AETNA BETTER HEALTH®

May 8, 2015

Arkansas Department of Human Services
Attn: John Selig
Director
Via: dhhs.medicaid.rfi@dhs.arkansas.gov

Dear Mr. Selig:

Aetna Medicaid is pleased to respond to the State of Arkansas, Department of Health Services Draft Request for Information (RFI) for Behavioral Health Services, Developmental Disabilities Services and Care of the Aged, Frail and Physically Disabled.

We ask that DHS consider the following recommendations:

In general we strongly recommend that DHS directs all questions to a MCO’s Medicaid-specific risk based managed care experience. Many companies that serve the Medicaid population also serve a myriad of other populations and products (i.e. commercial, Medicare, IT, etc.) and are large conglomerates. The state is best served in narrowing questions to the entities Medicaid business to gather the most relevant and pertinent information.

1.3 INTENT OF THE RFI

In addition to exploring opportunities to utilize risk-based managed care for the populations listed, we urge the state to also include Temporary Assistance for Needy Families (TANF) and Children’s Health Insurance Program (CHIP) and other similar groups. Under a managed care program there are many opportunities to increase health and wellness for the TANF and CHIP populations through better care coordination that provides increased preventive care, immunizations, prenatal care and better birth outcomes to name just a few of the benefits.

3.1 GENERAL EXPECTATIONS

Operational Functions: Please clarify what DHS means by “eligibility attribution.” Medicaid eligibility should remain separate from the services an MCO provides. States routinely work with an enrollment broker to determine a person’s eligibility for Medicaid. Such entity must be neutral on the recipients’ MCO plan selection.

Emergency services: Please clarify that “24/7 crisis intervention” is for behavioral health services only.

Integration of care: Please provide information on the state’s expectation of what role an MCO is to play in making Electronic Health Records available.

4.1 PROGRAM DESIGN

Please allow respondents three pages for each cell they respond to rather than three pages total; limiting to three pages in total disadvantages those who choose to respond to more than one cell.

We applaud the State of Arkansas, Department of Human Services for planning to issue a RFI to further understand how risk-based managed care can play an instrumental role for Arkansas to improve coordination of care and increase quality for Medicaid recipients. We look forward to the opportunity to respond to the final RFI release.

Sincerely,

Taira Green-Kelley
Regional Vice President of Business Development
May 8, 2015

Arkansas Department of Human Services
dhhs.medicaid.rfi@arkansas.gov

RE: Behavioral Health Services, Developmental Disabilities Services and Care for the Aged, Frail and Physically Disabled Draft RFI Request for Feedback

The Arkansas Department of Human Services (“DHS”) has released a draft RFI for comments with regard to contracting with one or more at-risk managed care organizations (“MCOs”) to serve Medicaid-eligible Arkansans who require Long-Term Services and Supports (“LTSS”). It is our understanding that DHS is examining innovating ways in which to:

- Improve the health of the population
- Enhance the patient experience of care, including quality, access, and reliability
- Reduce or controlling the cost of healthcare

Sandata Technologies, LLC (“Sandata”) is a leading provider of Electronic Visit Verification™ (“EVV™”) solutions which are used to support LTSS delivery. We are fully aligned with DHS’s goals and objectives with respect to your home and community based services programs (“HCBS”) by providing real-time HCBS monitoring capabilities through the use of EVV technologies.

EVV automates the remote acquisition of service data by capturing time, attendance and care plan information entered by the home care worker at the point of care; helping to reduce fraud in home care delivery by removing the elements most closely associated with improper record keeping including paper time sheets and manual billing. EVV gives provider, care coordinators, and DHS access to service delivery information in real time to ensure there are no gaps in care throughout the entire course of the service plan and can contribute to DHS’ overall goals as shown below.

<table>
<thead>
<tr>
<th>DHS Goal</th>
<th>Sandata’s Solution</th>
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<tbody>
<tr>
<td><strong>Improve the health of the population</strong></td>
<td>• Helps to ensure home and community based services are being delivered as authorized;</td>
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<td></td>
<td>• Quickly identifies gaps in care and alerts administrators to late/missed visits to reduce the likelihood for admission/readmission; and</td>
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<td></td>
<td>• Offers delivery models whereby caregivers can provide real-time data for changes in patient status which may trigger care management outreach and/or additional services.</td>
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<td><strong>Enhance the patient experience of care</strong></td>
<td>• Allows the patient to receive care in their preferred home setting;</td>
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<td></td>
<td>• Increases care timeliness and quality by ensuring the right caregiver is delivering the right plan of care; and</td>
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<td></td>
<td>• Provides real-time alerts to case managers and provider agencies for late or missed visits that can be immediately addressed by home care</td>
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agency management improving the member experience and allowing members to safely remain in their homes.

<table>
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<tr>
<th><strong>Reduce or control the cost of healthcare</strong></th>
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<tr>
<td>• Automates manual and paper-based processes, removing potential human error or time sheet ‘rounding’ by caregivers, reducing overall claims cost;</td>
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<tr>
<td>• Helps to ensure that only visits verified against authorized services and limits are paid, mitigating the potential for fraudulent claims and reducing the workload for claims adjudicators and program integrity staff; and</td>
</tr>
<tr>
<td>• Offers proven, third-party outcomes including saving the State of Florida over $20 million and cut home care costs by 50% in the first year of the program.</td>
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Additionally, Sandata’s solutions help promote coordinated care using innovative, health information technology, including Remote Care Monitoring offerings, to help measure system and member-level outcomes. Our solutions, including EVV, helps to ensure that clients are able to stay in the care setting best matched to individual need by verifying home care visits are occurring as authorized. Further, data from the EVV system can be used to support provider incentives and Pay for Performance programs. Lastly, EVV technologies help to decrease the administrative burden for all stakeholders – caregivers, home care providers, care managers, managed care organizations, and DHS – through the automation of remote data collection, back-office administrative home care processes and claims submission procedures.

Sandata has over 38 years of experience in providing EVV solutions and services. We have national expertise in the operational aspects of home care, which the Centers for Medicare & Medicaid Services has categorized as moderate to high risk for fraud, waste and abuse. Today, many MCOs managing LTSS members use EVV for traditional provider agency and self-directed models, including United Healthcare, Amerigroup Tennessee, Amerigroup Florida, Sunshine State (Centene), Blue Care of Tennessee, as well as national agreements with Molina, and Centene. We also have direct relationships with six State Medicaid organizations.

We strongly recommend the inclusion of EVV services as a mandatory component of the upcoming RFI and look forward to the opportunity to partnering with Arkansas’ Managed Care Organizations. Please contact me directly if I can provide additional information and a demonstration of our solutions.

Sincerely,

Jamie Richardson  
Vice President, Payer Sales  
Sandata Technologies, LLC  
516.484.4400 x 4163  
jrichardson@sandata.com
ANCOR Principles of Managed Long Term Services and Supports (MLTSS)

The central organizing goal of system reform must be to assist people with disabilities to live full, healthy, participatory lives in their community. Recognizing the many unique challenges involved, ANCOR recommends the following guiding principles are rigorously applied in designing and operating Medicaid managed long term services and supports (MLTSS) systems serving children and adults with chronic disabilities:

Core Values

1. Managed Long Term Services and Supports (MLTSS) systems must treat people with disabilities with dignity and respect.

2. MLTSS systems must be designed to honor, support and implement person-centered practices and consumer choice. People with disabilities will be able to hire and fire providers, choose outcomes important to their lives, and change priorities as dictated by life events or as needed.

3. Delivery systems for MLTSS must be capable of addressing the diverse needs of all beneficiaries on an individualized basis.

4. All individuals should be able to access comprehensible information and usable communication technologies to promote self-determination and engage meaningfully in major aspects of life.

5. Beneficiaries in managed long term services and supports must have access to the durable medical equipment, assistive technology and technology-enabled supports to function independently and live in the most appropriate integrated setting.

6. Primary and specialty health services must be effectively coordinated with any long-term services and supports an individual might require.

7. MLTSS must result in choice for the beneficiary in the most appropriate integrated setting.

8. MLTSS must plan to provide support over the lifespan in addition to a person’s episodic needs.

9. Services and supports accessed through each managed care entity must be sufficiently robust and diverse to meet the contracted scope and needs of all beneficiaries with disabilities.

10. Beneficiaries must have a choice among Managed Care entities.

11. MLTSS must promote an Employment First philosophy. Working-age enrollees with disabilities must receive the supports necessary to secure and retain competitive employment or other meaningful daytime activity. For people who have not succeeded in being able to sustain employment with appropriate supports, there must be meaningful alternatives that meet that person’s needs available during any period of unemployment.

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12. All eligible individuals must be included in the transition, including those residing in state institutions. Resolving waitlists, including addressing the needs of individuals who are underserved, should be addressed in state plans, such as using any savings to reduce the waitlist.

Stakeholder Engagement
1. MLTSS must allow for multiple opportunities for meaningful stakeholder engagement throughout the process to include people with disabilities, families, providers of supports, state government and other individuals knowledgeable about integrated community settings and both medical and non-medical outcomes for people with disabilities. States should be required to identify stakeholder input to CMS, how they incorporated input into plans, or why they chose not to do so.

2. The existing reservoir of disability-specific expertise, both within and outside of state government, should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system.

