

Looking into the PASSE

Provider led Arkansas Shared Savings Entity

An unique alternative to traditional managed care for clients with developmental disabilities and behavioral health needs

Arkansas Department of Human Services

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Why System Transformation

- 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

Why System Transformation

- ▶ Need for new home and community based services (HCBS)
- ▶ Use of Behavioral Health (BH) services to fill HCBS gap
- ▶ Rising cost of care without improved service outcomes
- ▶ No coordination of care for specialty populations with high needs
- ▶ Lack of primary care access for those with high needs
- ▶ Lack of access to quality services
- ▶ Specialty service providers reluctance to accept difficult clients
- ▶ A fragmented and siloed approach to clients who are dually diagnosed with IDD and behavioral health needs
- ▶ The high utilization of one on one direct staff for IDD clients

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 |

Organized Care—A Hybrid Approach

- ▶ AR General Assembly Health Care Task Force (HCTF) considered competing proposals—traditional managed care and TPA—but could not get consensus
- ▶ Fall of 2016 DHS developed “third way” of organized care
- ▶ Stakeholder input and development over several months through webinars with live and online participation
- ▶ DHS studied other state models around regional care coordination organizations, evolved into statewide
- ▶ No RFP—allowed for multiple qualified entities
- ▶ Act 775 passed March 2017—market-based rather than protectionist policies
- ▶ “Hands off approach” to formation of PASSEs—our motto: pick your partners wisely!!
- ▶ Generates savings two year sooner than anticipated

System Transformation—Internal and External

- ▶ Overhaul of a 30 year old BH FFS (fend for self) system
- ▶ DHS had to re-organize itself
- ▶ Team approach
 - ▶ Simultaneous with Independent Assessment across populations
 - ▶ BH Transformation
 - ▶ DD Transformation
- ▶ Hired outside national experts to guide, but not “outsourced”
- ▶ Allowed DHS staff who know the AR landscape develop and direct the new model

AR Organized Care Model- Collaboration at Every Level

- ▶ The Provider-led Arkansas Shared Savings Entity (PASSE) is the model of organized care created by Arkansas law
- ▶ Arkansas Medicaid providers entered into new partnerships with each other and with experienced organizations who perform administrative managed care functions such as claims processing, member enrollment and appeals
- ▶ Arkansas Medicaid providers retain majority ownership of at least 51%
- ▶ Each PASSE is regulated by the Arkansas Insurance Department (AID) as a risk-based provider organization and is accountable to DHS under the federal rules that provide protections for Medicaid beneficiaries
- ▶ Five (5) PASSEs were initially formed, licensed and the first readiness review but only four (4) signed the provider agreement and were included in attribution
- ▶ Each PASSE must contain a governing body that includes:
 - ▶ A developmentally disabled specialty provider
 - ▶ A behavioral health specialty provider
 - ▶ A hospital
 - ▶ A Physician
 - ▶ A Pharmacist

The AR Independent Assessment (ARIA)

- ▶ Arkansas procured and has a current contract with Optum to perform independent assessments for various specialty populations including IDD and BH beneficiaries
- ▶ Optum utilizes an Arkansas tailored tool called MN Choices
- ▶ The tool assesses the beneficiaries functional ability rather than diagnosis
- ▶ The tool utilizes branching logic to place beneficiaries into tiers

One ARIA Multiple Uses

- ▶ For the BH population the tool determines eligibility to the PASSE as well as the tier
- ▶ For the DD population the tool determines the tier only because all IDD beneficiaries referred for the IA have already met Institutional Level of Care
- ▶ Results of the IA are used to develop a Person Centered Service Plan (PCSP)
- ▶ For both populations Tier results are linked to a rate cell
- ▶ Unintended but fortunate use-uncovering service overlaps and gaps

Client centered attribution methodology

- ▶ The attribution methodology is currently weighted to attribute IDD and BH beneficiaries based upon utilization of their specialty provider
- ▶ The methodology was designed with the intent of minimizing service disruption
- ▶ The order of referrals to the Independent Assessment vendor intentional waiting to last to assess current IDD clients on the Community and Employment Supports 1915c waiver due to the transition in care coordination
- ▶ The beneficiary (now member) has 90 days to change PASSEs

