

TRANSFORMING MEDICAID IN ARKANSAS: AN EARLY LOOK AT THE PASSE PROGRAM



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KEY TAKEAWAYS

Arkansas has a new Medicaid managed care program called the Provider-Led Shared Savings Entities (PASSE) model. Created by the Legislature in 2017, it's designed to coordinate health care services for Behavioral Health and Intellectual/Developmental Disability beneficiaries.

Many hope this program will help address the challenges of providing high-quality care to individuals with the most intensive medical needs, while also reducing the high cost of care in Medicaid.

It's still in the early stages, and we've seen mixed results so far. There have been several positive changes to the health care system, such as care coordination and access to home- and community-based services previously not covered by Medicaid. However, consumers and providers have noted many concerns with the independent assessment process, communication problems, and the short implementation timeline.

The state should improve the PASSE model by changing the assessment process, communication processes, considering additional funding opportunities, and extending the implementation timeline. These measures will help to ensure there are no gaps in health care coverage for beneficiaries and increase the likelihood of successfully implementing this model in Arkansas.



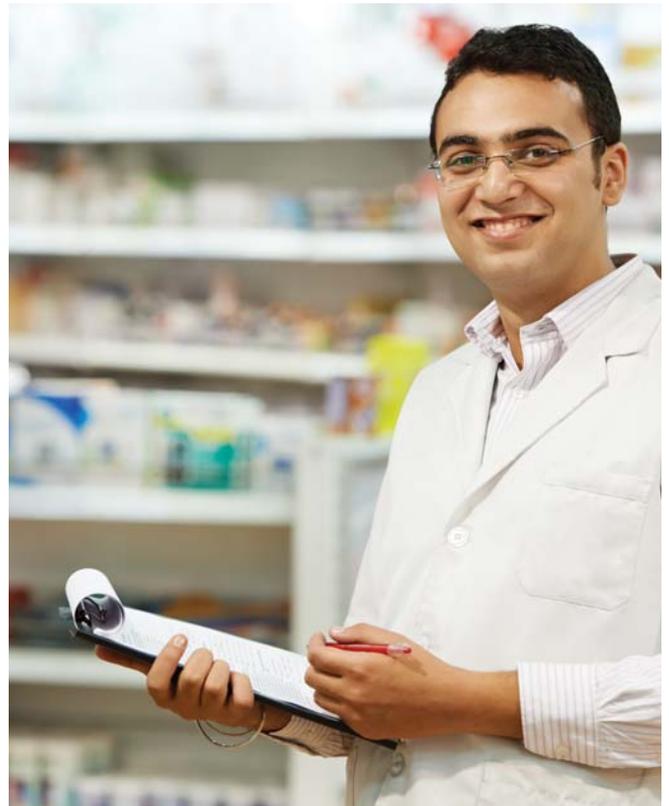
INTRODUCTION

Many of the recent changes to the Arkansas health care system, like the state's Medicaid expansion program and the addition of work-reporting requirements in the Medicaid program, have received local and national attention. Yet, there is another major change underway that has not received much media coverage or public scrutiny: the rollout of a managed care model for beneficiaries receiving behavioral health and intellectual/developmental disability (IDD) services. In 2017, Arkansas lawmakers passed Act 775. This new law creates a managed care model known as the Provider-Led Shared Savings Entities (PASSE) model, which focuses on the delivery of physical health, behavioral health and specialized home- and community-based services for Medicaid enrollees. The PASSE model organizes these services by having local health care providers join their network. PASSE in turn provides the administrative functions necessary to support providers and coordinate care for beneficiaries.

Arkansas's program is different from most traditional third-party managed care organizations because the PASSE model requires at least 51 percent ownership by local health care providers. The legislation also defines a qualified provider as any of the following:

- A certified developmental disability or behavioral health provider
- An Arkansas licensed hospital or hospital services organization
- A licensed physician practice
- Any pharmacist licensed by the Arkansas State Board of Pharmacy¹

Arkansas has changed how behavioral health and intellectual/developmental disability services are managed under Medicaid.



