

PASSE Frequently Asked Questions

On June 27, 2017, the Department of Human Services (DHS) released two background papers on the implementation of the Provider-owned Arkansas Shared Savings Entity (PASSE) organized care model which addresses many issues that have been raised in various forums since Act 775 became law. In addition to those background papers, DHS is taking this opportunity to address the other frequently asked questions we have received from providers and to clarify the transition from fee-for-service into this innovative model, which will help ensure the overall sustainability of our state's Medicaid program.

Responsibilities of the PASSE

1. What changes for providers on October 1, 2017?

Starting October 1, 2017, the first members will be assigned into a PASSE based on an attribution methodology that matches an individual to the service providers with whom they have the strongest relationship. Once assigned, members will receive care coordination from the PASSE. The care coordinator employed by the PASSE is responsible for carrying out the total plan of care for each client assigned. The ultimate goal of care coordination is to assist the beneficiary in remaining in the most appropriate, most cost effective, and least restrictive setting. DHS will continue to pay for services on a fee-for-service basis until December 31, 2018. This October 1, 2017-December 31, 2018 period is being termed "Phase 1" for purposes of these FAQs.

2. What changes for providers on January 1, 2019?

Starting January 1, 2019, the PASSE will be responsible for the total management of the client, including being responsible for the total cost of care of the client. DHS will provide a Global Payment to cover the cost of benefits, administration, and care coordination (which includes the activities described as case management in Arkansas Medicaid) of those individuals attributed to the PASSE. This period is being termed "Phase 2" for purposes of these FAQs. Each PASSE will be responsible for paying providers that are in its network. Over the next 12 months, each PASSE will be recruiting providers to join its network.

Forming a PASSE

3. As a small or mid-sized provider, do I have to buy into or financially invest in a PASSE to participate in this model?

No. The provider is not required by law to invest in a PASSE. That is a business decision for a provider to make. Each PASSE must operate on a statewide basis and demonstrate that it has an adequate network of providers to ensure access to care. There will likely be one or more PASSEs that will recruit providers without requiring financial investment.

4. Can I join more than one PASSE's network?

Yes. A provider may join any or all PASSE's as a network provider and continue to provide services to Tier II and Tier III beneficiaries. Every PASSE must operate on a statewide basis and must have an adequate service delivery network of all provider types to ensure that beneficiaries have access to all Medicaid state plan and waiver services.

5. How will providers who are not investing in a PASSE know who is forming the PASSEs?

Letters of Intent to form a PASSE were due to the Arkansas Insurance Department (AID) on June 15, 2017. AID has shared that information with DHS and the following entities submitted Letters of Intent:

I. Empower Healthcare Solutions, LLC

- Beacon Health Options, Inc.
- Woodruff Health Group, LLC
- Preferred Family Healthcare
- The Arkansas Healthcare Alliance, LLC
- Statera, LLC
- Independent Case Management Inc.
- *Arkansas Community Health Network, LLC has signed an LOI to join Empower Healthcare Solutions, LLC as an equity member.*

II. Arkansas Total Care

- Mercy Health
- LifeShare Management Group, LLC
- Arkansas Health & Wellness Plan, Inc.

III. Arkansas Advanced Care, Inc.

- Baptist Health
- Bost, Inc.
- The University of Arkansas Board of Trustees, for and on behalf of the University of Arkansas for Medical Sciences
- USAble HMO, Inc.

IV. Forevercare, Inc.

- Gateway Health Plan
- Community Service, Incorporated
- Arkansas Pharmacists Association
- Rehabilitation Network of Arkansas
- Community Clinic
- Ouachita County Medical Center

V. Arkansas Provider Coalition

- Arkansas Provider Coalition, LLC
- Amerigroup Partnership Plan, LLC

6. What is the next step for those wanting to form a PASSE?

The entities intending to form a PASSE will now submit an application for conditional certification with the Arkansas Insurance Department (AID). The information to be provided is set forth in Emergency Rule 117 and is due to AID by the close of business on July 3, 2017. Information will not be submitted to the Department of Human Services.

Providers should expect communications from the entities forming a PASSE about joining their network as a network provider. The provider is not required by law to invest in a PASSE. That is a business decision for a provider to make. Each PASSE must operate on a statewide basis and demonstrate that it has an adequate network of providers to ensure access to care. There will likely be one or more PASSEs that will recruit providers without requiring financial investment.

7. When will DHS share claims data with those entities intending to form a PASSE?

DHS anticipates that it will share claims data in early July 2017.

Attribution & Enrollment in a PASSE

8. When will beneficiaries be assigned to a PASSE? How will those individuals and the PASSE be informed of the assignment?

Beneficiaries will be assigned to a PASSE after they undergo an independent assessment (IA) and are determined to meet a Tier II or Tier III level of care. The IA process will begin for the first set of individuals in September 2017. Individuals will then be matched to their providers through an attribution methodology that identifies whether a strong relationship between a provider and an individual exists. If a strong relationship exists, based on the “relationship score,” the individual will follow the provider into the PASSE which the provider joined.

Once attribution has occurred, a letter will be sent to the beneficiary and to the assigned PASSE notifying them of the assignment to that PASSE. The individual then becomes a “member” of the PASSE and is enrolled into that organization’s panel. The letter will also include information on how to choose a different PASSE within 90 days and where to go to find out more about the assigned PASSE.

