Provider-Led Arkansas Shared Savings Entity (PASSE)

Risk-Based Provider Organizations Under Title XIX Section 1915(b) Authority

Delivery of Comprehensive Care for Individuals with Needs for Developmental/Intellectual Disabilities Services and Behavioral Health Services

Background Paper

Arkansas Department of Human Services

June 27, 2017

Introduction

The purpose of this background paper is to describe a new model of organized care that is targeted to a small group of Arkansas Medicaid enrollees who represent a significant percentage of Medicaid spending due to their complex medical, behavioral health, and social service needs. Currently, Arkansas Medicaid spends approximately $2 billion annually on the entire array of Medicaid services on about 150,000 individuals who have at least one claim for behavioral health (BH) or developmental/intellectual disabilities (DD/ID) services. This model will target about 30,000 individuals from within that group with higher levels of need of behavioral health, substance use disorder, and developmental disability services, in addition to their medical care. Arkansas Medicaid spends about $1 billion annually on care for these 30,000 individuals.

Under this unique organized care model, providers of specialty and medical services will enter into new partnerships with experienced organizations that perform the administrative functions of managed care. Together, these groups of providers and their managed care partners will form a new business organization called a Provider-Led Arkansas Shared Savings Entity (PASSE). Providers must maintain ownership of at least fifty-one percent (51%) of the PASSE. Each PASSE will be responsible for integrating specialized services for individuals who have a need for intensive levels of treatment or care due to mental illness, substance abuse, or intellectual and developmental disabilities with their physical health care. The Arkansas Department of Insurance (AID) will license and regulate the PASSEs as risk-based provider organizations (RBPO). Each PASSE must enter into a Medicaid provider agreement with the Arkansas Department of Human Services (DHS) and, if approved, will be accountable to both AID and DHS. A PASSE must operate on a statewide basis and must meet the federal Medicaid managed care regulations.

Beginning September 1, 2017, individuals in need of or developmental disabilities (DD) services or a full array of behavioral health (BH) services will undergo an Independent Assessment (IA). Individuals will be stratified into three levels of need—Tier I (lowest), Tier II (intermediate), and Tier III (highest). Under the IA system, an individual may be found to not need services at that time. Individuals who experience a change in circumstances will be assessed again. Individuals meeting the level of care needs in Tier II and Tier III will be mandated to enroll in a PASSE under Section 1915(b) authority. Individuals will be attributed into a PASSE based on their recent relationship with providers who are members of or network providers for the PASSEs. Beginning October 1, 2017, the PASSE will assume responsibility of care coordination for each of their members. Each PASSE will receive a per member, per month (PMPM) payment for care coordination for each enrolled member. DHS will continue to pay for services on a fee-for-service basis. DHS may add additional services to be covered by the PASSE overtime under a shared savings arrangement. Beginning January 1, 2019, Individuals with BH or DD service needs who meet the Tier I level of care may voluntarily enroll in a PASSE.

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. Beginning January 1, 2019, DHS will provide a Global Payment to cover the cost of benefits, administration, case management, and care coordination of those individuals covered by the PASSE. The Global Payment will be actuarially sound and include a percentage reduction to be determined off the projected baseline

trend to achieve a guaranteed level of savings for the state and the federal government. The Global Payment will be made to each PASSE on a PMPM basis.

The PASSE will be regulated as an insurance entity by the Arkansas Insurance Department and thus subject to the existing 2.5 percent tax on insurance transactions in the state. DHS will use no less than fifty percent (50%) of the revenues to add slots to the Community and Employment Supports (CES), home and community based services waiver and thereby reduce and eventually eliminate the waiting list for the CES Waiver. DHS will also use a percentage of the tax revenues to fund an incentive pool that can be earned by providers meeting performance measurements.

Legislative History

For more than a year, Governor Asa Hutchinson, the Department of Human Services (DHS) and the bipartisan, bicameral Health Reform Legislative Task Force (Task Force) engaged in an unprecedented effort to examine potential reforms that would make the Arkansas Medicaid programs sustainable for the future. The Stephen Group (TSG) was retained by the Task Force to assess potential reforms. Through these efforts, two potential service delivery models were identified. One option was to contract with a small number of full-risk Managed Care Organizations (MCOs) through a competitive process. The second option, called "Diamond Care," was a "managed fee-for-service model" which would be administered by an Administrative Services Organization (ASO).