Health Information Technology (HIT) and Electronic Health Records (EHR)
3. MLTSS must design and implement health information technology and electronic health records prior to the implementation of the MLTSS system.

4. States should design, develop, and maintain state-of-the-art management information systems with the capabilities essential to operating an effective managed long term services and supports delivery system.

Assessment and Rate Setting Methodology
5. MLTSS rates and/or payment methodology and the provider rate-setting mechanisms must be actuarially sound, transparent, adequate to attract and retain a highly valued, stable, and qualified workforce; and, geared to achieve valued outcomes.

Implementation
6. MLTSS implementation must require states to complete a readiness assessment before enrolling people with disabilities.

Performance Measures and Metrics
7. Must include non-medical metrics focused on LTSS (in addition to acute and behavioral health into the RFP and contract). These metrics must incorporate equality of opportunity, independent living, economic self-sufficiency and full participation as defined in the Americans with Disabilities Act (ADA) and the integration mandate of the ADA and the Olmstead Supreme Court decision. Performance reports on these metrics will be shared with all stakeholders.

State Responsibility and Regulations
8. MLTSS implementation must be accompanied by regulations that encourage and support innovation, be modified to reduce process burden in exchange for performance outcome measures as the accountability standard, and allow provider creativity on how to meet the regulation.

9. MLTSS regulations must assure individuals are safe and secure without compromising an individual’s civil rights, choice, informed decision making and dignity of risk.

10. States must assure transparency in the contract procurement process for MLTSS, monitoring, and quality assessment.

11. MLTSS contracts must define financial risk between the state and the MLTSS entities and providers.
12. States must require MLTSS systems for people with disabilities to cover the full range of services and supports needed to address the diverse needs of people with disabilities on an individualized basis across the life span.

13. Benefit packages should build upon existing services and supports needed by beneficiaries to live in the community, including services for acquiring, restoring, maintaining and preventing deterioration of function or acquisition of secondary disabilities.

Appeals and Grievances
14. MLTSS must safeguard individual rights and all applicable federal (e.g. ADA/Olmstead) and state statutes.

15. Enrollees with disabilities should be fully informed of their rights and obligations under the plan, as well as the steps necessary to access needed services in accordance with the requirements of the Social Security Act.

16. Grievance and appeal procedures must be established that take into account physical, intellectual, behavioral, and sensory barriers to safeguarding individual rights.
Checklist for MLTSS

- Mission, Vision, Core Values
- Stakeholder Engagement
- Health Information Technology (HIT) And Electronic Health Records (EHR)
- Assessment/Rate Setting Methodology and Financial Risk Between The State And MLTSS Entities
- Implementation
- Performance Measures And Metrics
- State Responsibility And State Regulations
- Requirements for MLTSS Entities

Mission, Vision, & Core Values

1. Based on principles of independent living rather than a traditional medical model and principles of person-centered planning rather than facilities or previously established managed care criteria established for medical services
2. Fosters choice to: to receive supports in their own home over receiving supports in a nursing facility or other institutional setting; self-direct supports; and use natural supports and support over the lifespan rather than episodic need
3. Promotes an Employment First philosophy
4. Treats people with disabilities with dignity and respect

Stakeholder Engagement

1. Multiple opportunities for meaningful stakeholder engagement throughout the process to include people with disabilities, families, providers of supports, state government and other individuals knowledgeable about integrated community settings and both clinical and non-clinical outcomes for people with disabilities including the request for information process.
2. Occurs throughout the process and is continuous
3. Is transparent, with written documentation of input, state responses, and a demonstration of how input is utilized in the process
4. Includes dialogue with CMS as necessary and appropriate

Health Information Technology (HIT) and Electronic Health Records (EHR)

1. Designed and implemented prior to the implementation of the capitated system
2. State must identify costs of the software and staff training for providers including whether or not they will be provided by the state and/or the MLTSS.
3. Identifies costs for smart phones, laptop computers and/or notepads to be used by providers including whether or not they will be incurred by the state and/or the MLTSS entity.
4. Establishes IT infrastructure throughout the provider network and MLTSS entities with data points established (clinical and non-clinical) PRIOR to the “live” shift to MLTSS. (THIS IS ESSENTIAL AND CANNOT BE MINIMIZED. IT MUST BE IN PLACE PRIOR TO GOING LIVE.)
5. Defines the data elements required of the MLTSS and looks at ability to
   a. coordinate ability to provide quality services and attain high consumer satisfaction levels
   b. acute and post-acute care full complement of Medicaid waiver services, including HCBS
   c. MLTSS plans should routinely report their performance using such metrics
   d. Failure to reach a certain quality threshold should result in meaningful enforcement action by the state to correct the problem
e. Results must be shared with stakeholders and the general public within reasonable time frames to allow for outside analysis and evaluation

Assessment and Rate Setting Methodology
1. MLTSS capitation rates and the provider rate-setting mechanisms are transparent.
2. Uses a uniform performance and outcome-oriented assessment tool(s) that recognizes the diversity of support needed; and, is administered by an independent entity. It also recognizes needs change over time requiring assessments be re-done as an individual’s circumstances change.
3. Structures incentives to achieve valued outcomes consistent with core values (e.g. pays for employment supports, living in one’s own home, etc.)
4. Defines levels of support and recognizes 5–7 risk adjusters. Defines portion of risk, if any, to be shared with the provider network.
5. Must be actuarially sound to support people with IDD and adequate for providers to fully comply with existing and future federal and state regulations. Must be built upon at least 2–3 years of Medicaid (and, as appropriate, Medicare) claims data, including acute, behavioral health and LTSS claims. Emphasis should note that acute and behavioral health claims data should not be used to determine costs of LTSS as those supports are not medically based.
6. Rates are adequate to support a stable professional workforce, enables providers to offer wages sufficient to attract and retain qualified direct support staff. Recognizes geographic differentials for wages, fringe benefits, housing and transportation.
7. Articulates the level of reserves to be maintained by the MLTSS; minimum loss ratios, stop loss factors, shared savings, etc.; and, limits the % of revenue used for administration and profit margins

Implementation
1. Participation in MLTSS should be voluntary for people with disabilities, with a right to opt-out
2. Requires states to complete a readiness assessment before enrolling PWDs
3. Robust and diverse provider network, including the coordination of health services with LTSS
4. Any willing existing LTSS provider, health practitioner, and personal care worker permitted to remain if chosen by individual and if they accept rates and rules
5. Resources from existing state institutions and HCBS must both be included to fund MLTSS
6. Provides needed access to the durable medical equipment and assistive technology
7. Must articulate how the administrative and care coordination functions of the MLTSS are to be funded. If there are anticipated savings from new system of providing services, they should be transparent, public and actuarially sound calculations.

Performance Measures and Metrics
1. Must be non-clinical in nature and focused on LTSS (in addition to acute and behavioral health), incorporating equality of opportunity, independent living, economic self-sufficiency and full participation as defined in the Americans with Disabilities Act (ADA) and the integration mandate of the ADA and the Olmstead Supreme Court decision into the RFP.
2. Baseline data for performance measures and metrics and the definition of quality for non-clinical outcomes must be in place prior to implementing MLTSS.
3. Must be stated in state purchasing specifications and contract language. Roles of external quality reviews for primary, acute and LTSS; which organizations will be used; and what the frequency of reviews will be should be in place. If an accreditation process is to be used, it should be defined up front.
State Responsibility and Regulations

1. Regulations should encourage and support innovation; be modified to reduce process burden in exchange for performance outcome measures as the accountability standard, and allow provider creativity on the how to meet the regulation.

2. Basic safeguards assure that individuals are safe and secure without compromising an individual’s civil rights, choice, informed decision making and dignity of risk.

3. Assure active, independent oversight and monitoring and a robust evaluation of the MLTSSs and their provider networks.

4. The state must take the lead responsibility for a continuing statewide Direct Support Professional (DSP) workforce development or apprenticeship initiatives.

5. Oversight of day-to-day MLTSS should be assigned to highly qualified state and federal officials, with the authority to proactively administer the plan.

6. Contract Must Define Financial Risk between the State and the MLTSS Entities. It could be “full risk” to the MLTSS or could contain a “risk corridor” of a limited and/or shared risk between the state and the MLTSS.

7. Designates which state agency is responsible to license the MLTSS and which state regulations will be applied (e.g. such as those for an HMO should be disclosed).

8. Defines the role of and relationship to community mental health centers and federally qualified health centers.

Appeals and Grievances

1. Should provide timelines to assure a timely and transparent processes for individuals and families, providers, sub-contractors

2. Procedures that safeguard individual rights under the provisions of the MLTSS plan and all applicable federal (e.g. ADA/Olmstead) and state statutes.

3. Should take into account physical, intellectual, behavioral and sensory barriers and provide support so each beneficiary through the provision of independent entities for assistance in navigating these procedures.

4. Should authorize a state agency to overrule the plan’s refusal to provide services if warranted.

Requirements for MLTSS Entities

1. MLTSS entities should allow enrollees to retain their existing practitioners for health and long term services and supports to ensure continuity of care for at least one year, regardless of whether these practitioners participate in a MLTSS program. Choice of provider is a key factor in ensuring quality of care, especially for the disability population, which tends to develop close and long-lasting relations with providers who come to understand the intricacies of addressing the particular needs of people with disabilities.

