ARKANSAS ORGANIZED CARE MODEL

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Arkansas Organized Care Model

- Provider led and owned
- Coordinated care will expand access to community-based care and improve outcomes for enrollees
- Limited to high cost, high risk targeted Behavioral Health (BH) and Developmental Disabilities (DD) populations in Tiers II and III
- Builds on current Arkansas successes—Person-Centered Medical Homes
- Builds on Arkansas tradition—fee-for-service
- Builds on proven models for coordinated care—Oregon, Colorado, Maine
- Excludes Human Development Centers and Long-term Services and Supports (LTSS)

Purpose of Model

- To improve the health of Arkansans who have need of intensive levels of specialized care due to mental health or developmental disabilities.
- To link providers of physical health care with providers of behavioral health care and services for individuals with developmental disabilities.
- To coordinate all community-based services for individuals with intensive levels of specialized care needs.
- To reduce excess cost of care due to under-utilization and over-utilization of appropriate care.

Principles

- Provider-led and owned
- Comprehensive, integrated, whole-person care for individuals with diagnosis of severe and persistent mental illness or developmental disabilities who meet an institutional level of care criteria
- Provides incentives to providers to expand access to quality community-based services and avoid unnecessary use of Emergency Departments and inpatient hospitalizations
- Designed to generate revenue as non-federal share
- Providers will be eligible to receive incentive payments and share in savings
- Will reduce costs by organizing and managing care, not just money
- Will meet 5 year savings target

Arkansas Coordinating Care Entities (ACEs)(formerly Regional Coordinated Care Organizations)

- Community-based providers will voluntarily form local and regional organizations to coordinate the care of members
- Accountable for delivery of care
- Carry out individual care plans
- Will coordinate care among individual providers
- ACEs will be linked to provide access to specialty care, share information and data
- ACEs will choose administrative agency (PASSE) to process claims, interact with DHS on shared savings, performance measures, incentives
- Individual providers may choose to accept risk over time

Which Medicaid Enrollees will be Eligible to Participate?

- Eligibility is limited to a small group of Arkansans who have been assessed to need an intensive level of community-based behavioral health or developmental disabilities services.
- Individuals who may be eligible for services will receive an independent needs assessment.
- Only those individuals who require higher levels of care (Tier II or Tier III) will be served through this new model of coordinated care.
- DHS estimates 17,000 children and 4,900 adults in need of intensive BH services will be served under this model.
- DHS estimates 525 children and 3,462 adults in need of intensive DD services will be served under this model.

What Services are Covered?

- Services will include all state plan and waiver services that provide physical health, behavior health, and DD community services.
- Human Development Centers, Long-term Services and Supports (LTSS) for the elderly, dental, and transportation would be excluded.
- DHS estimates that around 4,900 adults with intensive BH needs received approximately $128 million in total services and approximately 17,000 children with intensive BH needs received approximately $255 million in total services in the past year.
- DHS estimates that around 3,462 adults with intensive DD needs received approximately $254 million in total services and about 525 children with intensive DD needs received approximately $22 million in total services in the past year.

Who Can be an ACE?

- A variety of providers could form an ACE including:
  - Physician practices—primary care and specialists
  - BH and DD service providers
  - Providers of home health and therapy services
  - Pharmacists
  - Patient-Centered Medical Homes
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health Centers (RHCs)
  - Hospitals

How Many ACEs will be Formed?

- DHS will define a minimum number of members an ACE must be capable of serving
- DHS will define geographic areas to be covered—for example, DHS could follow the 5 public health districts or 13 community mental health centers (CMHCs) catchment areas
- An ACE MUST coordinate the care of all members
- An ACE may provide direct care
- An ACE will contract with other providers including individual practitioners, including specialists, Patient-Centered Medical homes, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
- Multiple ACEs will promote choice and competition
- Individual providers may join more than one ACE

Responsibilities of ACE

- Ensuring every member has a medical home;
- Ensuring each member's plan of care is being met;
- Organizing a formal network of providers including independent primary care physicians, independent physician specialists, behavioral health providers, Patient Centered Medical Homes (PCMH), Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs);
- Ensuring every member receives the medically necessary services in his/her plan of care;
- Providing care coordination for every member;
- Sharing timely information and data with affiliated ACEs, providers, members, and family members as appropriate; and
- Reporting necessary data to ensure accountability and measure performance.

Definition of Care Coordination

- "Care coordination includes services delivered by health provider teams to empower patients in their health and health care, and improve the efficiency and effectiveness [of] the health sector. These services may include health education and coaching, navigation of the medical home services and the health care system at large, coordination of care with other providers including diagnostics and hospital services, support with the social determinants of health such as access to healthy food and exercise. Care coordination also requires health care team activities focused on the patient and communities' health including outreach, quality improvement and panel management."
- https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/la/la-gnoch-ca.pdf p. 6,7.

Provider-owned Arkansas Shared Savings Entity (PASSE) (formerly, Arkansas Provider-led Coordinated Care Organizations (APCCO)

- Individual ACEs will join together to select a PASSE that will perform the necessary administrative functions and be accountable to DHS and AID
- Responsibilities include: claims processing, performance measurement, organizational management, shared savings management, beneficiary and provider grievances and appeals
- May provide tools and staffing for care coordination
- A PASSE must ensure compliance with state and federal laws and regulations governing risk-based organizations and Medicaid managed care

Governance of PASSE

- Majority (not less than 51%) owned by providers
- Representation on Governance Board by providers, beneficiaries, consumer advocates
- Centralized administrative functions—process claims, network adequacy, member enrollment and support, performance measurement, incentive pool
- Accepts and administers Global Payment
- Will interact with DHS and AID to ensure compliance and administer Global Payment for benefits, administrative costs, and care coordination
- Accepts greater level of risk over time
- The ACEs will select their PASSE; given the small population of members, there will likely be less than 5 PASSEs statewide.

Administrative Simplification

- Global payment set by DHS with savings built in
- Will use a certification process
- DHS and AID will exercise their respective roles in oversight
- Does not require adoption of alternative payment models such as those used in Accountable Care Organizations (ACOs).
- Will use simple managed care waiver authority under Section 1915 rather than more complex Section 1115 authority.

Next Steps—Aggressive Schedule to Assess Viability

- This week—DHS, with input from TSG, draft initial concept paper; conduct briefings for additional interested provider and consumer groups
- Week of October 31—Working Session on provider-led organization structures (ACEs, PASSEs)
- Week of November 7—Working Session on ensuring quality and improving patient care including performance measures
- Week of November 14—Working Session on Governance and Certification
- Week of November 21—Working Session on shared savings, Global Payment, risk and financial issues
- Week of November 28—Draft final concept paper
- November 30—Submit Recommendation and Plan to Governor
- If this hybrid model is supported by the provider community, will work to develop into a legislative proposal.

Questions and Comments?

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