In the last quarter of 2016, DHS conducted a series of public meetings to assess the potential for developing a hybrid of the two proposals, borrowing advantages from each model. Under this model, Arkansas would merge its history and tradition of strong provider leadership with the tools and risk-bearing expertise offered by managed care companies.

During the winter of 2016-2017, interest and support among providers and their potential partners grew. The Governor's support led to the introduction of HB 1706, "To Create the Medicaid Provider-Led Organized Care Act," with Representative Aaron Pilkington as the chief sponsor. The Senate and House each passed the Act as amended with just 1 dissenting vote which became Act 775 of 2017 when Governor Hutchinson signed it into law on March 31, 2017.

Provider and Beneficiary Engagement and Public Comment

In 2016, the public engagement initiative included a series of widely advertised public meetings/webinars. Hundreds of providers, beneficiaries, and vendors participated in person or online over the course of three months. DHS produced a series of presentations that were available to the public. In addition, DHS conducted dozens of individualized stakeholder meetings with legislators, providers, associations, and beneficiary representatives.

After enactment, DHS immediately resumed its public education and engagement efforts. Throughout April 2017, DHS sponsored a series of webinars to examine 1) the journey of a BH client into a PASSE; 2) the journey of a DD client into a PASSE; 3) the journey of a provider into a PASSE; and 4) the AID regulatory process and solvency requirements.

Lessons from Other States and Payers

Every state Medicaid program has adopted some form of managed care. However, there is wide variation in these models. For much of the history of Medicaid managed care, behavioral health and developmental disabilities waiver services have been excluded ("carved out") from managed care that focus on the general Medicaid population. More recently these specialty services are being added back into the benefit package.

Since 2010, Medicaid, Medicare, and commercial payers have incentivized more providers to form "accountable care organizations" (ACOs) as a "value-based payment" (VBP) model for improving quality and lowering costs. However, according to a recent survey of more than 800 ACOs, providers continue to prefer Medicare and commercial ACO contracts to Medicaid.[1] ACOs typically include physicians and hospitals but do not include the entire spectrum of provider types required to appropriately serve individuals with BH and DD needs. Thus, while the experiences of other states were useful, none of those models were adequate solutions to meet the unique needs of the most vulnerable Arkansans--individuals with severe and persistent mental illness, children and youth with serious emotional disturbance, and individuals with intellectual and developmental disabilities. The Oregon Healthy Authority, which has experimented with coordinated care models since 2012, has emphasized the following lessons learned:

- Emphasize the importance of leadership
    - From the top
    - From health systems, community members, and Medicaid members
- Incorporate financial incentives
    - Incentive measures drive behavior change
- Allow for flexibility and experimentation
- Foster a culture of innovation
    - Incorporate relationship-building and improvement science
- Build on work already happening[2]

More than a dozen states have launched or are pursuing coordinated care organizations within their Medicaid programs.[3] Some states have adopted payer-led models, and others have adopted provider-led organizations. States have also blended coordinated care organizations with Medicaid Accountable Care Organizations (ACOs) which apply to the general Medicaid population and introduce complex payment reforms that are constantly changing and evolving. 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."[4] States employing coordinated care models such as Minnesota, Oregon, and Vermont

[1] http://leavittpartners.com/wp-content/uploads/2016/11/ACO_risks_whitepaper_v1.pdf
[2] Ibid. slide 35.
[3] Ibid.
[4] https://ajmc.s3.amazonaws.com/_media/_pdf/AJMC_10_2016_Schuster%20(final).pdf p. 678.

have demonstrated savings through lower rates of emergency department (ED) visits, reduction in hospital admissions for ambulatory sensitive conditions, and reductions in hospital readmissions.[5]

According to the National Alliance on Mental Illness (NAMI), "[t]here is significant overlap between physical and mental health conditions. Studies show that up to 70% of all primary care visits involve a mental health concern and nearly 68% of people with mental illness have chronic health conditions such as diabetes, hypertension or heart disease; yet primary care providers often lack the training to diagnose and treat mental health conditions. Integrated care models that provide coordination between mental and physical healthcare improve quality of care, reduce costs and provide opportunities for training and collaboration among professionals."[6]

