AR Organized Care Model

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Why System Reform

- Analysis of 2015 data showed 74% of traditional Medicaid claims were for the aged, blind, disabled population with claims falling heavily under institutional care categories and services to high risk populations and included additional medical costs
- Key health value improvement programs (PCMH and Episodes of Care) did not address the costs incurred by the population
- Institutional care accounted for 1/3 of total developmental disabilities claims
- Over 2,900 people who were on waiver waitlist for I/DD services and this accounts for $32 million in Medicaid costs for 2,640
- 96% of spending for individuals receiving I/DD services was supportive living
- The mental health system was highly siloed and fragmented and dually diagnosed clients were not receiving appropriate services in either system

Total I/DD and BH Populations and Expenditures 2016

Enrollee Groups	Estimated Total Enrollees	Total Cost	DD/BH Costs	Halo Costs
Individuals with Intellectual/ Developmental Disabilities	55,145	$1,010,560,947	$641,131,157	$369,429,790
Behavioral Health	101,718	$1,128,833,459	$452,094,539	$676,738,920
Total	156,863	$2,139,394,405	$1,093,225,696	$1,046,168,710

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

Stakeholder Engagement Model Development Stage

- The Legislative Task Force on Health Care Reform was formed through Arkansas Health Reform Act of 2015 to recommend an alternative healthcare coverage model
- The Task Force utilized a consulting group that brought together members of the task force with specialty providers, DHS staff members, beneficiaries, family members and other stakeholders to review strategies
- Findings for I/DD population included program expenditures concentrated in:
  - Human Development Centers Alternative Community Services Waiver and Developmental Day Treatment Clinic and Child Health Management Services programs
  - Lack of independent assessment and authorization for OT, PT, and SL services
  - Current waiver plans of care and cost were not based on need for services derived from an independent assessment
  - Case management was not independent from the waiver services providers

Stakeholder Engagement Model Development Stage

- Task Force recommendations included a three tier based waiver:
  - Essential Family Supports when a person choses to live at home with their families
  - Essential Supports for Employment and Independent Living when a person chooses to live independently in the community and wishes to be employed
  - Comprehensive Supports for Employment and Community Living when a person requires more complex services
  - Use of an independent assessment to determine person's tier of care
  - A comprehensive approach that provides care management and coordination to all behavioral health and non-institutional I/DD populations
  - Selection of a model to integrate and coordinate the care of all instead of continuing the siloed approach to care

Provider-led Arkansas Shared Savings Entity (PASSE)

- The Provider-Owned Arkansas Shared Savings Entity (PASSE) is a new model of organized care created by Act 775
- AR service providers entered into new partnerships with each other and an experienced organization that performs the administrative functions similar to insurance companies such as claims processing, member enrollment, and grievances and appeals
- Providers retain majority ownership (at least 51%)of each PASSE
- The governing body of each PASSE must include several types of providers including:
  - Developmentally Disabled Specialty Provider,
  - Behavioral Health Specialty Provider
  - Hospital
  - Physician
  - Pharmacist

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PASSE

- The PASSE is regulated by the Arkansas Insurance Department (AID) as a risk-based provider organization and also accountable to the Department of Human Services (DHS) under federal rules that provide protections for Medicaid beneficiaries
- Each PASSE is required to cover the entire state
- Five PASSEs were formed, licensed and passed readiness review but only four PASSEs signed the provider agreement and began providing services
- The PASSE program has two 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–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

PASSE Phase I

- Independent Assessment (IA)vendor was procured and contract awarded to Optum
- The MN Choices assessment tool was implemented for three specialty populations to assess functional needs and support development of person centered service plans
- Logic model for each population developed to place beneficiaries in three tiers
- IA used to determine eligibility for PASSE for behavioral health clients and to determine level of need for I/DD clients
- Attribution to a PASSE based on a provider relationship score established through review of beneficiary paid claims
- Once attributed to PASSE a PASSE employed care coordinator is assigned
- PASSE received per member per month prospective payment for care coordination services

PASSE 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

Services Available in Phase II

CES Waiver Services

- DD Waiver Services
- CES Supported Employment
- Supportive Living
- Caregiver Respite
- Adaptive Equipment
- Community Transition Services
- Consultation
- Crisis Intervention
- Environmental Modifications
- Supplemental Support
- Specialized Medical Supplies

1915(i)HCBS Services

- Behavioral Assistance
- Adult Rehabilitative Day Services
- Peer Support
- Family Support Partners
- Supportive Life Skills Development
- Child and Youth Support Services
- Supportive Employment
- Supportive Housing
- Partial Hospitalization
- Mobile Crisis Intervention
- Therapeutic Host Home
- Therapeutic Communities
- Residential Community Reintegration
- Planned and Emergency Respite Services

Stakeholder Engagement Implementation

- Facebook Live presentation targeted to beneficiaries
- Medicaid Saves Lives AR Facebook page with host traveling AR to explain changes to family groups
- Town Hall meetings to present changes and answer questions and concerns
- Webinar series for service providers and PASSEs
- Consumer Advocacy Councils required for each PASSE
- Weekly PASSE meetings with workgroups that include service provider PASSE membership

Successes

- Population does not have to be integrated into existing Managed Care delivery model it was built for the high needs population
- The organized care model requires ownership and leadership from specialty population provider community
- Use of a phased in approach beginning with PCCM care coordination to move beneficiaries from existing programs to PASSEs
- Use of phased in approach in independently assessing beneficiaries and attributing to PASSE
- Beneficiaries have 90 days to choose a different PASSE and an open enrollment period used early in Phase II
- Identification and development of services for dually diagnosed I/DD and BH population

Challenges

- Tight timelines for Independent Assessment process and PASSE phase I
- Dividing the I/DD and BH populations out form other populations and high needs population from lower needs population
- Multiple transformation efforts across all specialty populations
- Lack of service provider understanding of new system generating fear and spread misinformation