016 Managed Care Regulations

Leadership
Ruth Ann Norton, President and CEO
Michael T. McKnight, Vice President

Author
Andrew E. Olson, Social Innovation Specialist

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A policy analysis and review specific to the implications of managed care regulations to the fields of Pay for Success, the Green & Healthy Homes Initiative and health-based housing.

Note to reader: This document was originally published on 09 May 2016 as "2016 Managed Care Regulations". Since that date, the concept has been reviewed by CMS and we are pursuing a 'more appropriate' authority to authorize Pay for Success the leverages the authority of states regarding value-based purchasing.

The Green & Healthy Homes Initiative (GHHI), founded in 1986,
is a national 501(c)3 nonprofit organization that provides evidence-based direct services and technical assistance to create healthy, safe and energy efficient homes to improve health, economic and social outcomes for low-income families while reducing public and private healthcare costs.

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Executive summary

The new managed care regulations provide a state-led path forward for Pay for Success.

The Centers for Medicaid and Medicare Services (CMS) published new managed care regulations on 25 April 2016. They provide a way forward for Pay for Success projects by leveraging regulations that let managed care organizations pay for services "in lieu of existing state plan services", so long as specific conditions are met. If they are, managed care organizations can work with their state Medicaid leaders to allow for Federal Financial Participation or matching dollars in the reimbursement of Pay for Success projects.

GHHI will actively work to leverage this option to move forward its Pay for Success portfolio of 11 projects, where applicable.

Key Takeaways

- The new managed care regulations provide a path forward for Pay for Success by including "services in lieu of state plan services" in the CMS approved contracts between managed care organizations and the state, either directly or as an amendment, and without requiring a specific waiver or State Plan amendment.

- Services in lieu of state plan services can be offered if four conditions are met and, if so, they are considered as if they were state plan services. The conditions are:
  1. State determination that the alternative is medically appropriate, cost effective, and are included in the state's contract with the managed care provider;
  2. Enrollees with the managed care provider cannot be required to participate in the alternate services;
  3. Alternate services are provided at the option of the managed care provider; and
  4. If so, those alternate services are otherwise treated as if they were part of the state plan.

- Either contract – between CMS and managed care provider or the managed care provider contract with the provider of "in lieu" services – may be performance based or include performance based elements.

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Background

The Centers for Medicare and Medicaid Services ("CMS") periodically publish comprehensive topic-specific regulations such as those for managed care. The final rule (version) of the regulations governing managed care were recently published on 25 April 2016 and will take effect 60 days thereafter on 24 June 2016. These rules govern managed care organizations doing business with the federal or state governments as well as determine reimbursements.

GHHI was hoping that they would include clarification of an existing policy of providing "in lieu" services, which is the policy that had allowed states to cover medical goods and services that were not explicitly covered by the state plan under certain conditions.

Most frequently leveraged to include behavioral health services, the mechanism could feasibly be expanded to include other services such as environmental remediation, home-based education, and a number of other services. This would allow GHHI and many others to further their aims of providing cost-effective or value-adding services through a Pay for Success project or directly. This is especially true if the payments are structured as outcomes-based payments made in lieu of specific and priced based on services they are designed to prevent.

CMS clarification was necessary and made in the text in two distinct ways; the first was permissibility: under what specific conditions could a substitution be made? The second was actuarial soundness: how would actuaries that determine reimbursement rates treat such services?

Analysis

We believe that the new managed care regulations will allow Pay for Success investments in the social determinants of health including medical funding

The new Medicaid managed care regulation gives us a path forward for Pay for Success transactions. There are a number of key features worthy of note.

This option does:

- Allow for managed care organizations or states to initiate projects and system innovation.
- Require a contractual agreement between the state and managed care organization that explicitly includes the services to be offered in lieu of existing state plan services and CMS must approve the contract.
- Allow for reimbursement up to the existing cost of care by identifying the services that it is offered in lieu of.
- Treat payments for the alternate services as if they were state plan services.
- Allow working with an entire population or a targeted subpopulation.