The fragmentation of care is a barrier for individuals, which lead to higher costs. The National Association for the Dually Diagnosed (NADD) estimates that approximately one-third of individuals with intellectual or developmental disabilities (IDD) served by state developmental disabilities agencies also are in need of mental health services.[7] NADD states that, "[t]he lack of behavioral health and primary care providers with the specialized training to diagnosis and treat this population (the dually diagnosed) results in preventable and expensive health care and treatment, repeated hospitalizations, problematic drug interactions and the overuse of psychotropic medications."[8]

There is growing evidence that care coordination has produced positive health outcomes for individuals with Serious Mental Illness (SMI) and individuals with IDD. In Pennsylvania, researchers found that "[i]mprovements in mental health hospitalization and all-cause readmissions were observed for adult Medicaid beneficiaries with SMI in the Connected Care program."[9] Researchers have concluded that, "[a]s our understanding of the health needs and experiences of people with IDD advances, we find value in integrating not just the many potential elements of acute healthcare, but also linking acute with behavioral health, long-term services and support systems, and the community-based social and developmental support structures of the person with IDD …".[10]

The role of a PASSE is to organize and coordinate the continuum of care for each enrolled member except for those served in certain settings including long term care facilities such as nursing homes and Human Development Centers (HDCs) and those served under the state's waivers for elderly and physically disabled adults. 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 independent primary care physicians, independent physician specialists, behavioral health providers, Patient Centered Medical Homes (PCMHs), Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs);
- Ensuring every member receives the medically necessary services in his/her plan of care;

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[5] http://www.chcs.org/media/MedicaidACOProgramsWebinar_01.17.17.pdf

[6] http://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/State-Mental-Health-Legislation-2015/NAMI-StateMentalHealthLegislation2015.pdf p.7.

[7] https://aaidd.org/docs/default-source/policy/including-individuals-with-intellectual-developmental-disabilities-and-co-occurring-mental-illness-challenges-that-must-be-addressed-in-health-care-reform.pdf?sfvrsn=0

[8] American Journal of Managed Care. P. 678

[9] American Journal of Managed Care. p. 679.

[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4098023/

- Providing care coordination for every member;
- Sharing information and data with affiliated providers, members, and family members, as appropriate; and
- Reporting necessary data to ensure accountability and measure performance.

Under this model, the existing successful provider-based organizations such as PCMHs will be built upon, not supplanted. Arkansas now has more than 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.

A PASSE will be required to provide care coordination which includes the activities currently described in the Arkansas definition of case management. There is no single national 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:[11]

> 1. *Comprehensive*: All services an individual receives, including services 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.

DHS proposes to adopt the definition of care coordination approved by CMS for use in a Louisiana Section 1115 Demonstration Project:

> Care coordination includes services delivered by health provider teams to empower patients in their health and healthcare, 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.[12]

[11] https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-care-coordination-strategy-guide.pdf
[12] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/la/la-gnoch-ca.pdf p. 6,7.

DHS Responsibilities

DHS shall seek approval from the Centers for Medicare and Medicaid Services (CMS) under Section 1915(b) in order to require individuals to enroll with a PASSE. Medicaid managed care rules (42 C.F.R. Part 438) will apply to this model of care and DHS will fulfill its oversight responsibilities in order to ensure compliance.[13]

DHS will execute a series of waivers and waiver amendments with CMS to fully implement Act 775. The first waiver will be submitted under Section 1915(b) authority as a Primary Care Case Management (PCCM) entity. This reflects a transitional period during which a PASSE will be performing only care coordination functions during the transition period from October 1, 2017, to December 31, 2018, and will not be at full risk.

DHS will subsequently submit a second Section 1915(b) waiver that does reflect full risk beginning January 1, 2019.

DHS will also submit conforming amendments under Section 1915(c) authority to include individuals in need of DD/IDD services under the new CES HCBS waiver.