The PASSE program will be implemented in two phases. Arkansas is currently in phase one. During this phase, beneficiaries will receive an assessment, the PASSE will complete “readiness” activities, and the program will be responsible for providing beneficiaries with care coordination. During phase two, each PASSE provider will be responsible for coordinating all health care services for each beneficiary assigned to them. The providers will receive a capped payment for each beneficiary, called a capitated global payment, to cover the costs of care and care coordination. A capitated global payment covers the cost of each beneficiary on a monthly basis, known as a per-member-per-month payment. The PASSEs will take on the financial risk of ensuring the needed care is provided within the global payment budget, so if a beneficiary's costs are higher than the payment amount, the PASSE is responsible for covering it.

Phase two was scheduled to begin in January 2019, but the state recently announced that the open enrollment for beneficiaries to join a PASSE will occur in March 2019. This is the first managed care model of this type to be established in Arkansas's Medicaid program. Also, the move to implement managed care first for the populations with the most intensive Medicaid needs is unlike other Medicaid managed care models. This report will take a closer look at how the state came to develop the PASSE model in Arkansas.

CREATION OF PASSE MODEL

Concerns from families, state agency leaders and lawmakers signaled the need for changes to the behavioral health and IDD health care systems in Arkansas. These concerns included a lack of care coordination, minimal provider state oversight, and a list of services and supports for families that had not been updated for many years. These and other challenges led to Governor Asa Hutchinson forming the Arkansas Health Reform Legislative Task Force in 2015. The Governor gave them a goal of curbing Medicaid costs by \$835 million over a five-year span. Since the behavioral health and IDD systems needed drastic reforms, finding a way to bring down costs and improve services for these beneficiaries was a priority.

After meeting for over a year, the Task Force released a report with recommendations to modernize Arkansas Medicaid. Two models emerged about how to change care delivery – a traditional managed care model and a model called “Diamond Care.” The managed care model would require contracting with an organization that would receive a per-member-per-month payment to handle all the behavioral health and IDD services associated with

Medicaid. The plan also included the provision of care coordination. Alternatively, several lawmakers introduced Diamond Care. This plan used many of the same features, but with one key difference. Diamond Care would use an administrative service organization instead of a managed care organization. The administrative service organization would handle the functions of Medicaid while providers would still bill claims on a fee-for-service basis.² Diamond Care supporters were against the managed care plan for fear that it would lead to cutting essential services for beneficiaries. Those in favor of traditional managed care did not believe the administrative service model could bring down costs.

The Task Force worked with the consulting firm The Stephen Group, which developed the initial report with recommendations, to evaluate both plans. Eventually the PASSE model emerged, which was a hybrid of the key features in Diamond Care and the traditional managed care plan. Since the legislature passed the Medicaid Provider-Led Organized Care Act in 2017, four PASSEs have been established throughout the state. They are the Arkansas Provider Coalition, Arkansas Total Care, Forevercare and Empower Healthcare Solutions.



DESCRIPTION OF THE PASSE MODEL

The PASSE model includes many complex features. Several key features are described in the next section: the independent assessment, communication systems, and funding mechanisms.

INDEPENDENT ASSESSMENTS

Each PASSE must provide a comprehensive set of services for behavioral health and IDD beneficiaries. To do this, the PASSE model uses an independent assessment to estimate the level of care for selected beneficiaries. The assessments are “independent” since the assessor collecting information is not employed by the health providers who will deliver the services. The purpose of the independent assessment is to ensure the assessors interview clients in a neutral manner and to remove any financial incentive to recommend higher costs or unnecessary services. The results of the independent assessment are used to create a patient-centered service plan, which is a personalized health care plan to meet

each beneficiary’s needs. The state selected the MN Choices functional assessment tool. It is an altered version of the assessment tool for developmental disability screening and long-term services used by the Minnesota Department of Human Services.

Assessors receive both in-person and web-based training. The independent assessment process works in three parts. First, the state Division of Behavioral Health Services and the Division of Developmental Disability Services identify individuals in need of an independent assessment and give their contact information to the assessors (the state contracted with a company to conduct the assessments). Second, the assessor contacts the beneficiary to set up an appointment. Assessors complete the assessment and enter the results into a computer program. Finally, the computer program uses an algorithm to determine the level of care that’s appropriate for that beneficiary.³ The algorithm may place the beneficiary in one of three tiers, or levels of care. Beneficiaries in tiers 2 and 3 will automatically receive services through a PASSE. A detailed description of each tier is outlined in the figure below.

