Arkansas Organized Care Model
Working Session on Provider-led Organizational Structures

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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 Development 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.

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.

Arkansas Coordinating Care Entities (ACEs)

- 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

Why Are ACEs Necessary?

- Ensure statewide coverage of all types of providers
- Ensure coordination of medical care and non-medical services in timely and efficient manner
- Improve experience of member and provider
- Expand experience of Person-Centered Medical Home (PCMH)

Who Can be an ACE?

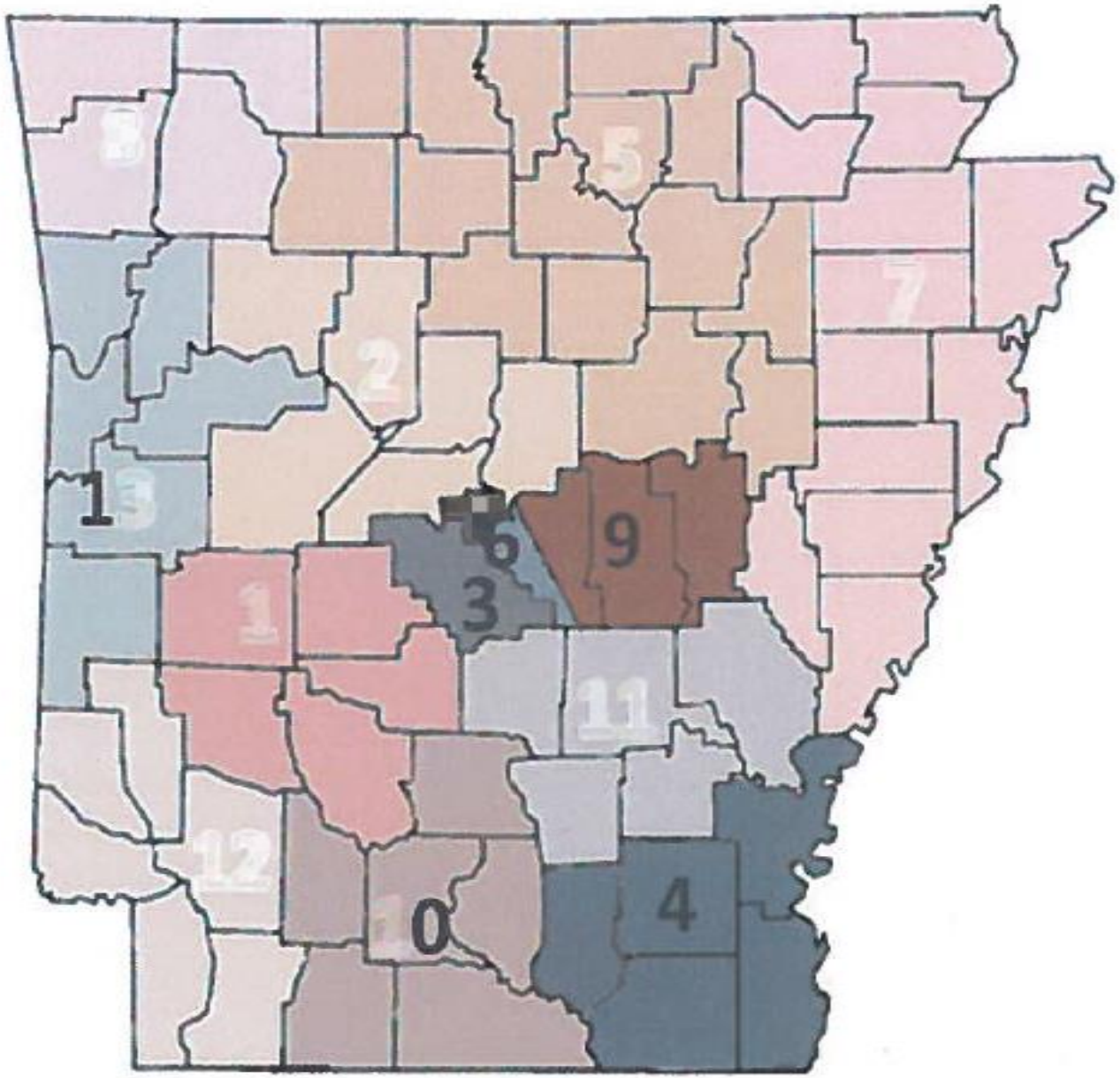
- A variety of providers could form an ACE including:
  - Physician practices—primary care and specialists
  - BH and DD service providers
  - Providers of home health and therapy services
  - Pharmacists
  - Patient-Centered Medical Homes
  - Federally Qualified Health Centers (FQHCs)
  - Rural Health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

Public Health Districts

Community Mental Health Catchment Areas



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);
- Support medical homes
- Increase access to specialists
- 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.

What are Expected Results?

- Increase utilization of recommended services that improve health and lower costs
- Decrease use of high cost services such as emergency room visits
- Increase medication adherence
- Increase follow-up care after a hospitalization
- Increase well-child check-ups
- Decrease hospital readmissions
- Increase access to after-hours care in the community

Provider-owned Arkansas Shared Savings Entity (PASSE)

- Individual ACEs will join together to select a PASSE that will perform the necessary administrative functions and be accountable to DHS and AID
- Providers, not DHS will select PASSE
- Formed from bottom up, not top down
- 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

DHS will Define Qualifications of a PASSE

- PASSE must be able to:
  - Provide DHS, ACEs, and individual providers with actionable data for individual members.
  - Data will be used to evaluate and improve performance.
  - Member-level data will be used to support care coordination and case management
  - Track Key Performance Indicators (KPIs)

Responsibilities of PASSE

- Member enrollment and member materials
- Pay providers
- Financial performance
- Incentive payments
- Program performance
- Practice support—provide clinical tools
- Administrative support—recordkeeping, audits, appeals and grievances

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 ADI 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

- 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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