The Division of Behavioral Health Services (DBHS) is responsible for ensuring the provision of public behavioral health services, including mental health and substance abuse prevention, treatment, and recovery services. It also funds eight Regional Prevention Providers, eight Substance Abuse Treatment Providers, and 13 Community Mental Health Centers. DBHS also operates two behavioral health institutions: the Arkansas State Hospital located in Little Rock and the Arkansas Health Center in Benton. As of July 1, 2017, the new Division of Provider Support and Quality Assurance (DPSQA) will be responsible for certifying Outpatient Behavioral Health (OBH) Agency Providers and Independently Licensed Practitioners,, and licensing Substance Abuse providers.

The Division of Developmental Services (DDS) is responsible for the overall coordination of services for individuals with developmental disabilities. DDS administers the CES waiver under the authority of Section 1915(c) which serves approximately 4,200 individuals. Children also receive Medicaid services through the Developmental Day Treatment Clinic (DDTCS) Services program and the Child Health Management Services (CHMS) program.

Any PASSE meets the requirements of AID and successfully executes a provider enrollment agreement with DHS will be able to participate in Medicaid.

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

[13] https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf

Assessment (IA) for a Tier II or III determination while individuals who need Tier I or crisis services will be able to access them directly from certified providers

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/office, healthcare center, physician office, and/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 requires a broader array of services to address functional deficits.

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 placement in residential settings for more intensive delivery of services.

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.

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.

Estimated Lives and Medicaid Expenditures 2016

Tier II and Tier III Estimated Expenditures 2016				
Enrollee Groups	**Estimated Total Enrollees**	**Total Cost**	**DD/BH Costs**	**Halo Costs**
Individuals with Intellectual/ Developmental Disabilities (includes Waitlist)	7,437	$394,306,835	**$**310,346,871	$83,959,964
Behavioral Health Tiers Based on Total Expenditures	**20,344**	**$731,389,729**	**$272,513,518**	$458,876,211
Total	**27,781**	$1,125,696,564	**$582,860,389**	**$542,836,175**

FY 2016 Intellectually/Developmentally Disabled Halo and Non-Halo Cost (Tiers II and III) Per Capita Spending (does not include waitlist)				
Tiers	Recipients	Total Per Capita Cost	DD Per Capita Cost	Halo Per Capita Cost
Adult DD Tier 2	2,866	$53,605	$45,676	$7,930
Adult DD Tier 3	1,195	$110,749	$99,599	$11,150
Children DD Tier 2	469	$50,607	$36,164	$ 14,443
Children DD Tier 3	201	$138,537	$105,703	$32,834

FY 2016 Behavioral Health Halo and Non-Halo Cost (Tiers II and III Total Costs) Per Capita Spending				
Tiers	Recipients	Total Per Capita Cost	BH Per Capita Cost	Halo Per Capita Cost
Adult BH Tier 2	7,748	$24,566	$5,096	$19,469
Adult BH Tier 3	3,059	$73,090	$11,797	$61,293
Children BH Tier 2	7,510	$22,229	$11,991	$10,239
Children BH Tier 3	2,027	$74,263	$52,734	$21,529

Beneficiary Choice /Beneficiary Attribution

Members will be enrolled in a PASSE by DHS through an attribution methodology based on the member's relationship with providers who joined that PASSE's network of providers. Given the medical complexity of these individuals, they most likely receive care from multiple providers. The National Quality Forum (NQF) found that visits and spending are the two most common approaches to determine the qualifying events for attribution. NQF also "… recognized that claims-based approaches have the benefit of reflecting the care that was actually provided."[14]

Based on a member's IA and relationships with providers, DHS will attribute that member into a PASSE. For existing Medicaid clients, DHS will examine claims history to determine specialty service providers, primary care providers, pharmacists, and other providers used by the member. Then, the member will be attributed to a PASSE according to a methodology that will be weighted toward the individual's DD and BH specialty providers.

However, as noted by NQF, "… providers are not inherently equal in their roles in patient care even when they have similar levels of contact with patients."[15] "The issue of care dispersion creates

[14] National Quality Forum, *Attribution Principles and Approaches Final Report December 2016,* Washington, DC, p. 19.
[15] Ibid. p. 54.

additional challenges when selecting an appropriate method to attribute patients to providers."[16] Therefore, attribution must consider the ability of a provider to influence other providers in the total cost of care.