DIVISION-SPECIFIC TIERS OF SERVICE

Division of Behavioral Health Services

TIER 1	Time-limited behavioral health services provided by a qualified licensed practitioner in an outpatient-based setting for assessing and treating mental health and/or substance abuse conditions. Tier 1 service settings are a behavioral health clinic/office, healthcare center, physician office and/or school.
TIER 2	At this level of need, services are provided in a Tier 1 service setting, but the level of need requires a broader array of services.
TIER 3	Eligibility for this level of need will be identified by additional criteria, which could lead to inpatient admission or residential placement.

Division of Developmental Disabilities Services

TIER 1	Individual receives services in a center-based clinic such as Developmental Day Treatment Clinic Services or Child Health Management Services or successor program; or receives services such as personal care, occupational therapy, physical therapy, or speech therapy due to the developmental disability or delay.
TIER 2	The individual meets the institutional level of care criteria but does not currently require 24 hours a day of paid support and services to maintain his or her current placement.
TIER 3	The individual meets the institutional level of care criteria and does require 24 hours a day of paid support and services to maintain his or her current placement.

Source: PASSE Independent Assessment Guide, Arkansas Department of Human Services, https://medicaid.mmis.arkansas.gov/Download/general/programs/PASSE_IAGuide.doc

For this report, we interviewed stakeholders to get their perspectives on the independent assessment process. Consumers, PASSEs and state agencies express several concerns about independent assessments:

- Assessments started months later than expected. Thus, PASSEs were assigned to many beneficiaries in May and June rather than over the course of several months.
- Discrepancies in the quality and objectivity of assessors was a consistent issue. Consumers and providers noted that some assessors are unable to carry out a neutral assessment or lack the necessary training to understand how to use the MN Choices tool.
- It was difficult to reach beneficiaries and set up appointments in their homes. This led to DHS embedding assessors in physician clinics to assess behavioral health beneficiaries. Yet, many assessors still refuse to meet individuals outside of their homes, which could be a result of poor assessor training about client rights and the assessment process.
- Consumers have not had enough time to learn about the new system. DHS receives many calls from consumers who think the calls from the assessors are scams or they are unsure how to navigate the PASSEs.
- Consumers and health care advocates also criticize the assessment tool and algorithm used to determine a beneficiary's tier level. Some

consumers have sought appeals of their tier placements because they felt it was incorrect. Also, individuals questioned the validity of the MN Choices assessment tool for evaluating both behavioral health and IDD beneficiaries. Additionally, the MN Choices tool is quite lengthy, with up to 400 questions for a beneficiary to answer.

Since the services offered to the behavioral health and IDD groups affect the quality of everyday life, addressing these issues with the independent assessment process should be a high priority for the state.

There are some lessons that can be applied in Arkansas based on a similar independent assessment process in New York. The New York State Medicaid Program assesses behavioral health beneficiaries and provides services in a process like the PASSE model. However, there are several notable differences. The state of New York requires assessors to have more educational and professional qualifications. Assessors undergo rigorous training with mandated supervision before administering the assessment tool. The state also created the New York State Community Mental Health Assessment Tool specifically for the behavioral health population. The use of an assessment created specifically for the mental health community aligns with the independent assessment tool recommendations in the Stephen Group report to the Arkansas Health Reform Legislative Task Force.⁴



COMMUNICATION SYSTEMS

The PASSE model requires constant communication between state agencies, PASSEs and consumers. Good communication ensures the organization of coordinated health care for beneficiaries.

