Arkansas Organized Care Model

Provider-owned Arkansas Shared Savings Entity (PASSE) Information

Introduction

Under this model of organized care, provider-led and owned organizations in Arkansas will become responsible for integrating the physical health care services, behavioral health services, and specialized home and community based services (HCBS) for approximately 30,000 individuals who have intensive levels of treatment or care due to mental illness, substance abuse, or intellectual and developmental disabilities. These vulnerable Arkansans will benefit from the provision and continuity of all medically necessary care in a well-organized system of coordinated care.

Organizing the array of services for these individuals will lower costs by achieving the appropriate utilization of services. "Care coordination is expected to improve health outcomes and lower costs by decreasing gaps in care, thereby lowering the rates of crisis and acute care, decreasing duplication of services, and improving medication management."[1] States have demonstrated savings through lower rates of emergency department (ED) visits, reduction in hospital admissions for ambulatory sensitive conditions, and reductions in hospital readmissions.[2]

An important element of this proposal is the creation of several regional Arkansas Coordinating Care Entities (ACEs) throughout the state. Groups of local providers may form ACEs. The ACEs will select a Provider-owned Arkansas Shared Savings Entity (PASSE) to perform the necessary administrative functions to support the ACEs. Providers must own a majority (at least 51%) of a PASSE. A PASSE must operate on a statewide basis.

These ACEs would likely be formed by provider groups which currently provide direct care services. The PASSE will be responsible for coordinating care across all types of providers. Under this proposal, providers who become part of an ACE delivery system will be paid by the PASSE for services rendered and for care coordination. In addition, providers would be eligible to participate in shared savings and in a performance-based incentive pool developed by the PASSE.

Individual providers will be linked electronically by the PASSE through interoperable IT systems or alternative means to ensure timely information about utilization. They would share information and data through an administrative organization they would create (or join). The PASSE would perform the administrative functions necessary to support their providers, including claims processing and financial accountability as well as meeting the federal and state regulatory requirements of a managed care organization. A PASSE must meet the certification requirements established by the state and would be responsible for administering payment to

[1] https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_10_2016_Schuster%20(final).pdf p. 678.
[2] http://www.chcs.org/media/ACO-Fact-Sheet-9-21-16.pdf

ACEs and providers. The Arkansas Insurance Department (AID) will certify and regulate a PASSE. The Arkansas Department of Human Services (DHS) will provide a Global Payment to the PASSE to cover the total cost of care of beneficiaries covered by this model, which includes benefits, administration, case management, and care coordination.

A PASSE must submit an annual Letter of Intent to participate in the program by April 1 each year.

This draft application is intended to provide interested parties with important information regarding insurance requirements, governance, financial requirements, and how the model will evolve from a shared savings approach to full risk. The document should be viewed as a request/solicitation for public input and should not be considered to represent final decisions of AID or DHS. In particular, dollar amounts and percentages are specifically bracketed to show that all such figures are examples and subject to change.

Responsibilities of a PASSE

The PASSE is a risk bearing entity that is responsible for the administration of payment to ACEs and providers. The PASSE is responsible for building a network of providers to ensure access to care. Individual ACEs and providers will join together to select a PASSE that will perform the necessary administrative functions for their entities and members. A PASSE must ensure compliance with state and federal laws and regulations governing risk-based organizations and Medicaid managed care. Responsibilities include claims processing, performance measurement, organizational management, shared savings management, and beneficiary and provider grievances and appeals. It may provide tools and staffing to conduct coordination. Other functions include:

- Beneficiary protections and rights including providing a member handbook on rights and responsibilities
- Enrollment and disenrollment of beneficiaries
- Beneficiary coordination and continuity of care
- Network adequacy
- Access to providers
- Member communications
- Coordination of benefits
- Transition planning and implementation
- Encounter data reporting
- Quality of care
- Meeting state monitoring standards
- Recordkeeping and audits
- Appeals and grievances
- Payments and claims processing to providers
- Reimbursement and compensation for individual practitioners

- Which organization conducts utilization management functions
- IT systems and platforms to use
- Qualifications of providers (ACE's and providers will be required to follow federal regulations on excluded providers)
- Quality incentive payments
- Whether individual providers will be expected to bear risk
- Group purchasing arrangements

Risk and Financial Options

This organized care model will be designed to achieve savings over a five year period in the overall effort to "bend the cost curve" of Medicaid and help the program to become sustainable. DHS will construct a financial baseline to reflect the five-year cost of covering the targeted population. DHS will provide a Global Payment to cover the cost of benefits, administration, case management, and care coordination of those individuals covered by this model. The Global Payment would be adjusted by taking [x] percentage reduction off the baseline trend rate to achieve a guaranteed level of savings for the state. Participating entities would be able to share in a percentage of savings that is attributed to the model as determined by the PASSE. DHS intends to incorporate a "stop/loss" protection against aggregate losses if occurred in an individual year.

