ARKANSAS DEPARTMENT OF HUMAN SERVICES

Request for Information

Behavioral Health Services, Developmental Disabilities Services
and Care for the Aged, Frail and Physically Disabled

Issue Date: May 15, 2015

Closing Date: June 15, 2015

The Arkansas Department of Human Services (DHS) is exploring opportunities in 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 referred to as Long-Term Services and Supports, or LTSS).

1. INTRODUCTION

1.1 INSTRUCTIONS TO RESPONDENTS

The State of Arkansas is issuing a Request for Information (RFI) as specified below. Responses are to be submitted by **12 PM Central Time on June 15, 2015** in an e-mail attachment in Microsoft readable format not to exceed the page limits as specified below. Responses should be submitted to dhs.medicaid.rfi@arkansas.gov.

Questions regarding the contents of this RFI may be directed to the above address prior to 12 PM CT on June 1, 2015. Responses to questions will be posted no later than June 8, 2015.

1.2 DISPOSITION OF RESPONSES

All responses become the public property of the State and will be a matter of public record subject to the provisions of the Arkansas Freedom of Information Act, Ark. Code Ann. § 25-19-101 *et seq*.

If the response contains material that is considered by the respondent to be confidential under state or federal law for any reason including because it is proprietary, copyrighted, or capable of giving an unfair advantage to competitors, the respondent must submit a second electronic copy of the response in Microsoft readable format with that material redacted. In an attachment to the response, respondent shall set out the basis for the claim of confidentiality or potential unfair advantage. Even if redacted material is withheld from public release, the redacted material may nonetheless be shared in full with members of the Arkansas Health Reform Legislative Task Force created by Act 46 of 2015.

The State shall have the right to use all ideas, or adaptations of those ideas, contained in any response received to this RFI. While all questions in this RFI are optional, respondents are strongly encouraged to provide responses to all questions as thoroughly as possible.

1.3 INTENT OF THE RFI

DHS is issuing this RFI for planning purposes with the intent to gather information on potential future strategic opportunities related to the program areas covered. This RFI shall not be construed as a commitment by DHS to solicit contractual offers or award contracts.

Evaluation of the responses to this RFI by DHS will be undertaken primarily to gauge the aggregate level of qualified interest from potential vendors, assess the overall magnitude of the opportunity identified by potential vendors, and inform the design of any RFP or eventual managed care program. Responses will not be evaluated on a competitive basis, and at no point does DHS intend to publish formal results of an evaluation of responses to this RFI.

DHS will, at its sole discretion, exercise the option to meet with one or more organizations who submit responses to this RFI, after the submission of responses by the deadline specified above.

1.4 PURPOSE

Over the past three years, Arkansas has been involved in a multi-payer and multi-stakeholder reform effort to create a sustainable, patient-centered health system that (1) improves the health of the population; (2) enhances the patient experience of care, including quality, access and reliability, and (3) reduces, or controls, the cost of health care. At the center of this effort is the desire to deliver coordinated, patient-centered and cost-effective care, organized around consumers' comprehensive health needs across providers and over time.

As part of its continued commitment to reform and innovation, the Arkansas Department of Human Services (DHS) is exploring opportunities to contract 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 (referred to in this document and accompanying materials as Long-Term Services and Supports, or LTSS).

1.4.1 Goals and objectives

DHS considers the following goals to be central to its efforts to continually improve care for each of the populations covered by this RFI:

- **Improving the experience of care,** including quality, access and reliability, for all Arkansans that use these services
- **Enhancing the performance of the broader health system,** leading to improved overall population health
- **Slowing or reversing spending growth** for these populations and services while maintaining quality and access to care
- **Furthering the objectives of Arkansas payment reform** and the State's ongoing commitment to innovation as outlined in this document.