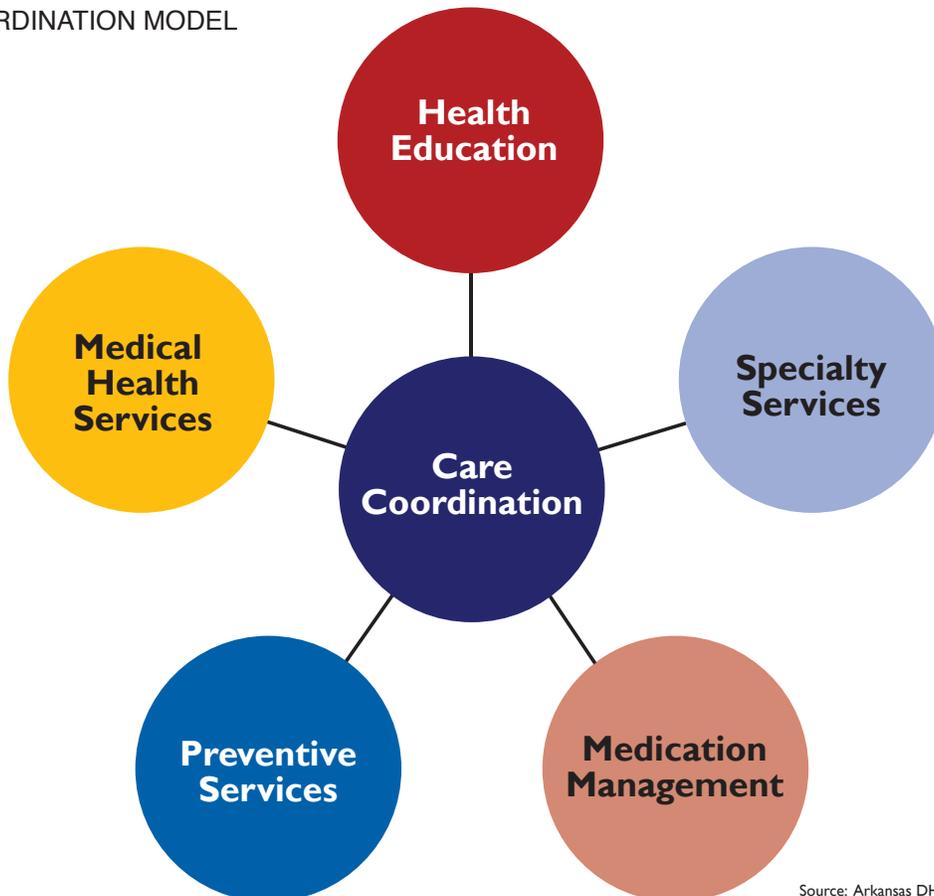
Communication in the PASSE model starts from the top with DHS. DHS carries out readiness reviews and produces provider/consumer manuals. The readiness review involves DHS evaluating the technological and administrative capabilities of each PASSE to ensure they can provide care coordination, collect data and deliver health care services. These procedures ensure the PASSEs can also collect and share information across providers in the network. Additionally, DHS offers the PASSEs the following support:

- Training on care coordination and provider networks
- Ongoing planning for the global payments coming with phase two
- Conferences and educational webinars aimed at providers and consumers

During the interview, providers and consumers expressed appreciation for the efforts from DHS, but the PASSE implementation's tight timeframe has come with many obstacles. For example, in response to concerns from PASSEs and providers, DHS implemented weekly workgroup meetings on care coordination, provider networks, technological issues and operations. While a welcomed solution, this approach came only months away from when the PASSEs will be taking on the full financial risk for each beneficiary. Also, it's important to note that the company contracted by the state has not set the global payment rates (they were expected during the summer of 2018, which must be set before the state begins phase two).

Each PASSE needs to communicate with consumers to provide quality care coordination. Once a tier 2 or 3 beneficiary is assessed and assigned to a PASSE, their designated PASSE care coordinator works with them to ensure that they receive the appropriate services and supports. These services include health education and coaching, coordination with health care providers, promotion of activities focused on healthy living, and management of community-based medication therapy.⁵

PASSE CARE COORDINATION MODEL



Source: Arkansas DHS Slides, "PASSE-PHASE II," May 2018

While care coordination was already available as a developmental disability service, this system is a huge change for individuals receiving behavioral health services. In the new PASSE system, the state has also created new services that were not previously covered by Medicaid, such as peer support. The care coordinators are a vital part of this system because they ensure there are no gaps in health care for beneficiaries. This is also why it's so important to have a reliable communication process for consumers and providers to offer feedback about these services. Each PASSE must also include a Consumer Advisory Council as required in the state legislation, which was added after advocates pushed for this change. The council must hear and address the concerns consumers have with their individual PASSE. Based on interviews, some providers and consumers expressed concerns about the qualifications of the care coordinators and frustration with how they managed services for their clients.