2. Any licensed provider in good standing willing to adhere to plan rules and payment schedules should be able to be part of a plan.

3. Medicaid MLTSS plans should be required to adhere to existing access protections in the Medicare Part D program.

4. States should require MLTSS systems for people with disabilities to cover the full range of services and supports needed to address the diverse needs of people with disabilities on an individualized basis across the life span. Benefit package should build upon existing services and supports needed by beneficiaries to live in the community, including services for acquiring,
restoring, maintaining and preventing deterioration of function or acquisition of secondary disabilities.

5. MLTSS entities should be required to have transparent and functional advisory boards that include meaningful and supported opportunities for people with disabilities and families to be at the table. Infrastructure should be available to support and enhance existing and new self-advocacy and family support service options.

6. MLTSS entities must fully inform individuals of their rights and obligations under the plan as well as the steps necessary to access needed services. The information should be made available to the public before enrollment deadlines, provided in multiple concise, understandable, and accessible formats (for enrollees with disabilities as well as those with limited English proficiency).

7. MLTSS entities must create provider networks with adequate numbers of experienced and qualified providers of primary and specialty health care, behavioral health care, and long term services and supports, including home and community based services, so participants can obtain care without excessive travel or unreasonable delays in scheduling appointments.

8. If health care and long term services and supports are financed and administered separately, systems must ensure coordination and continuity of care across systems.

9. MLTSS entities must define data elements required of the provider networks.
May 8, 2015

Arkansas Department of Human Services
Donaghey Plaza, P.O. Box 1437
Little Rock, AR 72203
Submitted to: ddhs.medicaid.rfi@dhs.arkansas.gov

Re: Response to the Draft Request for Information for Managed Care for Medicaid Special Needs Populations

We appreciate the opportunity offered by the Arkansas Department of Human Services to provide comments on the Draft Request for Information (RFI) concerning behavioral health services, long term supports and services (LTSS), and Intellectual and Developmental Disabilities (ID/DD) services. We appreciate the State’s consideration of managed care as a path forward for improving care for many of Arkansas’ highest need Medicaid clients.

UnitedHealthcare and Optum are part of a broader enterprise known as UnitedHealth Group. The UnitedHealth Group approach leverages the national capabilities of all business segments through a local market delivery model to support effective care coordination, strong local partnerships, and improved clinical outcomes for our members. Because we are part of the same enterprise, we can work together to integrate comprehensive benefits for our members.

- UnitedHealthcare Community & State operates in 24 states with more than five million members across a broad spectrum of populations and programs including Medicaid, Dual Special Needs Plans, and Medicare Medicaid Plans. For nearly 30 years, we have supported states in developing solutions that not only address the complex physical needs of individuals but also address individuals’ behavioral, functional, and social needs.

- Optum is the largest managed behavioral health organization in the nation, recognized as a proven and trusted leader in this industry. Optum has provided customized behavioral health services for more than 25 years and we currently serve approximately 62 million people in both commercial and publicly funded programs through our vast provider network of approximately 135,000 clinicians nationwide.

Collectively our enterprise has extensive knowledge and experience in the full scope of Medicaid benefits and services. The following information represents our collective expertise and experience.

We believe that a RFI is an important step in the process of designing a sustainable program that addresses the needs of individuals served by Medicaid. RFIs serve a distinct role of gathering stakeholder input to develop the program and shape the Request for Proposals (RFP). These program design considerations and RFP considerations establish the foundation for an effective contract and contractual relationship between a state Medicaid agency and its selected Managed Care Organizations (MCOs). Inviting feedback on a draft RFI represents an additional level of commitment to ensuring that the entire development and procurement process is transparent, responsive, and results in an effective, stable and sustainable program.
We have reviewed the draft RFI and the Fact Sheet and are directing our comments to the content and format of the information in those documents. Our recommendations are intended to ensure that the final RFI generates the information needed by the Department to effectively evaluate program design considerations, establish clear next steps, develop an RFP, and conduct a procurement process that selects the vendors best qualified to help the Department continue toward its commitment of improving quality, access and cost of services for its Medicaid population.

While we recognize that the draft RFI is a “fact-gathering process for special needs populations is targeted only toward these populations, and not the broader Medicaid population,” we would encourage Arkansas to open the RFI to considerations for integration of the broader Medicaid population. As the State considers this important shift in the management of Medicaid services for the most complex populations, it is important that the State also think holistically about the system of services it offers to all individuals. Reducing system fragmentation and simplifying the system for individuals receiving services is one of the most significant factors in most Medicaid program transformations. We encourage Arkansas to include additional questions or allow for the scope of the RFI to include a broad look at the Medicaid program to ensure improvements also support administrative efficiencies, improved member experience, and allow for the greatest opportunities to improve overall outcomes.

We have broad-based experience in managing behavioral healthcare services both as part of a comprehensive package of Medicaid benefits and as part of a specialized program (behavioral health carve-out) for individuals who require behavioral health services. In some of the carve-out programs we administer, all behavioral health services are covered. In others, only members with significant behavioral health issues, such as serious mental illness or serious emotional disturbances are served in the carve-out program. Regardless of which behavioral health services are managed, it is critical that the state require effective coordination and integration with medical services, especially primary care. In the final RFI, Arkansas may wish to request information about potential designs and their relative benefits, especially related to reducing barriers to care for members.

While we recognize the need for Arkansas to validate the approach and experience of the respondents to the RFI, we do ask that considerations are made for the proprietary nature of health plan innovations, service delivery, and detailed experiences. As noted in the RFI, the information shared will become public, yet the RFP will require health plans to compete on the basis of these qualities. An RFI is typically designed to provide interested parties with the opportunity to shape the content of the State’s proposed design for the service delivery system and the content of the RFP. Through the RFP the State then poses the key questions that will enable them to differentiate bidders and assess bidders’ experience, capability, capacity and strategies for supporting the State implement its program.

In lieu of questions detailing experience and capabilities of RFI respondents, we would suggest the inclusion of an RFI question related to specific capabilities or experience that any health plans contracted to serve these populations or manage these services should possess. For example, on the second page of the Fact Sheet under the header “Support for client and provider interests,” a question is posed about how the State is considering provider interests. If responses to the final RFI are actually an initial screening or evaluation “to assess any potential vendor’s fit…” the RFI would become part of the official procurement process.
Additional recommendations on the content and format of the draft RFI are included in the chart that follows.

We appreciate your effort to enable input throughout your process and we are happy to respond to any questions you may have regarding our comments to the RFI. If any additional information or insights would be helpful, please contact either:

- Catherine Anderson, VP State Programs, UnitedHealthcare Community & State at 202-654-8281 or catherine_anderson@uhc.com
- Candice Nardini, Vice President of Public Sector Growth, Optum at 515 287-5785 or candice.nardini@optum.com

Again we thank you for the opportunity to provide input in your process and look forward to responding to your RFI in the near future.