In support of the above goals, DHS seeks to achieve the following objectives for this RFI process specifically:

- **Understanding the capabilities and interests of potential partners** in serving the populations and services described below
- **Learning from the experience and perspectives of MCOs** on program structure and design for a potential managed care program
- **Generating new ideas and approaches** that will inform the course of the State's evaluation of managed care opportunities
- **Garnering an initial view** from potential partners on the potential for performance improvement in outcomes, access and efficiency available within each program area

1.4.2 Scope

Respondents can elect to address one or more of the three programs listed in Information Table 1 that follows. For each program, a coverage model should be proposed based on the options

provided. It is acceptable to select a different coverage model for each population chosen (e.g., "specialty services only" for LTSS and "full population-based coverage" for behavioral health). Section 2.2 as well as the accompanying Data Appendix defines in detail the full scope of clients and services included in each of these program areas.

Section 4 provides further detail to guide responses. Respondents will be asked to specify the program areas and populations included in the scope of their response, describe the chosen coverage models, provide appropriate rationale for their selections, and elaborate on the perceived challenges and opportunities associated with different options for population and service coverage, program integration and implementation.

Information Table 1: Arkansas Special Needs Programs and Coverage Models				
	Coverage Models			
Programs	Specialty services only	Select population-based coverage	Full population-based coverage	Full population-based coverage with Medicare integration
1. Behavioral health	Coverage of BH services for all clients eligible to receive them, including BH specialty pharmaceuticals	Coverage of all BH services and Medicaid-funded "halo" spend (i.e, medical and pharmacy) for a subset of BH clients	Coverage of BH services and Medicaid-funded halo spend for all clients receiving any BH services	"Full population-based coverage", plus all medical/ pharmaceutical coverage for Dual-eligibles within the BH population
2. Developmental Disabilities	Coverage of DD services for all clients eligible to receive them	Coverage of DD services and Medicaid-funded halo spend for a subset of DD clients	Coverage of DD services and Medicaid-funded halo spend for all clients receiving any DD services	"Full population-based coverage", plus all medical/ pharmaceutical coverage for Dual-eligibles within the DD population
3. Long-Term Services and Supports	Coverage of LTSS services for all clients eligible to receive them	Coverage of LTSS services and Medicaid-funded halo spend for a subset of LTSS clients	Coverage of LTSS services and Medicaid-funded halo spend for all clients receiving any LTSS services	"Full population-based coverage", plus all medical/ pharmaceutical coverage for Dual-eligibles within the LTSS population

2. CONTEXT

2.1 MEDICAID IN ARKANSAS

DHS' vision for Medicaid programs in Arkansas is to ensure that all Arkansans are healthy, safe, and enjoy a high quality of life. Arkansas' Medicaid program served over 902,378 beneficiaries in State Fiscal Year (SFY) 2014, or 30% of the state's total population; this number was up 16% from SFY 2013. Total beneficiaries included 496,121 children, or 58% of children in the state, as well as approximately 240,000 clients as part of the premium assistance expansion program. Claims were processed for 11,785 providers. For purposes of this RFI, clients included in Arkansas' premium assistance Medicaid expansion program are considered outside the scope of the included programs and populations.

The Medicaid operating budget for SFY 2014 was $5.3 billion. Arkansas funded approximately 29.9% of its Medicaid program-related expenditures in State Fiscal Year 2014, with the federal government funding the remaining 70.1%. Administrative expenses generally are funded 50% by the state and 50% by the federal government.

Respondents are advised that Arkansas Medicaid is subject to the *AMS vs. Reynolds* consent decree[1], which has the potential to limit flexibility in reducing or maintaining provider rates for certain services. These services include physicians; home health; private duty nursing; physical therapy; speech therapy; occupational therapy; podiatrists, chiropractors; and dental services.

2.2 OVERVIEW OF BH, DD AND LTSS POPULATIONS AND THEIR CARE

Arkansas DHS has an important responsibility to care for some of the state's most vulnerable populations including those with behavioral health needs (BH), intellectual and developmental disabilities (DD), and the aged, frail and physically disabled (LTSS). The sections below detail the key facts for Arkansas Medicaid for each program area as well as select comparisons to national benchmarks based on available reports. Each program area consists of a mix of waiver and non-waiver services, as well as institutional, inpatient, outpatient and home and community-based services, all of which are included in the scope of this RFI. The full details of each population, program and service area considered in-scope for this RFI, along with relevant definitions, are contained in the Data Appendix.