FUNDING MECHANISMS

DHS created the PASSE program through a combination of federal Medicaid waivers.⁶ These waivers allowed Arkansas to create a managed care system that includes home- and community-based services. Under these waivers, the services are paid for using the traditional Medicaid match rate. The federal government pays for 70 percent of Medicaid services and 50 percent of administrative services, while the state funds the rest. PASSEs receive Medicaid funds for administrative services in phase one, and physicians continue to be reimbursed under the existing fee-for-service system. This will change with phase two. In phase two, each PASSE receives a member monthly global payment, which is capped, to pay for all the Medicaid-covered services a beneficiary receives. Upholding the patient bill of rights, PASSEs must meet quality metrics. PASSEs receive monetary incentives or penalties based on meeting these quality metrics. This method of funding Medicaid services is new to Arkansas, but many other states use a variety of different managed care models, as detailed in the next section.



HOW PASSE COMPARES TO OTHER MANAGED CARE MODELS

COMMON FEATURES	TRADITIONAL MANAGED CARE (MCO)	ACCOUNTABLE CARE ORGANIZATION (ACO)	HEALTH HOMES (HH)	PASSE MODEL
STATE EXAMPLE	Tennessee	Oregon and Colorado	Missouri	Arkansas
FINANCIAL RISK	Yes	Yes	State Decides	Yes
INDEPENDENT ASSESSMENT	No	No	Yes	Yes
CARE COORDINATION	Yes	Yes	Yes	Yes
ADDITIONAL FEDERAL FUNDING PROVIDED	No	No	Yes	No
BENEFICIARIES RESTRICTED TO PROVIDERS IN NETWORK	Yes	No	No	Decided on a case-by-case basis



TRADITIONAL MANAGED CARE

In a traditional managed care model, a state negotiates a health care contract with a managed care organization. The organization receives a capitated payment plan and provides full Medicaid benefits to beneficiaries. As stated earlier, the PASSE model differs from traditional managed care since the PASSE must have at least 51 percent local provider ownership. Also, states implementing managed care have the option to contract with national or local MCOs to handle health care plans. TennCare, Tennessee’s Medicaid managed care program, is a traditional managed care model that contracts with three different organizations that are both national and local. TennCare covers all groups of Medicaid recipients, including children eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. In 1998, the *John B. v Menke* lawsuit established carelessness in the TennCare system’s ability to uphold the federal Medicaid requirements of comprehensive care for EPSDT recipients and adequate outreach. In response, TennCare established specific standards and outreach programs to prevent any unlawful cutting of services for beneficiaries.⁷ Because of the changes to TennCare, it is highlighted as the standard for providing high-risk beneficiaries with services through a managed care model. Also, federal Medicaid rules require state Medicaid agencies to identify quality metrics for contracted organizations and make the results regarding their performance public.⁸

