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## Alternative “in lieu of” Services under Managed Care



# In Lieu of Services under Managed Care

- Federal Requirements
- Changes in New Managed Care Rules
- Overview of Review and Approval Process
- Clinical Review Process
- Fiscal Review Process
- Approval Notification
- Monitoring and Reporting



# Federal Provisions for In Lieu of Services

- 483.3(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;



# Federal Provisions for In Lieu of Services

- (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



# Federal Provisions for In Lieu of Services

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



# What's New in the Rules?

- Approved in lieu of services must be authorized and identified in each MCO's contract.
  - **December 1 , 2016 is the deadline for “in lieu of” service definitions to be submitted for inclusion in the July 1, 2017 DMA contract.**
- Costs and utilization are included in the development of the capitation rate, unless specifically noted in statute or regulation.



# In Lieu of Services Requirements

- Designed to meet specific needs and gaps identified by each MCO
- No limit to the number of alternative services allowed
- Must be approved and in contract and therefore may be added only through a contract amendment
- Provided voluntarily by the MCO; may not be mandated by the state



# In Lieu of Services Requirements

- Do not replace the State Plan and 1915(b) (3) services included in the waiver
  - LME-MCOs are still required to provide all State Plan and B3 services.
- Are completely new services or substantially altered State Plan services
- Must be cost effective compared to the State Plan service or other service that it is replacing





# In Lieu of Services Requirements

## In Lieu of Services Requirements

- May not be covered under the provisions of EPSDT
  - is it a coverable state plan service, i.e. listed in Social Security Act Section 1905(a)?
  - does the service being considered waive only a limit of age, number of units, admission criteria for beneficiaries under age 21?
- Reminder: EPSDT provisions do not waive provider qualifications or prior authorization requirements



# In e In Lieu of Services Requirements

- If offered, alternative services become an entitlement, subject to appeal on the basis of medical necessity determination.
- LME-MCO may choose to discontinue providing the alternative service by notifying DMA in writing with a minimum notice of 60 days.
- LME-MCO must obtain approval from DMA Behavioral Health (BH) Clinical Policy and from DMA Reimbursement.



# In Lieu of Services Approval Process

- LME-MCO obtain approval from DMA BH Clinical Policy by completing and submitting the In Lieu of Service Request Template for review.
- This template has three components:
  - Service description
  - Rate methodology
  - Cost effectiveness data



# Required Components of Service Description

- Service name
- Information on target population:
  - ages, numbers to be served, characteristics
- Treatment program philosophy, goals, objectives
- Any available supporting evidence of effectiveness
- Expected outcomes



# Required Components of Service Description

- Staffing qualifications, credentialing process, clinical and administrative supervision
- Unit of service
- Anticipated number of units/person
- Targeted length of stay



# Required Components of Service Description

- Description of why service is needed and different from any other State Plan, B3 or previously approved in lieu of service
- If implemented in other states, the outcomes



# Clinical Review of Description

- Does it meet federal requirements for in lieu of services?
- Is it coverable under Medicaid, i.e., is it educational or vocational?
- Can it be covered under EPSDT?
- Does it fill a gap or meet an unmet need in the array of services for target population?



# Clinical Review of Description

- Is it substantially different from a State Plan service, B3 or other in lieu of service?
- Are eligibility requirements clearly stated?
- Are service components delineated?
- Are staffing qualifications specified including education, certification, experience?





# Clinical Review of Description

- Are staff responsibilities for delivery of service components clearly delineated and in line with licensure and practice rules?
- Are terms such as “crisis” “required trainings” “supervision” defined?
- Are components in line with relevant Medicaid policy, such as the use of tele psychiatry?
- Are expected outcomes measurable?



# Cost Effectiveness Review

- Provider Reimbursement receives approved request from DMA BH Clinical Policy
- Reviews Cost-Benefit Analysis portion of request
- Per CMS, any alternate services need to be cost-effective in comparison to a current State Plan service or set of services



# Cost Effectiveness Review

- The MCO provides a cost analysis of the alternative service as compared to the required State Plan service that documents that the alternative service is no more costly than the State Plan service.
- If actual expenditures do not meet cost neutrality, those expenses will be excluded from the rate development process.



# Cost Effectiveness Review

- The MCO must clearly document the cost-effective nature of the alternative service including evidence of how rate was developed, what billing codes will be used, and how services will be billed.
- The MCO will provide a description of how they plan to document the utilization in the encounters.



# Cost Effectiveness Review

- Encounter reporting should support an assessment of rate setting and the cost effectiveness of the alternative service compared to the reimbursement under the State Plan.
- Provider Reimbursement will either approve or deny within 14 business days.
- DMA will notify MCO of the review process.



# Monitoring

The LME-MCO must:

- Monitor cost effectiveness by tracking utilization and expenditures.
- Submit a report of findings to DMA quarterly.
- Submit an annual update providing an evaluation of cost effectiveness of the alternative service during the previous 12 months.



# Monitoring

- Alternative services will be included in routine encounter data submissions along with State Plan and 1915(b) (3) services.



Questions ?





# Contact Information

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