

Arkansas Organized Care Model

A Provider's Journey into A PASSE

October, 2017



What is a PASSE?

- The Provider-Led Arkansas Shared Savings Entity (PASSE) is a new model of organized care created by Act 775 of 2017. Providers will enter into new partnerships with each other and an experienced organization that will perform the administrative functions similar to insurance companies such as claims processing, member enrollment, and grievances and appeals.
- Providers will retain majority ownership (at least 51%) of each PASSE. Under Act 775, the governing body of each PASSE must include several types of providers licensed or certified to deliver services in Arkansas including a Developmental Disabilities Services specialty provider, a Behavioral Health Services specialty provider, a hospital, a physician, and a pharmacist.
- The PASSE is the entity that will be regulated by the Arkansas Insurance Department (AID) as a risk-based provider organization. It will also be accountable to the Department of Human Services (DHS) under federal managed care rules that provide protections for Medicaid beneficiaries. Beginning January 1, 2019, each PASSE will pay for all services, not otherwise excluded in Act 775 provided to its members and perform other administrative functions, very similar to an insurance company.

What are the requirements for becoming a PASSE?

- PASSEs are a new Medicaid provider type under Section 1915(b) authority approved by the Centers for Medicare & Medicaid Services (CMS)
- Each PASSE will be required to have coverage of services for the entire state
- Five potential PASSEs have been formed and have submitted applications for licensure with AID
- PASSEs will need to prove network adequacy, provide a \$250,000 surety bond, and meet a \$6 million capital reserve requirement prior to becoming licensed
- An additional amount of reserves may be required by AID based on the risk assumed and the projected liabilities
- PASSEs will be regulated by AID as a type of insurance and will be accountable to DHS through the PASSE agreement as well as the PASSE provider manual and federal Medicaid managed care rules.

Which Medicaid Enrollees will be served by a PASSE?

- AR Medicaid beneficiaries who:
 - Have a developmental/intellectual disability (DD/ID) and were determined in need of institutional level of care
 - Have a behavioral health (BH) condition and have received an independent assessment that determined the need for an intensive level of community-based or residential treatment services
- Only individuals requiring intensive levels of care will be mandatory members of this new model of coordinated care.
- Individuals will initially be attributed into a PASSE based on their relationships with providers but will have a choice to switch to a different PASSE within 90 days. An individual will have their choice of PASSEs each year.

Purpose of Model

- The primary purpose of AID and DHS regulatory roles is to protect the interests of the consumer/beneficiary
- To improve the health of Arkansans who need intensive levels of specialized care due to behavioral health issues or developmental/intellectual disabilities
- To link providers of physical health care with specialty providers of behavioral health and developmental/intellectual disabilities services
- To coordinate care for all community-based services for individuals with intensive levels of specialized care needs

Purpose of the Model (continued)

- To reduce excess cost of care due to over-utilization and under-utilization of appropriate care
- To allow flexibility in the array of services offered to the population served
- Will reduce costs by organizing care, not just by managing finances
- To increase the number of service providers available in the community to the population covered

PASSE Phases

- Phase I-- February 1, 2018- December 31, 2018
 - Each PASSE provides care coordination only using the Primary Care Case Management (PCCM) model
- Phase II– Begins January 1, 2019
 - Each PASSE will receive a global payment, be responsible for members total cost of care, and accept full risk using the Managed Care Organization (MCO) model

Phase I

- Care Coordination – Is to be provided by the PASSE which will be responsible for the coordination of care across multiple systems, including BH, DD/ID and Medical treatment
- All other services will continue to be provided on a fee for service basis
- Beneficiaries will continue to access treatment services directly from community providers and providers will continue their current relationship with AR Medicaid