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<th>RFI Section</th>
<th>Comments</th>
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<tr>
<td>1.1</td>
<td>Allowing respondents to select the areas in which they have relevant information to share will enhance the quality of responses received while minimizing irrelevant and redundant information.</td>
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<tr>
<td>1.3.2</td>
<td>Some of the Medicaid-eligible Arkansans who would be included in this program are probably also receiving services through a HCBS waiver. Some MCOs have experience administering HCBS waivers, and waiver participants can have better coordinated services with the support of a managed care organization. It is important to indicate (1) whether those who are receiving waiver services will be included in the covered population and (2) what responsibilities for those waiver services will be delegated to the MCO and which will be retained by the State. If those decisions are under consideration, we would encourage the State to add a question pertaining to this design feature.</td>
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| 1.3.2       | Information Table 1  
We ask that the State clarify the term “halo services” to ensure respondents are referencing the same scope when responding to the RFI. We assume that the term is referencing all other Medicaid benefits, but would ask for additional clarification. Additionally, we encourage the State to provide a definition of BH populations if one is already established or defined. If the definition of BH populations is yet to be defined, the State may consider asking for feedback on definitions and criteria. Many individuals will require some form of behavioral health services, but would not be in the category of high needs behavioral health clients. |
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<td>1.3.2 4.1.C</td>
<td>There are other coverage models that Arkansas can consider. For instance, some states have offered people who have chronic health care needs the option to receive fully integrated Medicaid services in specialty health homes in which responsibility for coordinating medical care is assigned to providers who meet standards qualifying them to oversee a broader array of services. Other states have used specialty programs similar as the one described in the RFI as the first step to moving people into a fully integrated managed care plan. Still other states have pursued an all populations and all services integrated managed care model for the Medicaid system. We encourage the State to allow respondents to share insights on program design approaches and considerations outside this grid that will support Arkansas in achieving its goals.</td>
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<td>2.1</td>
<td>In a Bidders’ Library or as an Appendix to the RFI, it will be important to include sufficient information on the scope and impact of the AMS vs Reynolds consent decree to enable respondents to accurately assess the impact of the decree on provider rates and/or service delivery.</td>
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<td>2.2.1 – 2.2.3</td>
<td>The background information on service-related expenditures and the growth pattern is important. It also is important to provide respondents with access to a list of all services covered and through the Arkansas Medicaid program and their utilization by clients in these specialty populations. Additionally, if the State would be willing to share additional concerns or detail on the origin of the objectives for considering this transformation, it could help inform the RFI responses.</td>
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<td>3.1</td>
<td>Typically, eligibility attribution and enrollment in specialty programs remains the responsibility of the State Medicaid agency. Conversely, responsibility for claims payment, which is not mentioned in this section, is delegated to the managed care entity, whether the program design is an ASO, partial or full risk.</td>
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<td>3.1</td>
<td>If the State has particular preferences or requirements about which functions remain with the MCO and which remain with the direct service provider, it is good to state them, especially related to areas such as multi-disciplinary treatment planning, use of electronic health records, quality improvement and case management. RFI comments can either be focused on providing recommendations if these are areas that remain open for discussion and consideration or if decisions have been made about where these functions remain then comments will focus on optimizing the system within those constraints.</td>
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<td>3.2.1</td>
<td>One of the most important benefits that managed care can offer clients in special populations is flexibility, either by adding new services or by enabling the provision of wraparound services. However, to enable those special service arrangements to be counted toward the next capitation rate, the State must have worked out agreement(s) with CMS. In the RFI, the State should describe the flexibility that respondents will have to offer new services.</td>
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<tr>
<td>3.2.1</td>
<td>We would encourage the State to consider inclusion of a question in the RFI regarding additional benefits or services that could be offered to higher-need clients to improve outcomes.</td>
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<td>RFI Section</td>
<td>Comments</td>
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<tr>
<td>3.2.1</td>
<td>MCOs have a variety of strategies that enable them to ensure that care is appropriate and medically necessary for those they serve. Many of those functions previously have been carried out by states through administrative rules. In the RFI, the State should describe the extent to which existing administrative rules and other state policies and procedures must be implemented without variation in the new program.</td>
</tr>
<tr>
<td>3.2.2</td>
<td>To the extent that all MCOs will be required to follow the same policies and procedures (e.g. responding to complaints, grievances and appeals; implementing standardized instruments for screening, evaluation, and assessment; measuring outcomes or implementing provider performance standards), RFI responses can be simplified by stating those requirements and requiring bidders to stipulate their willingness to comply or to propose alternative strategies for the state’s consideration.</td>
</tr>
<tr>
<td>3.2.3</td>
<td>If these questions remain in the final RFI, it should be made clear whether, as they respond to the RFI, respondents will be tied to the choice(s) they indicated in this section. Making a fully informed decision may require in-depth analysis of more utilization data than is typically provided with an RFI.</td>
</tr>
<tr>
<td>4.1</td>
<td>We recommend that these questions be reserved for the RFP because they require inclusion of a significant amount of competitive information that, if shared, could impact the outcome of the procurement.</td>
</tr>
<tr>
<td>4.3</td>
<td>Given the level of detail requested in this response and others throughout the draft RFI, please provide at least four weeks’ response time to enable research and formulation of thoughtful answers.</td>
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</tbody>
</table>
Arkansas Health & Wellness Solutions is pleased to see The Arkansas Department of Human Services (DHS) take the first steps towards implementing a Medicaid managed care program. We would recommend that, rather than limit the scope of the Request for Information (RFI) to only Behavioral Health Services, Developmental Disabilities Services and Care for the Aged, Frail and Physically Disabled, DHS expand the scope to solicit information for all populations and services.

The inclusion of categories of eligibility not currently included, such as TANF, CHIP and ABD, would allow DHS to expand the impact of the program being contemplated and enhance the ability to meet the Program goals:

- Improving quality and the patient experience for all Arkansans that use the included services
- Improving the performance of the overall health system including improved access to care and overall population health
- Slowing or reversing spending growth trends for these populations and services
- Furthering the objectives of Arkansas payment reform.

We believe that this RFI represents the ideal forum for gathering this information. The information will better position DHS to make an informed decision on the upcoming program without requiring you to make any decisions or program changes.
This is in response to the public notice and input on Request for Information on Managed Care for Medicaid Special Needs Populations:

Section 1.3 Intent of the RFI

Comment: Arkansas should seek opportunities in contracting with one or more “coordinated care organizations” instead of insurance companies who only seek to reduce payments which will have long term effects on the individuals requiring more medical and institutional levels of care. It is merely a quick way to claim less spending, when in fact, it will cost more in the long run. Individuals with developmental disabilities require more in depth coordination of care in order to have life-long effective outcomes. There have been numerous studies which found a range of returns between $4 and $9 for every dollar invested in early intervention. They found that through intensive early intervention (for example in day treatment clinics) before the age of 5 that there is a decrease in expenditures in the juvenile and criminal justice systems and decreased special education costs to the public schools.

Angela Traweek  
Friendship Community Care, Inc.

Visit www.fccare.org to learn more about services provided by Friendship to children and adults with developmental and intellectual disabilities.

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Community Health Centers of Arkansas, Inc.
ARKANSAS PRIMARY CARE ASSOCIATION
Expanding Access to Affordable Quality Health Care

May 7, 2015

John Selig, Director
Arkansas Department of Human Services
Donaghey Plaza
P. O. Box 1437
Little Rock, AR  72203

Dear Mr. Selig,

Please accept the following comments to the recently issued Public Notice and Input on Request for Information on Managed Care for Medicaid Special Needs Populations. As you know, federally qualified health centers are required to integrate medical care with behavioral health care and pharmacy needs. As you seek information on managed care for a select population, we ask that you require those responding to your Request for Information (RFI) to include their use of federally qualified health centers in providing integrated care for behavioral health patients. Specifically, we ask the following changes be made to the RFI:

Section 3.1 GENERAL EXPECTATIONS

“Network. Develop and maintain a provider panel, inclusive of all federally qualified health centers within a service delivery area, that is adequate to meet the needs of all individuals covered within the scope of the contract.”

Section 3.2.1 Behavioral Health

“Respondents are expected to collaborate with the existing deliver system, provider network including all federally qualified health centers within a service delivery area, and the state to establish functioning systems to achieve the following aims:”

Section 4.3.1. M. Choice and Competition. Add the following question: “How have you structured contracts with federally qualified health centers to ensure access to care in underserved areas?”

Section 4.3.1. N. Enrollment. Add the following questions: “How will you use Assistors in clinical settings in the enrollment process or use eligibility specialists through a federally qualified health center? How do you ensure quality of patient care through the enrollment process, particularly for continuity of care of behavioral health patients that have integrated care through a federally qualified health center?”

119 S. Izard St., Little Rock, AR, 72201, 501-374-8225 Fax 501-374-9734
We look forward to continuing to be a lead provider of primary care for Arkansas’s Medicaid population. As you evaluate the responses to your RFI, Community Health Centers of Arkansas offers to provide you with assistance particularly as you review the response to “Section 4.1 PROGRAM DESIGN – D. Approach to Population-Based Coverage. Several of our federally qualified health centers have extensive experience in “the opportunities and challenges associated with providing population-based coverage (e.g., coverage that integrates some core medical and pharmacy services) rather than coverage of specialty services only”. We offer our experiences to help you in your review process in any way that you may need as we have been integrating care and evaluating our services through a nationally recognized patient centered medical home model for many years.

And, we would welcome an opportunity to explain exactly how our integrated model for behavioral health has been successful in a primary care setting.

Finally, we look forward to the day that we are included in Arkansas’s Payment Improvement Initiative.

Thank you for your consideration of these comments. Should you need any clarification, please contact me directly at 501.492-8384.

Sincerely,

Mary Leath
Chief Executive Officer
May 8, 2015

John Selig, Director
Arkansas Department of Human Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

Dear Director Selig:

On behalf of our over 100 Arkansas hospitals, the more than 40,000 Arkansans employed by them, and the patients and communities they serve, the Arkansas Hospital Association (AHA) appreciates the opportunity to comment on the proposed Request for Information (RFI) to be issued by the Arkansas Department of Human Services to explore contracting with one or more at-risk managed care organizations (MCOs) to serve Medicaid-eligible Arkansans who require services in one or more of the following special needs areas: Behavioral Health Services (BH), Developmental Disabilities Services (DD), and care for the Aged, Frail and Physically Disabled (collectively, Long-Term Services and Supports or LTSS).

The AHA will offer substantive comments on the RFI draft, but at the outset, we must note that we vehemently oppose moving any patients from the current Medicaid program or the Arkansas Private Option into a managed care program. Simply put, moving to a private MCO system will not advance better healthcare for Arkansans. There is a significant distinction between coordinated care and “managed” care. We support coordinated care, as evidenced by our participation in the Arkansas Payment Improvement Initiative (PII), which has generated proven savings to the healthcare system in the state as well as improved patient outcomes. Moving to a managed care system ignores the demonstrated success of the PII and other healthcare reforms ongoing within the state. Healthcare providers, not insurance executives, are the best care managers to ensure both higher quality and more cost-effective care for patients.

**Specific Comments on the Proposed RFI**

1. As an initial matter, the RFI respondents should be required to articulate their overall philosophy of managed care, including the company’s overall approach to Medicaid managed care (risk-based, primary care case management, etc.) and the reasons it contends that this is the best option to further the goals of improving quality, ensuring access and cutting costs.

   Innovation has been the watchword in Arkansas healthcare, and the state has established itself as a leader in this arena. We know that managed care is not a new concept, so the philosophy espoused by the respondents should highlight their program as a new, improved version of the old-school managed care mechanism. Unless Arkansas establishes this as an essential foundation of any movement to managed care, we risk losing the dramatic improvements
established through current, innovative programs that are showing great success in our state and cementing Arkansas as a healthcare leader.