Attribution Methodology

It is critical to bear in mind that the individuals to be attributed to a PASSE have complex needs. The attribution in general values the relationship between the patient and the provider AND recognizes the ability of the provider to influence the total cost of care. DHS will use a methodology that is:

- Prospective—the individual will be enrolled into a PASSE prior to the beginning of services provided by the PASSE.
- Plurality-based—using paid claims to identify all providers connected to the individual in the previous 12 month period.
- Not risk-based—all enrollees will already have been identified as individuals who have high needs and are high utilizers of services and are determined to meet a Tier II or Tier III level of care through the Independent Assessment (IA) system.

An individual will be attributed to a PASSE based on their "relationship score." **The "relationship score" is the product of the visit points and the specialty points plus the cost points** (RS=VPxSP+CP)

1. Visit Points

Using available databases, DHS will determine if there is an established relationship between the individual and providers based on whether an individual received at least one service from a provider in any month in the previous 12 month period. Each provider that rendered a service to an individual in a month will be recognized for that month. There are no additional points for multiple visits within the same month. A visit must include direct contact with the individual to deliver a reimbursable service in that month and must not be incidental. For example, a mere referral will not be recognized as a visit. Receiving a payment for case management merely because an individual is in a provider's panel will not be recognized as a visit. A service must have been performed to be recognized. Visit points will be assigned as follows:

12 months	100 points
9-11 months	75 points
6-8 months	50 points
Less than 6 months	0 points

2. Specialty Points

Weights will be assigned among provider classes to reflect the importance of specialty providers for this population. Providers will be grouped into Provider Classes by specialty. Provider Classes will be assigned the following point values:

[16] Ibid.

Provider class 5 (5 points)

- Certified Behavioral Health Provider including independent psychiatrists and psychologists
- Intermediate Care Facilities/DD/ID
- Supportive Living Provider
- Developmental Day Treatment Clinic Services (DDTCS) and successor programs
- Child Health Management Services (CHMS) and successor programs

Provider class 4 (4 points)

- Physician—PCP
- Pharmacy
- Federally Qualified Health Center (FQHC)
- Person-Centered Medical Home (PCMH)

Provider class 3 (3 points)

- Physician—non-PCP
- Nurse
- Nurse Practitioner
- Outpatient Clinic
- Inpatient Hospital Services including psychiatric stays for adults

Provider class 2 (2 points)

- Speech therapist
- Physical therapist
- Occupational therapist
- Case manager who is not otherwise a provider of direct services

Provider class 1 (1 point)

- DME
- Personal care
- Home health

3. Cost Points

The cost of care is also an important consideration in determining the relationship between the individual and the provider. Points will be added to the relationship score according to the percentage of total cost a provider rendered:

Less than 5% of total cost:	0 points
6-10% of total cost:	10 points
11-20% of total cost:	20 points
21-30% of total cost:	30 points
31-100% of total cost:	40 points

Majority/Plurality Rule

If a single provider accounts for at least fifty percent (50%) of both visits and spending for an individual, the individual will be attributed to that provider; and therefore assigned as a member into the PASSE that the provider has joined. If the majority rule provider belongs to more than one PASSE, there will be a proportional assignment made among those PASSEs. That is, if the majority provider belongs to two PASSEs, the first individual will be assigned into PASSE A; the second into PASSE B. If the majority provider belongs to three PASSEs, the first would be assigned into PASSE A; the second member into PASSE B; and the third member into PASSE C.

When there is no majority provider, the member will be attributed to the PASSE with the highest relationship score that is greater than 35% of the total possible score.

Tie-breaker

In the case in which there is no majority/plurality provider, but there is a tie between providers that represent at least 35% of the total possible relationship score, DHS will review an additional 12 months of data to determine whether there is a majority provider or break the tie using the highest relationship score after considering the additional 12 months of claims data.

Proportional assignment

If a majority/plurality provider relationship does not exist or a tie-breaker is needed such as when the majority-based provider has joined more than one PASSE, members will be assigned on a rotating basis. That is, if there are three PASSES, the first person would be assigned to PASSE A, the next to PASSE B, the next to PASSE C, the next to PASSE A, etc.