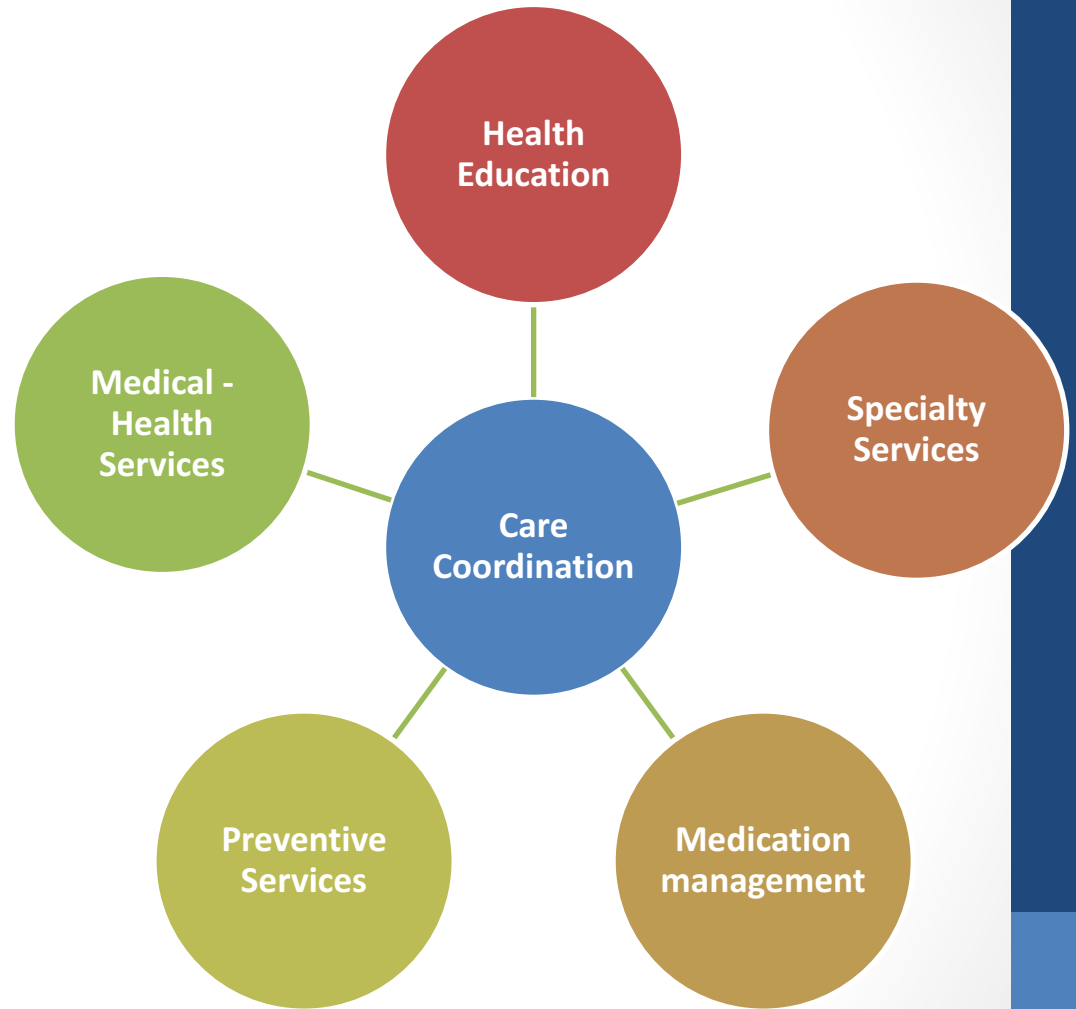
January 1, 2019, the PASSE will take over all above functions.

Responsibilities of PASSE in Phase I

- Ensuring every member has a medical home
- Ensuring each member's multiple plans of care are being met
- Organizing a formal network of providers including independent primary care physicians, independent physician specialists, BH providers, Patient Centered Medical Homes (PCMH), Federally Qualified Health Centers (FQHCs) Rural Health Centers (RHCs), pharmacists, and DD/ID providers
- Ensuring every member receives the medically necessary services in his/her plan of care
- Providing care coordination for every member

Care Coordination

Care Coordination assists adults and children develop person centered plans and facilitates access to needed services across multiple systems. The PASSE will be responsible for coordinating the care of attributed beneficiaries across these multiple systems.