The total population within the scope of this RFI included 170,149 clients in SFY2014, including 108,950 BH-only clients, 20,261 DD-only clients, 31,770 LTSS-only clients, and 9,168 clients utilizing services across two or more of these areas (see Data Appendix Exhibit 1). The scope of this RFI includes the Medicaid-eligible population only, excluding the population covered by the State's premium assistance Medicaid expansion program. Data provided is for the Medicaid spend of these individuals only, not including costs borne by other payers (e.g., Medicare).

[1] https://www.medicaid.mmis.arkansas.gov/Download/general/publicdata/reynolds_consent_decree_condensed.pdf

2.2.1 Behavioral Health

Total spend in behavioral health was $595 million in 2014, or approximately $5,050 per individual, reflecting growth of 1.5% per annum and -0.6% per annum per individual since 2011

- 54% of total BH expenditures were in outpatient settings; 26% in inpatient settings; 18% for specialty pharmacy (i.e., psychotropic drugs for behavioral health clients); and 3% home-based support services (i.e., personal care and home health for behavioral health clients)
- Total Medicaid-funded medication expenditures for behavioral health clients in Arkansas was $1,269 per client. According to the CDC, 9.9% of children in Arkansas received ADHD treatment in 2011-2012 relative to 6.1% of children nationally
- Children account for two thirds of total Arkansas BH clients, or 78,669 children relative to 39,138 adult clients
- For clients who received behavioral health services in specialist settings (excluding services for behavioral health diagnoses in settings such as primary care), average "core" behavioral health spend was approximately $6,530 per client in 2014. This same set of clients also had Medicaid-funded "halo" spend (all non-behavioral health inpatient, outpatient, professional and pharmacy spend) of approximately $3,700 per client
- 580 providers (based on provider billing ID) delivered services across "core" behavioral health service areas in 2014. 73% of clients received behavioral health services from just one provider during the year
- Spend is concentrated in a subset of severe clients, with the 10% highest-expenditure clients accounting for 50% of total costs (including both core and halo spend)

2.2.2 Developmental Disabilities

Spend in DD was $653 million in 2014, or approximately $23,730 per individual, representing a growth rate of 5.3% per annum and 2.2% per annum per individual since 2011

- 27% of total DD expenditures were in institutional settings; 41% in community settings; 30% in home settings; <1% in case management; and <1% in other outpatient service (i.e., Autism waiver services)
- 41% of Arkansas DD individuals live in a home or family setting, relative to 64% of DD individuals nationally
- Two DD waiver programs are operating in Arkansas, the Alternative Community Services (ACS) Waiver (4,126 unique clients in 2014) and the Autism Intensive Intervention Provider Waiver (114 unique clients in 2014). Most DD individuals, or 23,285 individuals, are non-waiver recipients
- Approximately 3,000 individuals have applied for, but are not currently receiving, waiver services through the Alternative Community Services (ACS) Waiver.
- Across all DD clients, average "halo" spend (all non-DDS inpatient, outpatient, professional and pharmacy spend) was approximately $6,380 in 2014. 92% of DD clients had Medicaid-funded halo spend in excess of $100 in 2014
- 717 providers (based on unique provider billing ID) delivered services across "core" DD

service areas in 2014. 56% of clients received DD services from only one provider during the year

2.2.3 Long-Term Services and Supports

Spend in LTSS was $903 million in 2014, or $26,490 per individual, representing a growth rate of 1.5% per annum and 2.8% per annum per individual since 2011