If no provider represents 35% or more of the total possible score, DHS will find that no relationship exists between the individual and any provider. In such cases, DHS will make proportional assignments among the PASSEs that exist at the time. That is, if there are three PASSES, the first member will be attributed to PASSE A, the second to PASSE B, the third member to PASSE C and the fourth to PASSE A, etc.

DHS may modify the proportional assignment rule in the future if necessary to ensure competition and thereby protect the interest of the taxpayers.

Claims Data

DHS will use all available Medicaid claims data that is fully adjudicated and refreshed on a quarterly basis. For example, for attribution of individual identified by the IA system as Tier II and Tier III, DHS will use claims data from the following time periods:

Attribution Period	Claims Data
October-December 2017	12 months of claims by date of service ending April 30, 2017
January-March 2018	12 months of claims by date of service ending June 30, 2017
April-June 2018	12 months of claims by date of service ending October 31, 2017

Exclusions from Attribution Methodology

- Payment for Medicare covered services for individuals who are eligible for Medicare and Medicaid ("dual eligible")
- Services covered by private insurance and private payment
- Cost of Transplants
- Emergency Department visits—may reflect lack of community access to services and therefore may not reflect patient choice
- Psychiatric Residential Treatment Facilities (PRTF)—may reflect lack of community access to services and therefore may not reflect patient choice

Disenrollment and Annual Selection

The member may voluntarily disenroll from their attributed PASSE and choose another PASSE within ninety (90) days of attribution. The member will not be permitted to change PASSE's more than once in a twelve (12) month period, unless there is good cause.

Typically, a member will be attributed into a PASSE only once. After the initial attribution, the member will have 90 days to switch to another PASSE and will stay enrolled in that PASSE until the anniversary of attribution. On his or her anniversary, if the member remains in Tier II or Tier III status, he or she will be allowed to choose to remain in the PASSE or enroll into another PASSE.

Tier I Status

Beginning on January 1, 2019, individuals identified as Tier 1 may join a PASSE on a voluntary basis. Thus, there is no need for attribution. Tier I individuals will have 90 days to choose another PASSE or opt out, but after 90 days, will remain in the PASSE until the anniversary of first choosing a PASSE.

If a Tier I individual who voluntarily joined a PASSE enters a Tier II or Tier III status, that individual will remain in that PASSE for 90 days and then may switch to another PASSE. On his/her anniversary, it the individual remains in Tier II or Tier III status, the person will again have a choice of PASSEs.

Covered Benefits

Services must be medically necessary for each individual. In addition to the mandatory and optional services covered under the Arkansas state plan and waivers, including therapy services and services

through the Early Periodic Screening Diagnosis and Treatment (EPSDT) program for children, the other benefits that would be delivered by or coordinated through the PASSE include:

Behavioral Health Services

- Rehabilitative Services for Persons with Mental Illness (RSPMI)
- Substance Abuse Treatment Services (SATS)
- Outpatient Behavioral Health Services (OBH)
- Mental health services, including inpatient psychiatric services , for adults
- Mental health services, including inpatient psychiatric services, for children

DD Services

- Adaptive equipment
- Case management
- Supportive living services
- Supported employment
- Environmental modifications
- Supplemental support services
- Consultation services
- Crisis intervention services
- Developmental Day Treatment Clinic Services (DDTCS) and successor programs
- Child Health Management Services (CHMS) and successor programs
- Developmental Rehabilitation Services
- Early intervention services

Excluded Benefits

- Human Development Centers
- Direct care provided by school staff
- Nonemergency transportation
- Dental benefits
- Nursing facilities
- Assisted living facilities

Care Coordination Payments and Setting the Global Payment to a PASSE

Between October 1, 2017 and December 31, 2018, DHS will make payments to each PASSE for case management and care coordination of its members. DHS proposes to make a one-time only origination payment of $208.00 to each PASSE for each member to meet start-up costs. The purpose of this payment is to review the IA and collect all other available information on a member, including the Master Treatment Plan (MTP) for individuals with BH service needs and the Person-Centered Service Plan (PCSP) for individuals with DD/ID service needs and to begin care coordination.