Care Coordination Includes

- Health education and coaching
- Coordination with other healthcare providers for diagnostics, ambulatory care and hospital services
- Assistance with social determinants of health, such as access to healthy food and exercise
- Promotion of activities focused on the health of a patient and their community, including without limitation outreach, quality improvement and patient panel management
- Coordination of community-based management of medication therapy

Phase II

- Beginning January 1, 2019, each PASSE will receive a “global payment” from DHS.
- The Global Payment will be an actuarially sound payment to cover the entire cost of care of all non-excluded services provided to all of the members of a PASSE.
- This calculation will include the cost of providing all services, including but not limited to, DD/ID and BH specialty services, primary care office visits, hospitalizations, personal care services, and pharmaceutical services.
- It includes any services a PASSE offers in addition to the mandatory and optional services covered by Medicaid state plan and applicable waiver services.
- It will include payment for care management and care coordination.
- It will include a reasonable cost to cover administrative expenses.

Responsibilities of PASSE Phase II

- Development of a care plan based on results received from the Independent Assessment
- Development and implementation of conflict free case management
- Sharing timely information and data with affiliated providers, members, and family members as appropriate
- Reporting necessary data to ensure accountability and measure performance
- Centralized administrative functions such as: process claims, network adequacy, member enrollment and support, performance measurement, and development of optional incentive payments to network members

Quality Incentive Pool

- In addition to the Global Payment, each PASSE will be eligible to receive incentive payments under the Quality Incentive Pool.
- Payments from the Pool will be based on outcome measures, not processes, for example medication adherence ratios greater than baseline, reductions in use of emergency room care for Ambulatory Sensitive Conditions, and reductions in inpatient lengths of stay.
- Will be data-driven, therefore, must be measurable and reportable.
- Must be assessed against baseline data.
- Specific to children and adults, in Tier II and Tier III BH and DD/ID

What Services are Covered?

Arkansas Medicaid Mandatory Services

- Hospital Services – Inpatient and Outpatient
- Physician Services
- Laboratory and X-Ray
- Child Health Services Early and Periodic Screening, Diagnosis and Treatment (Under 21)
- Rural Health Clinic
- Nurse Practitioner
- Home Health Services
- Federally Qualified Health Centers
- Family Planning Services and Supplies
- Certified Nurse Midwife Services

Covered Services Continued

Optional Services

There are 38 optional services

- Including behavioral, developmental, home and community-based services for the covered population

Examples include: DDTCS/CHMS, OT, PT or Speech Therapy

- Including specific types of providers, medical supplies and equipment

Examples include: podiatrists, chiropractors, prescription drugs, audiologists, private duty nurses, or durable medical equipment

Which Services are Excluded?

- Nonemergency medical transportation
- Dental benefits
- School-based services provided by school employees
- Skilled nursing facility services
- Assisted living facility services
- Human development center services
- Waiver services provided to adults with physical disabilities through the ARChoices in Homecare program or the AR Independent Choices program

What type of providers will join a PASSE Network?

- **All types.**
- Arkansas Medicaid has more than 47,000 enrolled providers including:
 - Over 9,600 physicians
 - Nearly 3,300 occupational, physical, and speech therapy service providers
 - More than 1,300 attendant care providers
 - Over 900 pharmacies
 - More than 450 hospitals

- **A PASSE WILL NEED ALL OF THESE TYPES OF PROVIDERS AND MORE**

As a provider, what are my options for participation in a PASSE?

- 1. The majority of providers will simply join a PASSE as a participating provider in the PASSE network of providers. Just as in becoming a participating provider for an insurance company, these providers will agree to be paid to deliver a service to a client/patient under the rules established by the PASSE.**
- 2. Some providers may join a PASSE under a shared savings financial arrangement. This higher level of commitment might include receiving value-based incentive payments or shared savings bonuses as well as being paid to provide a direct service.**
- 3. A small number of providers will help form the PASSE itself as equity owners in the PASSE. A PASSE may offer different classes (shares) of equity.**

THE DECISION AS TO HOW YOU WILL PARTICIPATE IS UP TO YOU

Am I limited to the number of PASSE networks in which I can participate?

No.

Much like insurance companies develop networks, each PASSE will develop its networks of providers as well.

A provider will likely want to be a network provider in all PASSEs to ensure that there is a continuum of coverage for the beneficiaries that it serves.

A PASSE will be required operate on a statewide basis and to meet federal and state network adequacy standards. Therefore each PASSE will need a wide and deep pool of providers.