2. Over the past several years, Arkansas Medicaid, private insurers and healthcare providers have jointly worked on a successful reform plan that has been good for taxpayers, good for our most vulnerable citizens and good for the providers who serve our state. Each RFI respondent should be required to acknowledge the success of the Arkansas Payment Improvement Initiative and describe, in detail, how it would integrate its operations into the PII without jeopardizing the high quality and cost savings achieved.

3. Arkansas Medicaid payments to providers historically have been extremely low and typically compensate providers well below the actual cost of providing care. In this environment, various mechanisms have been developed to offset at least some of the losses experienced by providers. Many of these mechanisms would be jeopardized by a move to Medicaid managed care. Thus, RFI respondents should be required to address how they would safeguard these existing mechanisms and make certain that additional funding continues to be available to providers and not diverted to the MCO.

4. Managed care historically has ignored the overall needs of the patient, focusing primarily on the costs of care. RFI respondents should produce documented evidence linking their proposed program(s) with improved quality for the specialized populations identified. Respondents also should be required to produce studies failing to link their program(s) with improved quality, and for each of these studies, the respondents should discuss their proposed changes to the program(s) to address this deficiency.

We have seen in other states that without such evidence, it is likely that any “cost savings” will be due primarily to reductions in care. When these reductions occur in a market in which there are limited providers available (as we have in Arkansas), the patients who still need care go to the emergency department – which must, by law, care for them. This is the least efficient setting for day-to-day care of patients, particularly those with special needs. This also drives up hospital uncompensated care costs when the industry already is facing $2.5 billion in Medicare payment reductions for Arkansas hospitals alone.

5. Other states have found that moving to Medicaid managed care has resulted in less transparency in operations. RFI respondents should specifically describe their proposal to avoid this result and provide appropriate accountability to the state.

6. In addition, in order to address some of the other issues that have arisen in Medicaid managed care programs in other states, we recommend that the RFI respondents be required to respond to the following specific questions in their response:

- Are you accredited by the National Commission on Quality Assurance (NCQA), URAC or a comparable, reputable, nationally-recognized accrediting organization for health plans? If not, what are your plans to move toward accreditation within the next year?
• Have you or any affiliate or subsidiary been involved as a plaintiff or defendant in a lawsuit with a state or any state agency? Explain.

• Have you or any affiliate or subsidiary filed for bankruptcy protection in any state? Explain.

• What are your plans to ensure access to care for Medicaid recipients? Provide examples of successful implementation of these plans in other states.

• What are your plans to improve health care quality for Medicaid recipients? Provide examples of successful implementation of these plans in other states.

• One of the successes of the Arkansas Payment Improvement Initiative has been its focus on assisting providers in improving their processes and systems to support changes in patient care operations. What amount do you propose to invest in system change? How do you propose to support providers in improving the system of care?

• Identify peer-reviewed studies showing your approach to Medicaid managed care decreases costs, while improving quality and access.

• How would you plan to add value to the newly formed All-Payer Claims Database in Arkansas?

• In order to increase competition within the private health insurance market, would your company agree to offer health plans to populations other than Medicaid participants? If so, please describe how you would do so. If not, please explain why you decline to participate in the private market.

The AHA, our Board and our members strongly believe that all Arkansans deserve the best and most cost-effective care, and we look forward to continuing our work with you to ensure that we achieve this goal. If you have any questions, please feel free to contact me directly. And once again, we thank you for the opportunity to comment on this RFI.

Sincerely,

[Signature]

Bo Ryall

BR/ae
May 8, 2015

Mr. John Selig, Director
Arkansas Department of Human Services
P.O. Box 1437
Little Rock, AR 72203
dhhs.medicaid.rfi@arkansas.gov

Director Selig:

The Arkansas Health Care Association (AHCA) represents 212 skilled nursing facilities in Arkansas, including tens of thousands of patients, employees and members of the communities in which they serve our state. Our facilities provide care 24 hours a day, 7 days a week to the most frail elderly citizens of our state.

We appreciate the opportunity to comment on the proposed Request for Information (RFI) to be issued by the Arkansas Department of Human Services to explore contracting with one or more at-risk managed care organizations (MCOs) to serve Medicaid-eligible Arkansans who require services in one or more of the following special needs areas: Behavioral Health Services (BH), Developmental Disabilities Services (DD) and care for the Aged, Frail and Physically Disabled (LTSS), which represents our population.

We are adamantly opposed to Medicaid managed care programs. It is our strong belief that Arkansas based providers can provide better care and outcomes for our residents than out of state companies. We have specific measures that will achieve both the stated goals of this RFI and those of the Arkansas Payment Improvement Initiative.

It has been stated publicly that our program is being included in this RFI because it is an area of Medicaid that has not participated with the Arkansas Payment Improvement Initiative. After meeting for over a year and providing feedback, our organization could not support the proposal from DHS regarding changes to our program. We responded with thorough comments and explanations as to our position – including areas of the proposal that would negatively affect quality of care and cost the taxpayers of Arkansas additional money in implementation and sustainability.

We look forward to presenting our proposals regarding quality and cost within our program to the appropriate audiences.

Sincerely,

Rachel Davis
Executive Director
May 8, 2015

John Selig, Director
Arkansas Department of Human Services
P.O. Box 1437
Little Rock, AR 72203

RE: Request for Information – Managed Care Organizations

Dear John,

AARP appreciates the opportunity to comment on the Arkansas Department of Human Services’ (DHS) draft Request for Information (RFI), which intends to gather information from potential at-risk managed care organizations (MCO) as to how they would best serve Medicaid-eligible Arkansans who require behavioral health, disability or long term services and supports. AARP is a nonprofit, nonpartisan organization with a membership of more than 320,000 in Arkansas. AARP works to help Arkansas residents age 50 and older live life to the fullest and ensure that all people in Arkansas remain vibrant and independent as they age.

AARP believes that the draft RFI outlines important questions for potential MCOs and holds great promise in the ability of the state to determine which organizations have the capacity, expertise, and vision to serve eligible Arkansans. We recognize that concepts, rather than details, serve as the guiding principles at this point in the process. As such, we would highlight a few concepts that we believe deserve further attention in this draft and in so doing can help the state elicit greater details from potential MCOs.

**Involvement of Family Caregivers**

Family caregivers provide the vast majority of Long Term Services and Supports (LTSS) in the home and community, and should be seen as a key component and partner in any effective Medicaid LTSS system. We recommend that the RFI ask managed care organizations to say how they would ensure that there is a mechanism for members, their families and/or advocates and caregivers, or others chosen by the member, to be actively involved in the care plan development. In addition, we recommend that the state fold into its evaluation criteria how the MCO will facilitate this involvement, including whether:
- Family caregivers have an opportunity to participate in assessment of need of their family member;
- Family caregivers receive an independent assessment to determine how the MCO can work with the caregiver and support their needs;
- MCOs train their case managers on how to communicate and work with family caregivers;
- MCOs have regular communication with the family caregiver and require paid home care/health provider to communicate/consult with the family caregiver on service delivery;
- MCOs offer caregiver training to family caregivers that covers both effective caregiving techniques and stress reduction practices; and
- MCOs provide paid respite support for family caregivers on a regular basis

**Timeframe**

Based on other states' experiences in adopting comprehensive Medicaid managed care including LTSS, AARP believes Arkansas should establish an achievable time frame for transition and implementation. The state should closely attend to the MCOs responses to 4.2.1 (I) and perhaps build out the question further to determine what is achievable from both the state and MCO perspective. We recommend asking potential MCOs to describe the amount of time needed to fully develop and implement the necessary protocols, information systems, staff, and infrastructure; build the provider network needed to ensure continuity of care and/or transition to community-based services for seniors and persons with disabilities (especially if MCOs do not have prior experience providing LTSS to a vulnerable population); appropriately educate new enrollees and their families about the changes taking place and their rights and responsibilities; and take necessary steps to ensure quality measurement.

**Fully Integrated Long Term Services and Supports Model**

A potential MCO may elect to include a limited selection in its proposed model for LTSS. In some states, individual MCOs have developed selective plans that provide for certain services to be covered and others to be excluded. And in others states, the Medicaid agency has allowed MCOs to carve out certain services (e.g., Nursing Home care) from their plans. Yet, evidence has shown that consumers are best served, states are able to preserve and achieve new rebalancing goals for LTSS, and quality is improved across all services when all services are fully integrated into the MCO models. We recommend that the RFI include language that instructs potential MCOs to show how any proposed model of LTSS will fully integrate the wide range of services that may benefit older Arkansans and persons with disabilities.

**State Oversight**

In shifting to a comprehensive managed care program, robust MCO contract oversight and monitoring is critical to ensure that capitated payments do not create incentives for MCOs to stint on needed care and services for this very vulnerable population. Robust oversight is also imperative to ensure that all reporting requirements and performance standards are being complied with and that they are leading to improved quality and access. A recent AARP Public Policy Institute report points out that "although contracts between states and MCOs establish standards and requirements, such contracts are empty promises if states are unable to monitor and enforce plan compliance and performance." AARP would encourage the state to include
language in the RFI asking potential MCOs to describe how they would communicate with and remain responsive to the state’s oversight. We hope also that as the state continues to develop its 1115 Waiver that it focus attention and detail on how it intends to conduct oversight, including a description of the resources it can dedicate to this effort.