Critical Requirements of a PASSE

A PASSE will be required to meet three critical requirements:

1. Provide coverage to any beneficiary attributed by DHS on a statewide basis starting October 1, 2017.
2. Provide coverage for a minimum number of [120,000] member months annually of individuals who have been identified by DHS as requiring Tier II and Tier III levels of care over a 3 year period as set forth below. "Member months" refer to the number of months in which persons are Medicaid eligible to receive services in a PASSE. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months to the total, for a total of four eligible member months.
3. Accept full risk of providing all care and administrative functions under a global payment over a 3 year period as set forth below.

The critical requirements above will be phased-in over a 3 year period according to the following schedule:

Geographic Requirements:

Year 1 (October 1, 2017 - June 30, 2018):

- Enrollment must be offered statewide to all qualified individuals that receive intensive levels of treatment or care due to mental illness, substance abuse, or intellectual and developmental disabilities and are in Tier II or Tier III as determined by an independent assessment under criteria established by DHS.

Member Months Requirements:

Year One (October 1, 2017 - June 30, 2018):

- By October 1, 2017, the PASSE must have the capacity to enroll and provide statewide coverage to not less than [6,000] members who have been identified to be in Tier II or Tier III as determined by an independent assessment under criteria established by DHS. By April 30, 2018, enrollment in the PASSE must exceed [3,000] members and [18,000] member months on an annualized basis.

Year Two (July 1, 2018 - June 30, 2019):

- By April 30, 2019, enrollment of members who have been identified to be in Tier II or Tier III as determined by an independent assessment under criteria established by DHS must exceed [7,000] members ([84,000] member months on an annualized basis).

Year Three (July 1, 2019 and beyond):

- By April 30, 2020, enrollment of members who have been identified to be in Tier II or Tier III as determined by an independent assessment under criteria established by DHS must exceed [10,000] members ([120,000] member months on an annualized basis).

Risk Requirements:

Year 1 —Shared Savings (October 1, 2017 – June 30, 2018):

DHS will process all benefit claims during SFY 2018 and share this data with the PASSE. DHS will pay the PASSE an initial care assessment fee of [$xxx] per member and a [$xx] monthly care coordination payment per member. Within 90 days of the end of SFY 2018, DHS will reconcile the total cost of care (benefits plus assessment fee, care coordination payment and

administrative fee) against the projected baseline per member per month (PMPM) and compute the realized savings. The PASSE will receive [xx%] of the savings.

Year Two Shared--Savings Plus Quality Incentives (July 1, 2018 – June 30, 2019):

DHS will pay the PASSE an initial care assessment fee of [$xxx] per member and a [$xx] monthly care coordination payment per member plus a [x-x%] administrative fee. In addition, DHS will make quality incentive payments based on performance measures. The PASSE will process benefit claims beginning January 1, 2019 and begin reporting encounter data. Beginning January 1, 2019, the PASSE will pay a premium tax. Within 90 days of the end of SFY 2019, DHS will reconcile the total cost of care (benefits plus assessment fee, care coordination payment, and administrative fee) against the projected baseline PMPM and compute the realized savings. The PASSE will receive [xx%] of the savings.

Year Three (Beginning July 1, 2019 and beyond)—Full risk with aggregate stop loss:

DHS will make a PMPM global payment equal to [xx%] of estimated benefit and administrative costs, while the PASSE receives the excess savings. DHS will withhold a percentage of payments to ensure quality measures are met. DHS will share losses that exceed [xxx%] of the aggregated projected cost of benefits.

Beneficiary Choice / Beneficiary Attribution

Based on an individual's independent assessment and recent choice of providers, including specialty services and primary care services, DHS will attribute members into a PASSE. The member may voluntarily disenroll from their attributed PASSE and choose another PASSE within [90 days] of attribution. An individual will not be permitted to change PASSEs more than one in a 12 month period.

Responsibilities of a PASSE

The role of a PASSE is to organize and coordinate the continuum of care for each enrolled member for all covered benefits. More specifically, a PASSE will be responsible for:

- Ensuring every member has a medical home;
- Ensuring each member's plan of care is being met;
- Organizing a formal network of providers including pharmacy providers, independent primary care physicians, independent physician specialists, behavioral health providers, developmental disability service 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 the member's plan of care;

- Providing care coordination for every member;
- Sharing information and data with affiliated ACEs, providers, members, and family members as appropriate; and
- Reporting necessary data to ensure accountability and measure performance.
- Delivery of services may be delineated to ACEs and local providers by the PASSE.