This option does not:

- Require a waiver, demonstration, or other exemption from CMS.
- Provide a forcing mechanism for a state to require compulsory participation in a program that offers services in lieu of existing state plan services for either managed care organizations or their enrollees.
- Specify or limit the way in which the managed care organization can contract for the provision of those services to their enrollees – meaning that those contracts are governed by existing contracting regulations, which Pay for Success can be structured to work within.
- Limit or restrict using performance-based contracting mechanisms between the state and managed care organization or between a managed care organization and the provider of services.

Next steps

An overview of the top priorities for Pay for Success at GHHI

GHHI will work to leverage these findings to advance our Pay for Success portfolio. We feel that this potentially opens the door to a major revolution in public health and we also understand that there is much work to be done.

At GHHI we will:

1. **Work to address specifics** and applicability with each of our partners.
2. **Develop standard contracting language** with our partners that will allow them to enter into transactions.
3. **Actively pursue negotiations** with and on behalf of our managed care partners to amend managed care contracts to include the Pay for Success project services as services in lieu of those listed in state plans.
4. **Ensure State agencies** that there is a clear path to federal payment participation in Pay for Success initiatives, including advising them on that path.

Addressing specifics

At GHHI we are cautiously very optimistic about the formalization of the regulatory language, specifically the permissiveness for brokered negotiations between private managed care organizations and states because it allows for either party to initiate projects. There are still a number of issues to be addressed. These include:

1. How willing will each state be to add a cost-neutral contract amendment with a managed care organization?
2. How willing will CMS be to sign off on contractual amendments after the state has given their blessing to the project?
3. How costly will the process be?
4. How much time will the process take once initiated?

We have already begun investigating these questions and hope to have answers in the near future.

Develop standard contracting language

The GHHI team has already identified the key issues that need to be resolved for a managed care organization to enter into a Pay for Success transaction and is actively translating their resolution into the foundational principles of a contractual arrangement. We will then turn to working with our legal counsel to formalize the language before distributing to outside parties. We expect this process to move quickly.

Actively pursue negotiations

While we have not started on this topic formally, we have lain the groundwork for those negotiations by working on behalf of our health partners and constructively engaging with state level officials to obtain buy-in for the ideas of Pay for Success, outcomes-based financing mechanisms, and the importance of addressing the environmental determinants of health. We feel that when we have specific language we will be able to enter into these negotiations with strong working relationships, a deep understanding of what each party's interests are, as well as what mutually beneficial terms would be.

We are hoping to begin this process formally at the conclusion of the economic analysis for each of our feasibility studies.

Ensure states that there is a path forward

We will work through negotiations and other means through collaborative efforts that may include CMS to ensure State Agencies that there is a path forward for their Pay for Success initiatives that will secure Federal Payment Participation funding to match their current Medicaid expenses. We are already working to establish a convening of leadership in the coming months to focus on the topic and determine the best way forward.

Specific language and notes

An overview of the actual text with limited discussion where appropriate

The new regulations are comprehensive and include hundreds of pages of specifics as well as nearly a thousand pages of written discussion as well as question and answer sections taken directly from public comments. This section outlies a number of discussion points that relate to Pay for Success through the "in lieu of" clause as well as a limited review of performance based contracting.

Relevant sections on payments in lieu of existing state plan services

Actual rule page 1249

(2) An MCO, PIHP, or PAHP may cover, for enrollees, services or settings that are in lieu of services or settings covered under the State plan as follows:

(i) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;

(ii) The enrollee is not required by the MCO, PIHP, or PAHP to use the alternative service or setting;

(iii) The approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract, and will be offered to enrollees at the option of the MCO, PIHP, or PAHP; and

(iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

Discussion on page 150

Language for discussion: Final capitation rates… must be specifically identified in the applicable contract submitted for our [CMS] approval… rates must be based only upon services covered in the state plan.

- **Comment 1**: "One commenter noted that states may cover services in addition to the state plan (for example, home and community based services) and suggested that distinguishing between State plan services and other waiver services for the purposes of capitation payment is unnecessary.
- **CMS response**: Services approved under a waiver are considered State plan services, which is why they do not need to be distinguished

- **Comment 2**: "A couple commenters requested clarification… of the Actuarial Standard of Practice."
- **CMS response**: CMS maintained that "When developing capitation rates… the actuary should reflect covered services for Medicaid beneficiaries, as defined in the contract between the state and the MCOs, which may include cost effective services provided in lieu of state plan services… Only capitation payments developed in accordance with §438.3(c) are eligible for [Federal Financial Participation (FFP)]."