Based on the experience of states that have successfully implemented Medicaid managed care, we are convinced that state governments must take a hands-on management approach to effectively oversee managed care contracts. Strong reporting requirements and potential corrective actions are a solid start to effective oversight, but the state must be committed and take steps (both from a staffing and knowledge perspective) to actively monitor and use all of the enforcement tools available to ensure that Arkansas consumers receive the right care, in the right place, at the right time. Arkansas (or any other state) should not be permitted to reduce its Medicaid role and responsibilities by simply paying MCOs and relinquishing these functions to them. Final accountability for the performance of its contractors, including managed care plans, must remain with the state.

Thank you again for this opportunity to comment on the draft RFI. We look forward to working with the state at each stage of the process – Request for Proposals, development of an 1115 Waiver, beneficiary enrollment, implementation of the Waiver, etc – to ensure that Arkansas residents age 50+ are best served.

Sincerely,

Herb Sanderson
AARP AR State Director, Interim

cc: John Gilmore
May 8, 2015

From: Loretta Cochran, Ph.D.

RE: Arkansas DHS Draft RFI for Behavioral Health Services, Developmental Disabilities Services and Care for the Aged, Frail and Physically Disabled

As a mother of a 13 year old son with autism and behavioral health challenges, I read this draft RFI carefully. A glaring error that runs throughout the document is the lack any requirement for person-centered planning and support delivery. Does the state of Arkansas intend to continue down the antiquated path of a traditional medical model and impose yet another paternal model on those who are least likely to The role of expert is not played by an institution, an insurance company, a managed care company, a doctor, or a service provider. The expert is the person with the disability - the person with the Medicaid number. That should be clear.

What has not been identified in this request is how a firm will place in the forefront of the process the need for each individual to be able to make their own decisions (with the needed supports and resources). Ultimately, each individual needs to make choices about their life without a managed care staff person being the “expert” or creating yet another road block. Person centered planning includes more choices, more innovation, greater opportunity for cost savings, greater social involvement for the person with a disability, and it promotes inclusion (rooted in universal design). This will not happened with managed care.

Dr. Dennis Kuo (from Arkansas Children’s Hospital) and his co-authors noted in a recent article in *Health Affairs* that children with medical complexities (5.8% of Medicaid children) account for 34% of Medicaid spending. Most of that is attributable to hospital care. My assumption from reading the RFI is that MCOs will be driven to reduce the time spent in the hospital. This could represent significant savings. However, MCOs were not recognized as a means to achieve such cost savings. Instead, targeted case management/care coordination could help prevent or quickly address problems that would otherwise require hospitalization.

Three things make care management difficult and make managed care impossible without risking the quality of life of the children. First, it is hard to accurately predict who will have substantial future expenditures. This is a tenet of managed care which indicates its lack of application to this population. Second, it is not easy to reduce all substantial future expenditures without compromising care. As a parent of a child with a disability, I assure you that this is unacceptable. And third, it is unclear what care management methods would reduce costs. This provides an opening for innovation in Arkansas to address care coordination in these populations.

Arkansas has spent years and thousands of dollars creating reasonable plans towards Medicaid transformation. I am very familiar with the model proposed in behavioral health and less so with the developmental disabilities model. However, I do know that both move us towards innovation and person centered care that this RFI clearly reverses. **Person Centered Care Coordination** will leave to cost savings that the state needs in order to serve the range of individuals requiring supports. One option would be an association of parents, individuals, providers, and the primary care medical home to support care coordination that is person driven across all systems.

To steal a phrase from Michael Kendrick, “people matter more than systems.” This RFI clearly indicates that Gov. Hutchinson disagrees. The lack of consideration given to the citizens of Arkansas should be an embarrassment to every member of the Healthcare Task Force. It is to me and to my son who is number 499 on the home and community based waiver wait list.
Community Input I

1.3.1 - Managed care principles do not fit long term service and support needs.

Long term care services, such as those provided by the Medicaid Home and Community Based Services (HCBS) waiver are not a natural fit for managed care models as developed and implemented by the insurance industry.

Medical managed care models correctly adopt as their premise that the appropriate management of health care can result in healthier customers who rely less on costly health care services. However, the HCBS waiver for persons with intellectual and developmental disabilities (IDD) is not a medical program. It is instead a means by which persons with long term services and supports can more effectively receive services and supports to maintain their lives in home and community based settings, rather than more expensive institutional placement and custodial care.

Managed care principles may help a person to become healthier, and thereby reduce their reliance on costly health care services, but those same principles have no means by which to prevent a person with IDD from having a lifetime of needs for varying levels of services and supports. The developmental disability has a life spanning duration.

1.3.1 - HCBS providers can assist States in designing successful managed health care programs for persons with IDD:

The State should focus on employing a managed care model for health care of all covered persons, and should pay special attention to the inherent needs of persons with IDD which are often different in terms of accessing appropriate health care, especially behavioral health care.

Key to a successful doctor/client relationship is their mutual ability to communicate clearly with one another, and that becomes a frequent challenge for health care professionals when treating or advising persons with IDD.

An HCBS service provider, or a targeted case manager, is likely to have an extended trusting relationship with the person for whom they have provided supports and services.

Introducing a person with IDD into a new managed care medical relationship is far more likely to be successful if the service provider or case manager whom the person trusts is by design a participant in that interaction.

Additionally, for the State to successfully manage the additional challenges of behavioral health services for persons with IDD into any managed care model will require that the State honestly assess the status of MH services currently available for persons with IDD, and consider additional safeguards or incentives which might enable the eventual managed care contractor to address the uniquely challenging barriers that currently stand between persons with IDD and effective MH services. Once again, the HCBS IDD service providers can be the State’s best resource to assure that behavioral health services are well designed
1.3.1 - **The challenges of employing multiple managed care organizations:**

It is a good decision, should the state go forward, that consumers have a choice as to the managed care organization (MCO) that will serve their needs. It is also, however, a challenging administrative matter for the provider community when multiple approaches are taken in the administration of managed care services and in establishing vendor relationships, contracting billing, etc.

Irrespective of the varying administrative approaches each managed care organization may prefer, it is in the interests of the State and in the interests of the State’s vendor community to insist upon conditions such as the following:

- That MCOs utilize common administrative approaches with which all vendors can readily interact.
- That MCOs employ contracting templates approved by the State that all vendors can easily utilize, and that MCOs’ subcontractors be held to the same requirement.
- That the State and the MCOs employ a single billing platform, as opposed to each vendor having to manage multiple billing and reimbursement technologies and protocols.
- That the MCOs not be given the latitude to produce multiple provider manuals. The State should utilize a single provider manual, with reasonable input from the MCOs.

1.3.1 - **Timelines versus preparedness:**

The State should consider a “preparedness calendar” for the consideration and ultimately the implementation of managed care, rather than establish a strict timeline for State officials and MCOs to meet, should there be a decision to go forward with a managed care model. It is impossible for implementation to be successful if steps forward are taken without first receiving and documenting satisfactory outcomes on the first steps of such a process.

2.1 - **HCBS providers can assist States in designing successful managed health care programs for persons with IDD:**

The State should focus on employing a managed care model for health care of all covered persons, and should pay special attention to the inherent needs of persons with IDD which are often different in terms of accessing appropriate health care, especially behavioral health care.

Key to a successful doctor/client relationship is their mutual ability to communicate clearly with one another, and that becomes a frequent challenge for health care professionals when treating or advising persons with IDD.

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Introducing a person with IDD into a new managed care medical relationship is far more likely to be successful if the service provider or case manager whom the person trusts is by design a participant in that interaction. Additionally, for the State to successfully manage the additional challenges of behavioral health services for persons with IDD into any managed care model will require that the State honestly assess the status of MH services currently available for persons with IDD, and consider additional safeguards or incentives which might enable the eventual managed care contractor to address the uniquely challenging barriers that currently stand between persons with IDD and effective MH services. Once again, the HCBS IDD service providers can be the State’s best resource to assure that behavioral health services are well designed and adequately provided.

Community Input II

1.3.1 Innovative Indiana Model with real savings across the entities

Many states are looking to traditional Managed Care Organizations (MCOs) to care for complex populations with mixed financial results. Most have been unable to get agreement to put all the services they receive under the financial responsibility of an MCO. This has limited the opportunity to fully engage everyone in improving the total care received and controlling costs. In Indiana a group of providers consisting of physicians, hospitals, developmental disability providers, mental health providers, and nursing homes have come together to develop an innovative solution to the care of these vulnerable populations.

The group developed a core set of principles by which to guide the model of care for the population. The core set of principals are as follows:
* Risk, responsibility and funding shall be shared across providers to align the system with shared incentives.
* Promotion and achievement of positive health outcomes
* Savings through elimination of unnecessary services through improved transitions between levels of care.
* Elimination of perverse incentives cause behaviors by one set of providers at a cost to the patient and the system of care.
* Improved opportunities for work and stable housing.

From a state perspective the payment methodology and desired budget certainty associated with "managed care" would not look any different from a "traditional" managed care approach. However, similar to Medicare ACOs a shared savings approach could be utilized.