- 76% of total LTSS expenditures were in institutional settings; 2% in community settings (i.e., assisted living and adult day care); 21% in home settings; and <1% in case management
- Four LTSS waiver programs are currently operating in Arkansas, the ElderChoices Waiver (6,315 recipients); the Independent Choices waiver (2,976 recipients); the Alternatives for Adults with Physical Disabilities waiver (2,655 recipients) and the Assisted Living waiver (1,082 recipients). A total of 11,688 unique clients participated in one or more LTSS waiver program in 2014, accounting for approximately 34% of all LTSS clients.
- There has historically been no sustained waiting list for HCBS services in Arkansas
- Across all LTSS clients, average "halo" spend (all non-LTSS inpatient, outpatient, professional and pharmacy spend) was approximately $2,485 in 2014. Approximately 50% of LTSS clients had Medicaid-funded "halo" spend in excess of $100 in 2014.
- 2,912 providers (based on unique provider billing ID) delivered services across "core" LTSS service areas in 2014. 48% of clients received LTSS services from only one provider during the year

2.3 OVERVIEW OF ARKANSAS PAYMENT REFORM

Arkansas is leading the nation in innovating the way that care is paid for and delivered across the state. This reform effort is a multi-payer commitment to creating a sustainable, patient-centered health system that simultaneously promotes the following three aims:

- Improving the health of the population
- Enhancing the patient experience of care, including quality, access, and reliability
- Reducing or controlling the cost of healthcare

The initial impetus for these reforms included poor overall health status of the Medicaid-eligible population in Arkansas; difficulties facing Medicaid-eligible clients in accessing services and navigating the system; and unsustainable cost growth across the Medicaid program. In response, Arkansas has developed a concept and plan for a statewide, multi-payer payment system that rewards value and patient health outcomes through innovative care delivery. Mechanisms include population-based care (i.e., medical homes, health homes) and episode-based payments. Beyond the populations and programs covered by this RFI, the payment reform initiative includes results-based payment and reporting; healthcare workforce development; consumer engagement, and health information technology (HIT) adoption.

It is the intention of DHS that any introduction of managed care build on the progress made in payment reform to-date and further the State's ongoing commitment to innovation in creating a

sustainable, patient-centered health system.

Arkansas' approach for the special needs populations included in the scope of this RFI has evolved over time in step with the overall payment reform initiative and is described in detail in section 3.2. Respondents are strongly encouraged to visit the Arkansas payment reform web site[2] to fully understand the scope of the effort and evolution of specific initiatives over time.

3. OVERVIEW OF EXPECTATIONS FOR MANAGED CARE ORGANIZATIONS

3.1 GENERAL EXPECTATIONS

Should the State decide to move towards managed Medicaid in one or more of these service areas, partner MCOs would be expected to establish a presence in the service area and demonstrate how the vendor will be responsive to the needs of the service area. These would include:

- **Operational functions**. Directly or through subcontract perform key functions including, at a minimum: eligibility verification; member services; provider network and provider services; provider relations; claims processing; medical management; quality management; utilization management; grievance system; and corporate compliance
- **Network**. Develop and maintain a provider panel that is adequate to meet the needs of all individuals covered within the scope of the contract
- **Emergency services**. Provide, either directly or through subcontract, 24/7 crisis intervention and access to emergency services staffed by qualified professionals (for responses including the Behavioral Health program area)
- **Continuum of care**. Ensure that the contracted delivery system provides the full continuum of care for the given special needs population/service area, including but not limited to home and community-based services, program-specific inpatient and residential services, supportive services, peer and family support, patient outreach, education, engagement and follow-up
- **Integration of care**. Employ a multi-disciplinary health care team approach to coordinating and facilitating integrated care with shared access to medical records and information as appropriate
- **Information technology**. Coordinate care using health information technology and an electronic health record which provides information to measure system and member-level outcomes
- **Quality improvement**. Measure and assess costs, quality, outcomes and processes in partnership with the state, accepting joint responsibility for system performance
- **Cultural sensitivity**. Provide services and supports that are culturally competent and sensitive to the needs of the Arkansas Medicaid population

[2] http://www.paymentinitiative.org/

3.2 EXPECTATIONS FOR ARKANSAS PAYMENT REFORM

Respondents are expected to propose an approach that meets Arkansas' general policy objectives set forth in the preceding pages, as well as its specific policy objectives for each special needs program as specified below. Respondents' proposed approach for each program should ultimately include a combination of the following:

- **Adoption of the existing elements of payment reform described below**, either in current or modified form, or;
- **Design and implementation of new models to achieve similar results,** combining capabilities, experience and expertise from other states or programs to help achieve Arkansas' stated policy objectives

Response guidelines follow in Section 4.