ACCOUNTABLE CARE ORGANIZATIONS

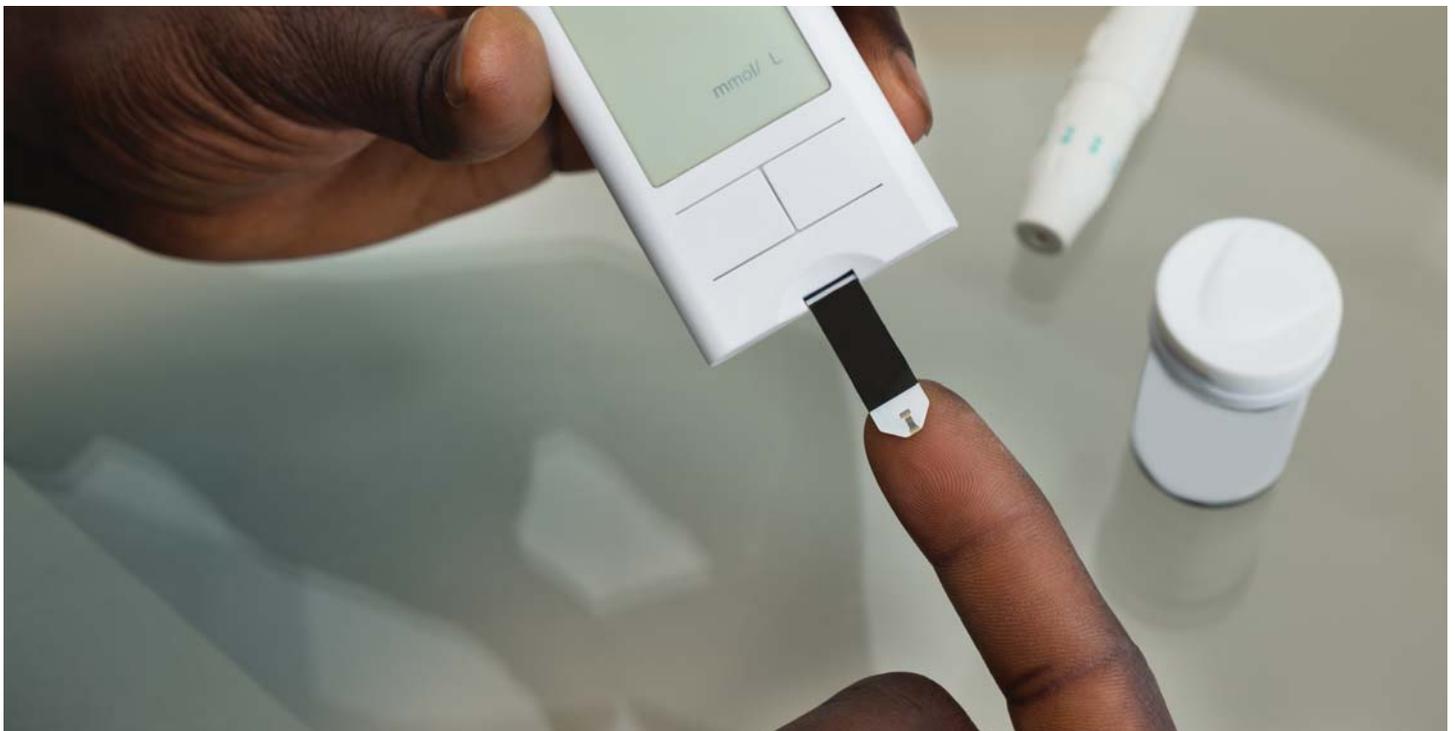
An Accountable Care Organization is a group of health care providers or regional entities that work with other providers to care for a beneficiary group. Many of these organizations use a shared-savings model to incentivize providers. In this model, they receive extra funds for meeting quality metrics. Some shared-savings models institute a penalty for lower-than-average quality measures. Unlike a managed care organization, an accountable care organization has local providers and entities form the organization. Also, members of these organizations can choose providers outside of their network. In fact, the programs in Oregon and Colorado influenced the creation of Arkansas's PASSE model.

Oregon's Coordinated Care Organizations program launched in August 2012. It addresses the needs of mental health beneficiaries. Under the approved federal waiver, the program uses the shared-savings partnership of local health care providers, community members and other components of the health care system. The organizations can coordinate and provide total care for beneficiaries through this model.⁹ Colorado's Regional Care Collaborative Organizations are part of Colorado's Accountable Care Collaborative. The organizations provide Medicaid beneficiaries with care coordination and community services. The Accountable Care Collaborative program reported an estimated net savings of \$77 million for Colorado Medicaid in 2015.¹⁰

HEALTH HOMES

Created under the Affordable Care Act, Health Homes provide home and community-based services for Medicaid enrollees with chronic conditions. A Health Home is a group of providers who coordinate all aspects of beneficiary care. Patients with either a mental health condition, substance use disorder, asthma, diabetes, heart disease or obesity qualify for Health Homes. These are the only specific conditions listed by the program. Yet, states have the flexibility to propose other chronic condition groups in their state plan amendment.

States implementing Health Homes are eligible for enhanced federal dollars. Each Health Home created by a state receives a federal match of 90 percent for the first two years, or eight quarters, of the program. The Health Home model allows states to choose how to pay and contract Health Home services on a state-wide basis.¹¹ Due to these incentives, many Arkansas stakeholders and state agencies pursued this model as part of the Legislative Task Force's deliberations. The Stephen Group cited Missouri's Health Home program in their 2016 report. The program promotes care coordination between primary care physicians and mental health providers.¹² The Missouri Health Home and PASSE model share goals. Both aim to reduce inpatient and ER services and support beneficiary transitions from institutional to community care. Missouri's commitment to quality and coordinated care saved the state a net \$38 million, surpassing the state's initial goal to save roughly \$21 million.¹³



RECOMMENDATIONS

As the state continues to roll out this unique model for delivering care to the most vulnerable Arkansans, there are several opportunities to ensure a more successful implementation and ensure people don't lose critical services. Several recommendations are outlined below.