An Indiana Integrated Provider Network (IIPN) would operate under a capitated payment model, with a single administrative structure managing the network, potentially via an arrangement with MCOs. The administrative structure would be responsible for claims processing, quality oversight, program integrity, marketing and all other related administrative functions necessary to operate a managed care system.
The network would operate as a business entity with a governance structure comprised of a board of directors representing all provider types represented within the network.

Any financial risk could be borne by each of the providers within the network with a financial commitment set forth by the board of directors and the members of the network. There would be different types of combined incentives across provider types that would be aligned with outcomes set forth by the state and network board that would:
1. Create financial incentives to ensure all entities are acting in the good of the population and the provider network as a whole.
2. Reduce duplication of services.
3. Increase coordination of transitions
4. Improve the potential for meaningful work for certain populations

The network would seek to align payment structures across the dually eligible population and to the extent possible participate in both the Medicaid and Medicare service provision. The network would form (or utilize a member’s) ACO in order to capture Medicare savings. By doing this it would further reduce pressure on state Medicaid rates.

Other states are moving towards more provided directed managed care. The two most notable are Illinois through Accountable Care Entities and Oregon through Coordinating Care entities. Minnesota is also in the process of adding ACOs to their managed care efforts. We believe the only way to achieve lower costs in the future and having a viable provider community is for the providers to be incentivized to take responsibility for all the needs of the population. Through their direct efforts costs created in the transitions of care will be minimized and incentives will be aligned to reduce overall costs.

Examples of these incentives could include:
1) Greater physician reimbursement for providing access to recent discharges lowering readmissions.
2) Nursing Home incentives to staff consistently between weekends and weekdays and make greater use of physicians and mid levels to prevent readmissions.
3) Incentives for Nursing Homes to assist patients who can be served in the community to transition back to the community.
4) Incentives for a variety of providers to employ people with IDD and SMI reducing costs of care and improving quality of life.

In consideration of major initiatives of change.

Sincerely,

Cindy Mahan, CEO
Friendship Community Care, Inc.
mahanc@fccare.org
479-967-2322 ext. 297
Visit www.fccare.org to learn more about services provided by Friendship to children and adults with developmental and intellectual disabilities.

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Arkansas Department of Human Services
Request for Information: Behavioral Health Services, Developmental Disabilities Services and Care for the Aged, Frail and Physically Disabled

To whom it may concern:

As a stakeholder, a parent of a three year old with developmental disabilities (i.e. a recipient of services), I, Amanda J. Riggs, am responding to Arkansas Department of Human Services’ Request for Information (RFI) exploring the option of contracting managed care organizations to serve Medicaid-eligible Arkansas who require services in one or more of the following special needs areas: Behavioral Health Services, Developmental Disabilities Services, and care for the Aged, Frail and Physically Disabled (collectively referred to as Long-Term Services and Supports). My comments, thus, are geared to the Developmental Disabilities (DD) Services/Programs.

The current model is working. Managed care is an ineffective and unreasonable option for DD services, however IF managed care is the outcome, then the managed care entity should be an association of providers, parents of DD children, individuals with DD and doctors (medical) which would result in a person center care coordination.

Managed care is the easy option....turning it over to an insurance provider who will take their percentage off the top and make up for at the service level...where the real impacts are between therapists and their tools/equipment for such an at risk group, specifically for those children on the Autism spectrum. Research shows that it is critical to have early intervention and begin therapy from age 0-3. Managed care will result in a delay of services, an astounding number of denials for services/treatments needed and assessment will be performed by a third party instead of the provider. This child/provider relationship is critical and the provider is a critical part in adequately assessing DD needs.

Whatever the outcome of the Legislative Task force, all changes must be gradual, staged stages. Most children with DDs do not transition well and often are negatively impacted by changes/stress in their environments.

And, I beg you to put your selves in the shoes of the children and the parents of DD children, especially those children that participate in daycare treatment facilities. More than likely changes implemented would result in moving these children to main-stream facilities that are not capable of handling DD issues. Many parents, including me, have stories about being removed or asked to leave main-stream daycare systems because our child is “not the same.” I would have to resign from my position (losing my salary) to become a stay at home mother to watch my child and coordinate my child’s occupational therapy, developmental therapy, physical therapy, and speech/language therapy from my hope. Consider that “cost” savings...cost to the family unit, cost to the child! I have and will continue to do whatever I need to in order to get the best care for my child that I possibly can! I have been empowered by the his teachers and therapist at Friendship Pediatric Services at Russellville to do so and I will not accept anything less!

Amanda J Riggs
Stakeholder; Parent of 3 year old with Developmental Disabilities
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In response to the State’s Request for Information on Managed Care for Medicaid recipients, I am addressing my input based on my experience with adults who have a serious mental illness, as that is my area of understanding.

To be effective, a managed care provider must:

- Have the interests of the recipients as top priority.
- Have strong knowledge of the area’s resources
- Have or develop a working relationship with ALL service providers
- Identify gaps in services as they appear, and
- Actively work with the community (and funding source as necessary) to fill those gaps*
- Be able to think outside the box in finding appropriate services for each individual, with the values of least restrictive environment and personal choice
- Always be client centered, which in the arena of adults experiencing serious mental illness may need to include family members. This is a serious issue and needs to be thought out carefully for the ultimate benefit of the client.

*there needs to be a means by which identified gaps are reported and dealt with in a timely fashion, such as regular meetings of managed care provider(s) and service providers to problem solve these and other issues as they arise

Managed care seems to me to be an administrative task which could either really facilitate or really cause harm to consumers or potential consumers and that is why I am responding to your RFI. The responsibility could easily be abused and work for the benefit of the managed care company and the providers, rather than for the consumer.

Sincerely,
Nancy Kahanak
Judicial Equality for Mental Illness Coalition member
Former Case Manager
Mental Health America Board member

May 8, 2015
Comments from Kathy Weatherl (FCC) and Jackie Fliss (ILS)

Specific to RFI -

Section 1.3.1 Goals and objectives:

On Goal 3 you state: Slowing or reversing spending growth for these populations and services. It should include a statement to the effect that this slowing or reversing of spending is not detrimental to the health and safety of the individuals receiving the services and supports. Overall care and safety is a key factor, not just the cost of the services.

Section 3.1 General Expectation:

The provider panel should be large enough to offer several options in all areas of the state. Choice must always be present.

How will all providers have access to electronic health records, the state will have to help with funding in this area. Most DD providers do not have EHR at this time and for those who do how will the MCO assure it can work with the EHR already in place at the provider company.

Section 3.2 Expectations for Arkansas Specific Policy Objectives

MCO needs to define how they will include stakeholders in the development of systems?

3.2.1 Behavioral Health, 3.2.2 LTSS, 3.2.3 Developmental Disabilities

Under LTSS you note 2 things: Ensure that clients are able to stay in the care setting best matched to individual need, potentially implementing provider incentives that support this aspiration and incentivizing institutional care facilities to seek out high needs patients. Both of these options should also be included in the DD side.

You note decreasing administrative burden by combining and simplifying existing services that have significant overlap. They should also address the overwhelming need to decrease the amount of required paperwork by regulatory and oversight bodies.

You note align incentives with outcomes. These outcomes should address areas that are not just cost saving and health related but should also address quality of life.

4.2.1 Qualifications and approach

I. Timelines:

- Time lines must include opportunities for stakeholders to comment during every aspect of the process. While these individuals may be experts in the MCO business, they are not experts in the Arkansas System and stakeholders will need to assure all assumptions made by the MCO are correct, especially when it comes to setting rates and assuring unfunded mandates providers have to meet are considered in those rates.
• Timelines should include when all stakeholders will be trained on new system and must include trainings around the state so all can access.

• There should be a Piloting of the new system to assure it works, before going live across the state. All issues/concerns should be worked out in order to assure individual services are not jeopardized and service contractors are not left without funding in order to assure necessary supports are provided.

**General comments on RFI and system change**

Before our state brings in another outside entity to look at our services and see how we can streamline and save costs, the state should look to the providers and assist the providers in finding a way to do this while keeping **ALL** of the savings within Arkansas. We spend too much time and money on outside entities and they are not always the ones who know how to change systems. The state is already paying consultants through the Stevens Firm to come in and make suggestions on changes, why couldn’t our state use these consultants to help Arkansas Providers and the state find ways to keep all of our dollars in this state by forming our own ACO

What will the role of the state be if we go in a managed care direction?

Will state rules and regulations from Medicaid and State Regulatory bodies remain in place? If not, how will decisions be made on expansion of services and providers?

Will MCO's be required to assure the contractors of services meet all HCBS setting rules, WIOA regulations, etc? What is their liability in this if a contractor does not meet these federal regulations?

Through this whole process we all need to remember that the earlier we are able to begin working with individuals the rate of successful skill acquisition is higher and in turn the cost of providing lifelong services and supports decreases.
SUGGESTED CHANGES TO DRAFT RFI

1. Respondents should disclose all litigation involving public or private customers over the past five years.

2. Respondents should detail their plans for sharing savings with the state.

3. Respondents should explain how they would coordinate work with the PCMH network for which Arkansas and primary care physicians have developed.

4. Respondents, or their subcontractors, should detail their previous Arkansas experience.

ADDITIONAL CONSIDERATIONS FOR DHS

1. Instead of trying to carve out managed care for all special needs populations, consider making it for the top 10% high-cost, high-needs populations.