PASSE Phased in Approach

- ▶ 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
 - ▶ Gives PASSEs experience with members without full risk
 - ▶ DHS provides PASSEs with claims data on their members
 - ▶ Initial payment to PASSEs for member intake
 - ▶ Monthly payment for care coordination
 - ▶ 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

Care Coordination as the Foundation

Advantages of a Phased in Approach

- ▶ “Provider-led” becomes “person-centered”
- ▶ Training and educating care coordinators on critical role of Person Centered Service Plan (PCSP)
- ▶ PASSEs accountable for PCSP
- ▶ Monthly attribution building to total not entire population at once
- ▶ Beneficiary Support Center developed at DMS to assist with transitions and complaints
- ▶ DHS working together to transition beneficiaries and providers to new system-
coordination starts at home

Phase II: Full Risk

- ▶ On January 1, 2019, PASSEs will switch from a Primary Care Case Management (PCCM) model to a full risk-based model
- ▶ DHS seeking authority from the Centers for Medicare & Medicaid Services (CMS) under §§ 1915(b)(4), 1915(c), and 1915(i) state plan authorities
 - ▶ §1915(b)(4) provides authority for mandatory enrollment into the PASSEs
 - ▶ §1915 (c) provides existing authority for providing home and community-based services for individuals with developmental disabilities
 - ▶ §1915(i) provides authority to target new services to certain individuals with the highest needs of BH services and to individuals who are dually diagnosed (behavioral health/developmental disability). These services will be available only through the PASSEs
- ▶ DHS contracted with Milliman to provide actuarial services to support the waivers (actuarially sound rates and waiver cost effectiveness)

HCBS Services Adding the (i)

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

HCBS and LTSS Services

- ▶ Creation of new provider types using PASSEs for credentialing
- ▶ Right services for needs of a dually diagnosed population
- ▶ Rescuing people that have fallen through the cracks
- ▶ Utilizing a rural state workforce
- ▶ Creating access to needed services
- ▶ Motivating providers to offer the services that people need not the ones that are easiest to provide-an opportunity to document and get paid for what you actually do!

PASSE Sub-populations

- ▶ Children and families involved in the child welfare system
- ▶ Youth involved in the juvenile justice system
- ▶ Adults entering the AR State Hospital
- ▶ BH clients accessing care in hospital settings only

Phase II: Full Risk

- ▶ “Risk corridor” strategy guaranteeing a level of savings in 2019 compared to Medicaid baseline
- ▶ PASSEs will keep a share of savings they create by holding spending below the baseline
- ▶ MLR will be required to be calculated for insurance purposes but we will not set threshold in 2019
- ▶ Benefit Expenditure Report (BER) required and used to calculate shared saving and create rates for 2020
- ▶ PASSEs can count up to 5% of the cost of “community investments” as benefit expenditures

Expectations for PASSE Model

- ▶ Development of new provider types and specialization
- ▶ Freeing beneficiaries caught in the paper trap
- ▶ Creative new services and service delivery
- ▶ Increased service collaboration at community level for PASSE builds infrastructure for others to use
- ▶ Get out of the Medicaid “black box”
- ▶ Demonstrate the value of truly organized and integrated care; uncoordinated sector silos that are merely consolidated on paper should not be confused with the true target of reform
- ▶ Affirm the proposition that cost of health care is not the fundamental issue of concern (Medicaid *already* provides low reimbursement rates for community-based care); efforts aimed at the excess cost (over-utilization, over-use of institution-based care, under-utilization, fragmentation among medical and nonmedical services and supports) will yield greatest results.

Next Steps

- ▶ Beginning July 1, 2019, individuals with BH or IDD identified as Tier 1 will be allowed to enroll in a PASSE
- ▶ Use of the premium tax to reduce the Community and Employment Supports 1915c waiver waiting list
- ▶ Design and implementation of a dually diagnosed independent assessment tool
- ▶ In calendar year 2020, DHS anticipates adding quality measures into the auto-assignment process. PASSEs that do not meet quality measures will be barred from auto-assignment

Questions and Contact Information

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