Community-based providers will voluntarily form local and regional organizations to coordinate the care of its members. They may provide direct care and they must coordinate the care of its members. Individual direct care providers may join more than one ACE.

Under this model, the existing provider-based organizations such as PCMHs will be built upon, not supplanted. Arkansas now has over 200 PCMHs throughout the state. Organizing and coordinating care extends beyond the typical definitions of case management. Federal regulations at 42 CFR §440.169(b) define targeted case management services to include:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services.

2. Development (and periodic revision) of a specific care plan based on the information collected through the assessment.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services.

4. Monitoring and follow up activities.

In addition to case management, a PASSE will be required to provide care coordination. There is no single definition of care coordination. However, according to Centers for Medicare and Medicaid Services (CMS) guidance, there are three key concepts that appear in many definitions:[3]

1. *Comprehensive*: All services an individual receives, including "flexible" services (those delivered by systems other than the health system) are to be coordinated.

2. *Patient-centered*: Care coordination is intended to meet the needs of the individual and the family, both developmentally and in addressing chronic conditions.

3. *Access and Follow-up*: Care coordination is intended not only to connect members and their families to services, but also to ensure that services are delivered appropriately and that information flows among care providers and back to the primary care provider.

"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,

[3] https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf

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."

Member Eligibility

Individuals served by this new coordinated care service delivery system must meet the Medicaid income, resources, and functional needs assessment qualifications. In addition, they must meet the Tier II or Tier III level of care defined by DBHS and DDS. Individuals will be required to have an Independent Assessment (IA) for a Tier Determination (TD).

For individuals served by DBHS, the three tiers are:

Tier I: Counseling Level Services

At this level, time-limited behavioral health services are provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Counseling services settings mean a behavioral health clinic or office, healthcare center, physician office, or school.

Tier II: Rehabilitative Level Services

At this level of need, services are provided in a counseling services setting, but the level of need based on the IA allows for additional services and additional units of services.

Tier III: Intensive Level Services

Eligibility for this level of need will be identified by additional criteria and questions derived through the IA which could lead to inpatient admission or residential placement.

For individuals served by DD, the three tiers are:

Tier I: Community Clinic Level of Care

At this level of need, the individual receives services in a center-based clinic such as a DDTC or CHMS and does not meet institutional level of care criteria.

Tier II: Institutional Level of Care

The individual meets the institutional level of care criteria but does not need care 24 hours a day and 7 days a week.

Tier III: Institutional Level of Care 24/7

The individual meets the institutional level of care and requires care 24 hours a day and 7 days a week.

Covered Benefits

Services must be medically necessary for each individual. A PASSE must cover all mandatory and optional services covered under the Arkansas state plan and DD Waiver services, including therapy services and services through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children. The PASSE must also provider care management and care coordination for all services.

Excluded Services

- Human Development Centers
- Direct care provided by school staff
- Nonemergency transportation
- Dental benefits
- Nursing Home
- Assisted Living Facility

The PASSE may offer additional benefits to support members in the treatment, rehabilitative, and recovery needs not currently included as state plan or waiver services. The PASSE may also expand the types of professionals that can provide services such as peer counselors or provide services in additional types of settings.

Quality and Improved Patient Care Measures

DHS will adopt quality and improved patient care measurements in order to assess performance of the PASSE and determine whether payments are to be made from the incentive pool. There are already hundreds of quality measurements employed among the various states for various populations. DHS intends to adopt measurements for the most appropriate utilization of services such as avoidance of unnecessary ED visits. States typically require Medicaid MCOs to report on the Healthcare Effectiveness Data and Information Set (HEDIS)[4] and Consumer Assessment of Healthcare Providers and Systems (CAHPS).[5] Organizations such as the National Quality Forum (NQF) already have adopted many quality improvement measures for physical health.[6]

DHS intends to adopt performance measures specifically for the BH and DD populations. For example, Arkansas participates in the National Core Indicators (NCI) which includes dozens of measures on beneficiary participation and satisfaction.[7] The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends performance measurements for service clients with BH needs through the National Behavioral Health Quality Framework.[8]

[4] http://www.ncqa.org/hedis-quality-measurement
[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/
[6] http://www.qualityforum.org/ProjectMeasures.aspx?projectID=74022
[7] http://www.nationalcoreindicators.org/charts/?i=200
[8] http://www.samhsa.gov/data/national-behavioral-health-quality-framework

DHS will use a public process including a working session on ensuring quality and improving patient care to build a consensus for the performance measures used in this model. Performance measures will focus on outcomes rather than processes and will likely address:

- Reduction in unnecessary ED utilization
- Medication adherence
- Reduction in avoidable hospitalizations for ambulatory sensitive conditions
- Reduction in Psychiatric Residential Treatment for children/youth
- Reduction in hospital readmissions