2. How large is the behavioral health scope? For instance, would the population include ADHD children who get care from pediatricians and family doctors?

3. What profit cap for respondents is deemed acceptable?

4. Allow a comment period from stakeholders regarding the RFI before it is released.
Is the state considering an effective Coordinated Care Organization that has the ability to manage the Person Centered Plan? The Family, the Medical provider, and the Community Provider best represent this state and its vulnerable populations. All savings should and shall go back to the Providers (direct care wages) and families (equipment, Therapies).

Does DHHS understand the implications of squeezing more revenue off the top of a system that cannot meet Federal mandates, minimum wage and benefits?

Federal reviews are being used to rebalance the inequities between State funded programs and Community providers.

The rebalancing of funding into the Community must be the driving force with a Coordinated Care Organization of Families, Providers, and the Medical team assuring the Revenues stay in the state of Arkansas.

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Visit www.fccare.org to learn more about services provided by Friendship to children and adults with developmental and intellectual disabilities.

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John and Dawn:

On behalf of the Arkansas Association of Area Agencies on Aging, we appreciate the opportunity to comment on the draft RFI for managed care for special needs populations. We have some specific comments below, but we have two overarching concerns that go beyond the RFI.

First, in the LTSS area, Arkansas Medicaid already uses a managed care approach, at least for the HCBS LTSS services themselves. The state assesses clients and applicants, develops the care plans and sets the rates paid to providers. While we recognize that there are a number of models for serving this population, we believe it would be instructive for everyone to recognize that a large portion of services to the LTSS population is already being provided in a managed environment.

Second, although opinions may vary on this subject, we believe that the current HCBS LTSS programs are under-funded. DHS has acknowledged this in the past. One of the items to be addressed by respondents is the opportunity to reduce spending or affect the rate of growth in expenditures. If a new approach begins with an under-funded program and then seeks ways to spend even less, it is not clear that service improvement will result. It might be useful to request the respondents’ perspectives on the appropriateness of spending levels in addition to approaches to affecting those spending levels.

1. We would suggest that the RFI request more specific information regarding recommended approaches to state-wide and provider-wide adoption of HIT and an EHR. Some providers use EHRs and some HIT features, but many do not have any significant information technology capacity. Thought should be given regarding a plan for funding and adopting the necessary technology for all providers.

2. The RFI does not describe the target population for the LTSS population. We recognize that additional details are being added to the RFI regarding each group. The information regarding the LTSS population should go beyond expenditures and number of enrollees. For example, is this group limited to those individuals who are either in a nursing facility or receiving waiver services? Will it include beneficiaries who do not meet the institutional level of care but who receive or would benefit from similar services—for example, personal care services provided outside of the current waiver population?

3. The RFI does not mention PACE as an option for LTSS clients. We believe that PACE should remain an option where it is available, no matter what managed care
approach may be adopted, and that respondents should address how they would address PACE in their suggested approach for the LTSS population.

4. The RFI will provide descriptive information regarding the beneficiary population. However, there is no similar information regarding the provider population. There are a number of issues that would potentially affect any approach to managed care that an MCO or other RFI respondent might not be able to fully appreciate in the short time given to respond to the RFI. For example, there are issues with different providers in the same program using different employment models that result in significant differences in cost. As mentioned previously, there is wide variation among providers in HIT capacity. The service delivery model in sparsely populated areas of rural Arkansas is often different than in urban areas as a matter of necessity. We are not suggesting that these specific items be included for response in the RFI. However, there is no item in the RFI that reflects a respondent’s knowledge of the provider population or collaboration with those providers. A managed care approach that has worked in another state may not be transferrable in whole or in part if it operates in a different provider environment.

5. Limiting each respondent to one coverage model for each program will also limit the value of the RFI responses. Particularly as the RFI seeks information regarding the respondents’ experience and expertise, one respondent may have useful experience that is relevant to two or more coverage models. But the RFI limits them to addressing only one of those models, thereby omitting the other information. We understand the need to limit the length of the responses; however, we also believe that the information-seeking process should be as complete as possible.

6. Although the RFI contains a brief description on pages 8 and 9 of payment reform efforts to date, a fully informed response requires a more complete understanding of the cooperative work done over the last three years, including the various options that have been considered and rejected and the rationale behind those decisions. This work should be organized and made available to RFI respondents as they prepare their responses.

Again, we appreciate the opportunity to share these comments with you. We look forward to learning more about the opportunities that will be identified as part of the RFI Process.

Robert W. Wright

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P.O. Box 1510
John and Dawn,

On behalf of the Developmental Disabilities Provider Association, we appreciate the opportunity to comment on the draft RFI for managed care for special needs populations. We have some specific comments below, but we have two overarching concerns that go beyond the RFI.

First, in the developmental disabilities area, Arkansas Medicaid already uses a managed care approach for home and community-based services. For developmental disabilities (as with aging and physical disabilities), the number of individuals receiving HCBS services, which are currently offered under a 1915(c) waiver, is capped. Further, the state uses a uniform assessment tool for all individuals receiving HCBS services, which is conducted by a third party and intended to determine accurate service needs. The state is in the process of developing a tiered-rate system for DD HCBS waiver services in which provider reimbursement for the core waiver service, supportive living, will be capped commensurate with the client’s assessed level of need so there is no provider ability to bill for additional supportive living services unless there is an emergency or significant change in condition. In the latter case, any changes in the plan cost must be prior authorized by the state.

Likewise, DDTCS day habilitation services are capped. Providers can only bill for a maximum number of DDTCS hours per day, which is typically less than the number of hours that clients are actually served. The number of clients receiving day habilitation services has been relatively stable in recent years, and growth in DDTCS is consistent with the rest of Medicaid and less than the Medicaid average. Further, day habilitation services are subject to a managed expansion law so that growth is contained by evaluating whether a county is unserved or underserved.

There are specific approval processes and caps for adaptive equipment, environmental modifications, specialized medical supplies, consultation, community transition, and case management. Therapy services (please specify whether those are included within DD/LTSS for purposes of the RFI) must meet specifically defined medical necessity criteria and are subject to intense scrutiny through a quarterly retrospective review process.

In short, on this first point, while we recognize that there are a number of models for serving this population, we believe it would be instructive for everyone to recognize that a large portion of services to the population is already being provided in a managed environment. There is no apparent reason to issue an RFI for managed care unless
institutional services are going to be included along with home and community-based services. The RFI seems to leave open the question of which types of services should be included in responses from the managed care organizations. We urge the state to make clear that any proposal must include all services, not just HCBS, and must specifically address rebalancing.

Second, the current HCBS DD programs are under-funded, as evidenced by the long waiting list as well as no rate increases for years. DHS has acknowledged this. One of the items to be addressed by respondents is the opportunity to reduce spending or affect the rate of growth in expenditures. If a new approach begins with an under-funded program and then seeks ways to spend even less, it is not clear that service improvement will result. It might be useful to request the respondents’ perspectives on the appropriateness of spending levels in addition to approaches to affecting those spending levels.

More specifically:

1. We would suggest that the RFI request more specific information regarding recommended approaches to state-wide and provider-wide adoption of health information technology, including electronic health records. Some providers use EHRs and some HIT features, but many do not have any significant information technology capacity. Thought should be given regarding a plan for funding and adopting the necessary technology for all providers. Effective care coordination and integration will be dependent upon development of an effective, interoperable, user-friendly HIT system. Ultimately the beneficiaries of HIT, the payers, should play a significant role in sustaining provider infrastructure needed to comply with the requirements of data collection and reporting.

2. The RFI does not describe the target populations (level of care) for the DD population. We recognize that additional details are being added to the RFI regarding each group. The information regarding the DD population should go beyond expenditures and number of enrollees. For example, is this group limited to those individuals who are either in a Human Development Center/ICF/nursing facility or receiving waiver services? Will it include beneficiaries who do not meet the institutional level of care but who receive or would benefit from similar services—for example, clinic-based services outside of the current waiver population? Personal care?

3. Limiting each respondent to one coverage model for each program will also limit the value of the RFI responses. Particularly as the RFI seeks information regarding the respondents’ experience and expertise, relevant information may not be addressed because it pertains to experience with different coverage models. We understand the need to limit the length of the responses; however, we also believe that the information-seeking process should be as complete as possible.

4. Although the RFI contains a brief description on page 9 of payment reform efforts to date, a fully informed response requires a more complete understanding of the
cooperative work done so far on DD payment and delivery reform. The volume of work that has been done over the last four years needs to be organized and made available to responding MCOs, including options considered and rejected. The data that has been collected and analyzed needs to be organized into “data books” and made available.

5. The RFI needs to request MCOs to be specific as to the mechanisms for stakeholder engagement and provider training.

6. In other states and in the federal government, the term “long term services and supports” or “LTSS” defines the services, not the populations. LTSS services are provided primarily to populations consisting of DD and elderly and those with physical disabilities. We would suggest, to avoid confusion and promote apples-to-apples comparisons with other states, that the terminology be changed so that LTSS is used to describe the services to all the relevant populations, and not as a short-hand reference to aged and physical disabilities population groups.

Again, we appreciate the opportunity to share these comments with you. We look forward to learning more about the opportunities that will be identified as part of the RFI Process.

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