Can I be excluded as a Network Provider?

- **No.** The Arkansas Any Willing Provider protections will apply to the PASSE.
- If the provider is willing to accept the terms of the PASSE, and is a qualified licensed or certified provider of services, the provider cannot be excluded from participation in the PASSE network of providers.

Should I Invest in a PASSE?

- Investing in a PASSE as an equity owner is entirely your decision.
- A PASSE is a private business venture. A return on investment is not guaranteed by any government agency.
- DHS does not require you to invest in a PASSE in order to join a PASSE's provider network.
- If a PASSE requires you to invest in order to join its network, you may wish to consider other PASSEs which do not. How much risk you are willing to take is up to you.
- The equity interest of a provider in a PASSE is not a factor in the DHS attribution methodology.

Am I Required to Join a PASSE Exclusively?

- No. Nothing in the statute or regulations requires you to offer your services exclusively to a single PASSE.
- Exclusivity is a business decision for you to make.

Where do I submit my claims for payment?

- For the remainder of 2017 and calendar year 2018, you will submit all claims through DHS just as you do today.
- In 2019, as the PASSE assumes full risk, claims for Tier II and Tier III clients will be submitted to the PASSE for payment. For Tier I beneficiaries who do not opt to join a PASSE, you will continue submitting claims to DHS.
- Beginning in 2019, the PASSE will no longer be tied to the FFS rates or services; therefore, you will negotiate your rates for services provided to the Tier II and Tier III beneficiaries with the PASSE. This will offer a number of benefits to providers who will no longer be confined to Medicaid FFS rules.

PASSE Applicants

- Contact information:
 - Arkansas Advanced Care
 - USABLE HMO Inc.
 - David Jacobson HDJacobson@arkbluecross.com
 - 320 W Capitol Ave, Ste. 211 Little Rock, AR 72201
 - Arkansas Provider Coalition
 - Amerigroup Partnership Plan LLC
 - David Ivers divers@mitchellblackstock.com
 - 1010 W Third Street Little Rock, AR 72201
 - Arkansas Total Care
 - AR Health and Wellness Health Plan
 - John Ryan jryan@centene.com
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Status of PASSE Applicants

10/9/17

- To become licensed by AID, an entity must meet the financial requirements under Act 775 and demonstrate the ability to establish an adequate medical service delivery network
- No entity has been licensed by AID yet
- 4 of 5 applicants have filed documentation with AID to meet the \$6 million reserve requirement and \$250,000 surety bond
- AID delegated the authority to determine the ability to establish an adequate medical service delivery network to DHS. DHS “mapped” the 5 required provider types (DD service provider, BH service provider, hospital, physician, pharmacist) submitted by the PASSE applicants to assess whether each provider type is accessible within a 60 mile radius
- No entity met the network adequacy requirements on the first round of network mapping
- PASSE applicants have the opportunity to update their provider networks every month.
- Updating provider networks serves 2 purposes—first to determine network adequacy.
- Second, once a PASSE is licensed, the provider network will be used to match a client to his/her providers to determine whether there is a strong relationship between a Medicaid beneficiary and providers. DHS will then “attribute” the members to each licensed PASSE. The DHS attribution methodology is weighted toward DD and BH specialty providers.
- If a Medicaid beneficiary is not satisfied with the PASSE, he/she may switch to another PASSE within 90 days.
- Each PASSE must continuously maintain an adequate network of all types of providers.

PASSE Applicants Licensure Timeline

- For the 5 PASSE applicants there is no “final” deadline for a PASSE to become licensed in state fiscal year 2018.
- However, DHS will attribute Medicaid beneficiaries only to licensed PASSEs.
- Approximately one-third of the current beneficiaries will be attributed based on provider networks submitted by January 15, 2018.
- Licensed PASSEs will be responsible for care coordination of its members beginning February 1, 2018.
- Approximately 60 percent of the current beneficiaries will be attributed based on provider networks submitted by March 15, 2018.
- Beginning April 1, 2018 each PASSE must be prepared to demonstrate its readiness “for provision of healthcare services ...” which will be based on its network of providers which are enrolled as Medicaid providers.

Questions? Contact Information

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