1. Improve assessor and care coordinator training.

Properly training assessors and care coordinators is a top priority because this is the first opportunity to ensure behavioral health or IDD beneficiaries receive quality services. Thus, it is important that the state provide adequate and consistent training. Reviewing the training process for opportunities to strengthen it would specifically focus on what can be done to avoid inappropriate tier assignments, better organize services, and improve beneficiary knowledge about the entire process. Additionally, assessor and care coordinator qualifications may need to be enhanced. Arkansas should consider the requirements and training for assessors in New York's mental health program. Assessors must have extensive experience working with the behavioral health population and undergo thorough training on how to use the assessment tool.

2. Implement distinct assessment tools for the behavioral health and IDD groups. DHS should use assessment tools specific to each of the PASSE populations. Many consumers and providers expressed concerns that the current tool is all-encompassing and does not produce proper assessment results. The Stephen Group made several recommendations in their reports to the Legislative Task Force, including: The Supports Intensity Scale for IDD services, Level of Care Utilization System for behavioral health services for adults, and the Children and Adolescent Needs and Strengths assessment for youth behavioral health services. These assessment tools are widely used in several states.

3. Increased transparency regarding the algorithm.

Due to the large number of questions about tier placement decisions, the state should be very transparent with consumers and providers about the algorithm used to determine tier placements. This high level of transparency is critical to ensure beneficiaries are getting the services they need. A flawed algorithm will result in gaps in services. If the state hopes to succeed in providing the services behavioral health and IDD beneficiaries need, the algorithm must be adaptable based on feedback from beneficiaries, their families and health care providers.



4. Improve communication with PASSEs, providers and consumers. While some improvements have been made, such as regular work group meetings, more steps should be taken to continue to ensure DHS and the PASSEs share information and data. This will be especially important once the PASSEs begin receiving monthly global payments. Also, DHS should consider ways to better educate consumers. Some educational material and manuals exist, but consumers say that these are dense and lengthy documents. However, the DHS webinars and social media posts from consumer coalitions appear to be helpful resources. DHS may consider improved social media outreach and video messages.

5. Further extend the timeline to implement the PASSE model. Many of the major concerns in phase one, like delayed assessments, communication problems, misinformed providers and consumers, and lack of per-patient monthly rates, resulted from the PASSE model's quick implementation. Educating providers and consumers, setting up provider networks, collecting data and distributing the necessary documents/materials requires more time to set up. The state should consider again changing the date for PASSEs to become full risk-based organizations. The added time will increase the chances of a successful transition to phase two and allow more time for important activities like producing educational materials.



6. Reconsider the Health Homes model. The state should consider seeking the necessary federal permission to classify the PASSE model as a Health Home. Arkansas Advocates for Children and Families and some lawmakers made this recommendation to the Legislative Task Force for many reasons. Arkansas would be eligible for the Health Home planning support funds of up to \$500,000. Also, the enhanced federal match – 90 percent – available to Health Homes for eight quarters applies to existing state programs.¹⁴ By doing so, Arkansas could improve the effectiveness of the PASSE program without increasing costs to the state. The PASSE model already includes the required Health Home features, and the state could reduce spending.

7. Make consumers the primary focus, not the cost savings. The state should approach the PASSE model with the intention to provide excellent care coordination and services for Arkansans who need behavioral health and IDD services. The primary purpose of the model should be providing suitable care for beneficiaries. Research has shown that care coordination and quality care will save money for Medicaid programs. As stated earlier, if implemented properly, the state will see long-term Medicaid savings because of the improvements in care. Just as Tennessee learned through their challenges with the EPSDT program, managed care models for vulnerable populations require adequate investment and thoughtful implementation.



CONCLUSION

The PASSE model shows great potential for improving the health care system for Arkansans who are most in need of high-quality care. Many of the beneficiaries assigned to a PASSE have never received care coordination or home- and community-based services. Improved health care for beneficiaries receiving these services is not out of reach. Still, decision makers in the state must be committed to rolling out this model with the time and care necessary to ensure no one in need of these important health care services falls through the cracks. Tens of thousands of Arkansans are depending on the success of the PASSE model, so the next steps must be the right steps toward creating a health care system that meets the needs of all Arkansans.

Decision makers in the state must be committed to rolling out this model with the time and care to ensure no one falls through the cracks.



ENDNOTES

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