Discussion on page 155

- **Comment 1**: "Several commenters requested that CMS specify requirements for in lieu of services in regulation.
- **CMS response 1**: "We are including regulation text in a new paragraph (2) to identify when and which services may be covered… in lieu of services that are explicitly part of the state plan. If a state authorizes the use of in lieu of services under contract in accordance with §438.3(e)(2), the managed care plan does not have to use in lieu of services as the introductory language at paragraph (e)(2) specifies that the MCO, PIHP, or PAHP may voluntarily use in lieu of services.
- **CMS response 2**: "Specifically, the new regulation imposes four criteria for in lieu of services under the managed care contract.
    - First, in paragraph (e)(2)(i), the state would determine that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan as a general matter. Because the in lieu of service is a substitute setting or service for a service or setting covered under the state plan, the determination must be made by the state that the in lieu of service is a medically appropriate and cost effective substitute as a general matter under the contract, rather than on an enrollee-specific basis.
    - This authorization is expressed through the contract, as any contract that includes in lieu of services must list the approved in lieu of services under paragraph (e)(2)(iii).
    - Under paragraph (e)(2)(ii), the enrollee cannot be required by the MCO, PIHP, or PAHP to use the alternative service or setting.

- In paragraph (e)(2)(iii), the approved in lieu of services are authorized and identified in the MCO, PIHP, or PAHP contract and are offered at the managed care plans' discretion, which is a corollary of paragraph (e)(2)(i).
- In paragraph (e)(2)(iv), the utilization and cost of in lieu of services are taken into account in developing the component of the capitation rates that represents the covered state plan services. This means that the base data capturing the cost and utilization of the in lieu of services are used in the rate setting process.

Discussion on page 228, originating on 225

- **CMS response**: "As part of a risk contract and in accordance with the requirement (at section 1903(m)(2)(A)(iii) of the Act) that capitation rates be actuarially sound and based on services covered under the state plan (as specified at §438.3(c) and §438.4 of this final rule), we have historically provided managed care plans the flexibility to use the capitation payment to provide substitute services or settings, including when there is no comparable service under the state plan or when the additional service or setting is in lieu of services or settings that are covered under the state plan. We have required that such services be medically appropriate and cost effective alternatives, which the enrollee agrees to receive in lieu of state plan services. So long as these substitute services or setting are medically appropriate, they provide a cost-effective means to secure the goal of the Medicaid program to diagnose, treat or ameliorate health or medical conditions.

Discussion on page 233

- "Second, we have modified §438.3(e), which explains additional services (not covered under the state plan) that may be covered by an MCO, PIHP, or PAHP on a voluntary basis, to include a new paragraph (e)(2) that sets forth the criteria for a separate category of additional services or settings provided in lieu of state plan services as follows: the state determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the state plan; the enrollee is not be required by the MCO, PIHP, or PAHP to use the alternative service or setting; the approved in lieu of services are

identified in the MCO, PIHP, or PAHP contract, and will be provided at the option of the MCO, PIHP, or PAHP; and the utilization and cost of in lieu of services would be taken into account in developing the component of the capitation rates that represents the covered state plan services."

Discussion on page 248

Section 438.6(e) is limited to risk-based MCOs and PIHPs; it is not applicable to FFS Medicaid delivery systems or non-risk delivery systems. Thus, this section is inapplicable to non-risk PIHPs that provide mental health or substance use disorder services. The use of in lieu of services only applies to risk contracts.

Relevant sections on performance based contracting

Performance based contracting is also addressed by the new regulations. It does not include language that explicitly encourages or permits Pay for Success, but it does not bar or rule out any necessary component that would either prohibit it or otherwise prevent Pay for Success from viability.