9. What factors will be considered when attributing a beneficiary to a PASSE?

DHS will attribute a client to a PASSE by looking at the past 12 months of claims data to establish the beneficiary-provider relationships for that client. The PASSE with the strongest relationship to the client is the one he or she will be attributed to.

More information about the attribution methodology is contained within the PASSE Attribution background paper which is being distributed with this FAQ document.

10. Can beneficiaries change PASSEs? If so, when?

Yes, beneficiaries can change PASSEs. Beneficiaries will have 90 days from the original attribution notice to select another PASSE if they choose. Thereafter, beneficiaries can change PASSEs once a year at the anniversary of their attribution, without cause. Beneficiaries can change PASSE’s anytime for cause.

Information on how to change PASSEs will be provided to beneficiaries in their attribution notice. Information on each PASSE will be maintained on DHS's website.

11. How will beneficiaries know which providers are in their PASSE's network?

The beneficiary will follow the provider with whom they have the strongest relationship into the PASSE the provider has joined. Information on each PASSE, including the list of providers in the PASSE's network, will be provided to beneficiaries when they are attributed.

12. Will beneficiaries have to switch providers once they are attributed to a PASSE?

During Phase 1, the PASSE will only provide care coordination to the beneficiary. Beneficiary-provider relationships should not be impacted during Phase 1.

During Phase 2, DHS is working to ensure that beneficiaries do not have to switch providers upon attribution to a PASSE. DHS is doing this in two ways:

(1) Attribution to a PASSE is primarily based on the beneficiary's existing relationships with providers; and

(2) We are encouraging providers to join every PASSE network, as long as they can meet the PASSE's provider certification requirements.

Beneficiaries can switch service providers any time after they are enrolled in a PASSE. However, they will have to choose a provider in the PASSE's network. To ensure adequate access for beneficiaries, DHS encourages providers to join multiple PASSEs.

13. If a beneficiary wants to switch providers after they are enrolled in a PASSE, can they?

Yes, beneficiaries can switch service providers any time after they are enrolled in a PASSE.

During Phase 1, the PASSE will provide only care coordination to the beneficiary. Beneficiary-provider relationships should not be impacted during Phase 1.

During Phase 2, the beneficiary will have to choose a provider in the PASSE's network.

14. Can a beneficiary be excluded from a PASSE if his or her health declines due to a critical illness, which results in multiple hospitalizations?

No. A PASSE will never be allowed to exclude a beneficiary due to the health needs of the individual. However, the beneficiary will be able to change PASSE's for cause—that is, for failure to provide access to certain services.

Services under the PASSE Model

15. Is the PASSE model going to function like a Health Home?

In Phase 1, the care coordination provided by the PASSE will reflect many of the same principals as specialty health homes used by other states.

In Phase 2, the scope broadens to take on the full risk of providing all state plan and waiver services as a PASSE will. The PASSE will have the ability to increase the level of care coordination and coordinate the efforts of all providers utilized or needed by the beneficiary.

16. Based on DHS presentations, it sounds like the PASSE model is going to offer more services than traditional Medicaid. If this is the case, how will savings be achieved?

The PASSE model is built on well-established research that demonstrates better case management and care coordination for high cost populations will minimize more costly acute services, such as hospitalizations and inpatient psychiatric stays, as well as unnecessary or duplicative services. Currently, \$1 billion dollars is spent annually on the approximately 30,000 clients with behavioral health needs and developmental disability service needs. A large portion of that spend goes to highest cost settings. Under the current Medicaid system, there is no incentive to keep beneficiaries out of these high cost settings. The PASSE model incentivizes the provision of the appropriate level of services in the most cost effective setting while maintaining and improving quality of care provided.

17. If a provider or beneficiary does not like the PASSE's determination for reimbursement for a service provided, can they appeal? If yes, are the timeframes the same as traditional Medicaid appeal timeframes?

During Phase 1, there will be no need for an appeal process to the PASSE as claims will continue to be submitted to DHS and paid via MMIS on a fee-for-service basis.

During Phase 2, both the service provider and the beneficiary can appeal a decision of a PASSE regarding a claim for services. The initial appeal is made to the PASSE itself, and then the provider or the beneficiary can appeal to the appropriate state agency. The timeframes for appeal are longer than those under traditional Medicaid and are set out in CMS's Medicaid Managed Care regulations. Those timeframes will be followed.

18. Under the PASSE model, who will be responsible for writing the person centered service plan (PCSP) for Developmental Disability Waiver clients?

Throughout Phase 1, the PASSE will only be providing care coordination. In general, the development of the Waiver PCSP will continue as it does today. However, those PCSPs must adhere to the findings of the Independent Assessment. The PASSE's care coordinator will be informed of the PCSP and assist with coordinating those services with the beneficiary's other needed services.

After January 2019, when the PASSE assumes full risk, development of the PCSP will be the responsibility of the PASSE.

Rates & Billing

19. Where will providers submit claims for services under the PASSE model?

During Phase 1, from October 1, 2017 until December 31, 2018, the PASSE will not assume full-risk and payments will continue to be made by DHS on a fee-for-service basis.

During Phase 2, beginning January 1, 2019, providers will submit claims to the PASSE for a client that is a member of the PASSE.

20. What will the rates be for claims from October 1, 2017, until the PASSE takes full risk in January 2019?

During Phase 1, providers will continue submitting claims through MMIS and DHS will pay for services on a fee-for-service basis.