DHS also proposes to make monthly payments of $173.33 per member per month beginning the second month of enrollment for ongoing care coordination.

DHS will provide an actuarially sound Global Payment (capitated payment) to each PASSE beginning January 1, 2019 to cover the cost of benefits, administration, case management, and care coordination of those individuals covered by this model. Using historical expenditures, DHS is in the process of constructing a financial baseline to reflect the five-year cost of covering the targeted population. DHS will continue to process fee-for-service claims on behalf of individuals who are identified through the IA process until January 1, 2019. The Department will also contract with an actuarial firm to develop an actuarially sound global payment that assumes a percentage of savings off the projected baseline to be determined.

UPL and Supplemental Payments to Hospitals

The $1 billion estimated costs of these populations do not include supplemental payments to hospitals. It is unclear whether moving to a Global Payment will have any financial impact on hospitals under the current methodologies for making supplemental payments. DHS recognizes the critical role of supplemental payments in particular to critical access hospitals, academic hospitals, psychiatric hospitals, and the children's hospital. There are a number of options for consideration as to how to mitigate the financial impact on these providers, if any. It is the intention of DHS to engage CMS and providers to address this issue prior to January 1, 2019 when the PASSEs accept full risk.

A PASSE is a Risk Based Provider Organization (RBPO) Under Arkansas Law

Act 775 defines a Risk Based Provider Organization (RBPO) as an entity that is licensed by the Insurance Commissioner as an insurance company in accordance with the Act. According to Act 775 of 2017, a RBPO have the following requirements:

(1) Participating Providers must own a majority (at least 51%) of the RBPO. A participating provider is defined as an organization or individual that is a member of or has an ownership interest in a RBPO and directly delivers health care services to enrollable Medicaid beneficiary populations.
(2) A RBPO must operate on a statewide basis and must maintain a network of direct service providers sufficient to ensure all services to recipients are adequately accessible.
(3) A RBPO must ensure the protection of beneficiary rights and due process in accordance with federally and state mandated regulations governing Medicaid managed care organizations, including the establishment of a consumer advisory council that consists of consumers of developmental disabilities and behavioral health services.
(4) A RBPO is required to comply with all data collection and reporting requirements. These include, at a minimum, quarterly reports detailing claims data, encounter data, unique identifiers, geographic information, demographic information, and patient satisfaction scores for all beneficiaries enrolled in the RBPO. Data collection and reporting will be utilized by DHS to measure the performance of the RBPO, specifically with regards to delivery of services, patient outcomes, efficiencies achieved, and quality measures.
(5) A RBPO must submit an annual Letter of Intent to participate in the program.

Each RBPO is required to have the following membership:

(1) An Arkansas licensed or certified direct service provider of developmental disabilities services which includes:
    a. Developmental Day Treatment Clinic Services ("DDTCS") and any successor program;
    b. Private (not state owned and operated) Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IDD
    c. DDS Waiver services
    d. Child Health Management Services ("CHMS")
    e. Early Intervention Services

(2) An Arkansas licensed or certified direct service provider of behavioral health services which includes:

    a. Rehabilitation Services for Persons with Mental Illness ("RSPMI") until June 30, 2018

    b. Outpatient Behavioral Health Agency ("OBHA)

    c. Licensed Mental Health Practitioner ("LMHP") until June 30, 2018

    d. Independently Licensed Practitioner (ILP)

    e. Psychiatric Residential Treatment Facility

(3) An Arkansas licensed hospital or hospital services organizations;
(4) An Arkansas licensed physician's practice; and
(5) A Pharmacist who is licensed by the Arkansas State Board of Pharmacy.

The following entities may be members of or contract with a RBPO:

(1) A carrier;
(2) An administrative entity;
(3) A federally qualified health center;
(4) A rural health clinic;
(5) An associated participant; or
(6) Any other type of direct service provider that delivers or is qualified to deliver services to enrollable Medicaid beneficiary populations.

Providers who contract with or join a RBPO will be eligible to participate in shared savings and in a performance-based incentive pool developed by the RBPO.