Types

- Base amount is the starting amount, calculated according to paragraph (d)(2) of this section, available for pass-through payments to hospitals in a given contract year subject to the schedule in paragraph (d)(3) of this section.
- Incentive arrangement means any payment mechanism under which a MCO, PIHP, or PAHP may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.
- Pass-through payment is any amount required by the State to be added to the contracted payment rates, and considered in calculating the actuarially sound capitation rate, between the MCO, PIHP, or PAHP and hospitals, physicians, or nursing facilities that is not for the following purposes: a specific service or benefit provided to a specific enrollee covered under the contract; a provider payment methodology permitted under paragraphs (c)(1)(i) through (iii) of this section for services and enrollees covered under the contract; a sub capitated payment arrangement for a specific set of services and enrollees covered under the contract; GME payments; or FQHC or RHC wrap around payments.
- Risk corridor means a risk sharing mechanism in which States and MCOs, PIHPs, or PAHPs may share in profits and losses under the contract outside of a predetermined threshold amount.
- Withhold arrangement means any payment mechanism under which a portion of a capitation rate is withheld from an MCO, PIHP, or PAHP and a portion of or all of the withheld amount will be paid to the MCO, PIHP, or PAHP for meeting targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. Arrangements that withhold a

portion of a capitation rate for noncompliance with general operational requirements are a penalty and not a withhold arrangement.

Limits

(1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract, and must be developed in accordance with §438.4, the rate development standards in §438.5, and generally accepted actuarial principles and practices.

(2) Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound. For all incentive arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the incentive arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the incentive arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy at §438.340.

(3) Contracts that provide for a withhold arrangement must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable is actuarially sound as determined by an actuary. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the MCO's, PIHP's or PAHP's financial operating needs accounting for the size and characteristics of the populations covered under the contract, as well as the MCO's, PIHP's or PAHP's capital reserves as measured

by the risk-based capital level, months of claims reserve, or other appropriate measure of reserves. The data, assumptions, and methodologies used to determine the portion of the withhold that is reasonably achievable must be submitted as part of the documentation required under §438.7(b)(6). For all withhold arrangements, the contract must provide that the arrangement is—

(i) For a fixed period of time and performance is measured during the rating period under the contract in which the withhold arrangement is applied.

(ii) Not to be renewed automatically.

(iii) Made available to both public and private contractors under the same terms of performance.

(iv) Does not condition MCO, PIHP, or PAHP participation in the withhold arrangement on the MCO, PIHP, or PAHP entering into or adhering to intergovernmental transfer agreements.

(v) Necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the State's quality strategy under §438.340.

Limitations and exceptions for State direction of managed care spending

Delivery system and provider payment initiatives under MCO, PIHP, or PAHP contracts

(1) General rule. Except as specified … the State may not direct the MCO's, PIHP's or PAHP's expenditures under the contract.

(i) The State may require the MCO, PIHP or PAHP to implement value-based purchasing models for provider reimbursement, such as pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services.

(ii) The State may require MCOs, PIHPs, or PAHPs to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

(iii) The State may require the MCO, PIHP or PAHP to:

(A) Adopt a minimum fee schedule for network providers that provide a particular service under the contract; or

(B) Provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract.

(C) Adopt a maximum fee schedule for network providers that provide a particular service under the contract, so long as the MCO, PIHP, or PAHP retains the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

The process for contract rate approval

(2) Process for approval.

(i) All contract arrangements that direct the MCO's, PIHP's or PAHP's expenditures under paragraphs (c)(1)(i) through (iii) of this section must be developed in accordance with §438.4, the standards specified in §438.5, generally accepted principles and practices, and have written approval prior to implementation.

To obtain written approval, a state must demonstrate, in writing, that the arrangement:

(A) Is based on the utilization and delivery of services;

(B) Directs expenditures equally, and using the same terms of performance, for a class of providers providing the service under the contract;

(C) Expects to advance at least one of the goals and objectives in the quality strategy in §438.340;

(D) Has an evaluation plan that measures the degree to which the arrangement advances at least one of the goals and objectives in the quality strategy in §438.340;

(E) Does not condition network provider participation in contract arrangements under paragraphs (c)(1)(i) through (iii) of this section on the network provider entering into or adhering to intergovernmental transfer agreements; and

(F) May not be renewed automatically.

Bibliography

Centers for Medicare & Medicaid Services. 2016. "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability." Final Rule, Department of Health and Human Services, Washington.