Responsibilities of a PASSE

A PASSE will perform the necessary administrative functions on behalf of their members and providers. 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

Application for PASSE Certification and Governance Requirements

The state intends to use a certification process for entering into agreements with PASSEs. A prospective PASSE must file a letter of intent with AID by June 15, 2017 and is required to file an annual letter of intent with AID by April 1 thereafter in order to participate in the following calendar year. A certified PASSE will be required to enter into a Medicaid provider agreement and will be subject to DHS oversight.

Among other things, PASSEs will:

- Establish organization bylaws
- Disclose statements of ownership or controlling interests
- Establish a Memorandum of Understanding for contracting with providers

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. It 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 a percentage reduction to be determined off the baseline trend rate to achieve a guaranteed level of savings for the state and the federal government. Even with these savings, the global payment will meet federal requirements of actuarial soundness. DHS intends to seek approval from CMS to incorporate a "stop/loss" protection against losses exceeding 102 percent of aggregate claims if occurred in an individual year. DHS intends also to offer an incentive pool financed by a percentage of the premium tax that can be earned by PASSES meeting performance measurements. Incentive payments will be in addition to the global payment.

Because PASSEs will be provider-led and owned, the state does not expect or intend to make business decisions for these provider-led organizations. Such decisions would include:

- Reimbursement and compensation for individual practitioners

- Which organization conducts utilization management functions
- Specific IT systems and platforms to use
- Qualifications of providers (though 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

Quality and Improved Patient Care Measures

DHS will adopt quality and improved patient care measurements in order to assess performance of the PASSEs and determine whether payments are to be made from the incentive pool. Presently, there are hundreds of quality measurements already 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)[17] and Consumer Assessment of Healthcare Providers and Systems (CAHPS).[18] Organizations such as the National Quality Forum (NQF) already have adopted many quality improvement measures for physical health.[19]

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.[20] 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.[21]

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 to be 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 hospital readmissions

Expected Outcomes

Medicaid beneficiaries with complex needs account for a substantial percentage of total Medicaid expenditures. States continue to look for models of care to impact the growth of expenditures for these individuals with high needs. Arkansas will implement an innovative approach to managing the care for these individuals with high needs with the Provider Led Organized Care model. In this model, impacting the cost of care for these high-cost beneficiaries is completed by activities that will be managed by the

[17] http://www.ncqa.org/hedis-quality-measurement
[18] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/
[19] http://www.qualityforum.org/ProjectMeasures.aspx?projectID=74022
[20] http://www.nationalcoreindicators.org/charts/?i=200
[21] http://www.samhsa.gov/data/national-behavioral-health-quality-framework

PASSE. These activities include incentivizing the use of lower-cost, preventive services; improving care coordination for clients; integrating care for clients with mental illness and substance use disorders; as well as keeping people with disabilities at home, in the community.

Act 775 specifies eight objectives of the Medicaid provider-led organized system:

1. Improve the experience of the care, including without limitation quality of care, access to care, and reliability of care for enrollable Medicaid beneficiary populations;
2. Enhance the performance of the broader healthcare system leading to improved overall population health;
3. Slow or reverse spending growth for enrollable Medicaid beneficiary populations and for covered services while maintaining quality of care and access to care;
4. Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation;
5. Discourage excessive use of services;
6. Reduce waste, fraud, and abuse;
7. Encourage the most efficient use of taxpayer funds; and
8. Operate under federal guidelines for patient rights.

DHS expects to see improved quality of care for beneficiaries and more efficient use of Medicaid funds. The implementation of targeted care coordination for individuals with high needs will allow beneficiaries attributed to the PASSE to have client-centered plans of care that are individualized and produce improved outcomes to better the lives of these most vulnerable Arkansans.

The state also expects to reduce and eventually eliminate the DD wait list for the CES HCBS waiver through the revenue generated by the 2.5 percent premium tax. Finally, this risk-based model will also help make the Medicaid program more sustainable through greater savings than under the current fee-for-service system.

Summary

Provider-led and owned organizations will become responsible for integrating specialized home and community based services for individuals who have a need for intensive levels of treatment or care due to mental illness, substance abuse, or intellectual and developmental disabilities with their physical health care and accept the financial risk for delivering these services. These vulnerable Arkansans will benefit from the provision and continuity of all medically necessary care in a well-organized system of coordinated care.