3.2.1 Behavioral Health

Respondents are expected to collaborate with DHS and the existing delivery system, including providers and other stakeholders, to establish functioning systems to achieve the following aims:

- **Improve the current service delivery system** through new services directed toward higher-needs clients (e.g., group recovery support, partial hospitalization)
- **Enhance early interventions** through reimbursements for selected services (e.g., crisis intervention, substance abuse treatment)
- **Incentivize cost-effective care** through payment reform. To date, Arkansas has developed and launched two episode-based models (i.e., ADHD and ODD) and has an additional episode preparing for launch (i.e., comorbid ADHD/ODD)
- **Improve care coordination** through health homes at two tiers of acuity (for clients with more complex behavioral health needs; clients who may need some BH services but who are at a lower level of overall BH need would see their care coordinated by their patient-centered medical home)
- **Improve screening and assessment** through a universal assessment process to identify services and develop care plans best matched to individual need.

3.2.2 Developmental Disabilities

Respondents are expected to collaborate with DHS and the existing delivery system, including providers and other stakeholders, to establish functioning systems to achieve the following aims:

- **Match level of care to need** (e.g., home vs. day vs. institutional setting) and increase access to early interventions and prevention-related services and activities
    - Implement standardized assessments to segment clients based on complexity of needs (i.e., DD-related and medical / behavioral)
    - Align incentives with outcomes by defining payment tiers based on complexity of needs

- Grant providers greater flexibility to allocate funds across the client base to optimize care and outcomes

- **Align incentives with outcomes** through the selection of quality metrics and improved use of incentives

  Promote coordinated care through innovative approaches, perhaps including a health home in the future.

3.2.3 Long-Term Services and Supports

Respondents are expected to collaborate with DHS and the existing delivery system, including providers and other stakeholders, to establish functioning systems to achieve the following aims:

- **Match level of care to need**
  - Provide standardized assessments at entry to identify service requirements and develop care plans best matched to individual need, while maintaining the tenets of "no wrong door" for gaining access to necessary services
  - Expand access to services in the home and community (e.g., by making services available to elderly clients that are currently only available to younger clients)
  - Ensure that clients are able to stay in the care setting best matched to individual need, potentially implementing provider incentives that support this aspiration
  - Incentivizing institutional care facilities to seek out high needs patients
- **Align incentives with outcomes** through the selection of quality metrics and improved use of incentives
- **Decrease administrative burden** by combining and simplifying existing services that have significant overlap
- **Promote coordinated care through innovative approaches**, perhaps including a health home in the future**.**

4. INFORMATION REQUESTED

4.1 PROGRAM DESIGN

Response to the lettered items in this section (4.1) should be limited to six pages in total.

A. Program inclusion. Please identify which cells of the Services and Populations matrix (Information Table 1) are covered in the response. Respondents can select one, two, or three of the programs below, and are encouraged to consider responding to all three as appropriate given the experience and capabilities of their organization:

- Behavioral Health
- Developmental Disabilities
- Long-Term Services and Supports

Respondents should briefly comment on why they have chosen to include – or exclude – any of the above programs from their responses. If respondents would propose to cover only a subset of the population included in any of the program areas as defined (e.g., adults or

children only, or high-needs clients based on spend or type of services), they should clearly describe the approach for defining and identifying the sub-population to be included, provide the rationale for the proposed approach, and describe how they would ensure seamless care and transitions between the managed care program and traditional Medicaid.

B. Program integration: Respondents should describe the opportunities and challenges associated with integrating care for more than one of the special needs programs listed above into the same managed care program (e.g., DD and LTSS). If including more than one program area in their response, respondents should comment on the degree to which the programs should be integrated, and are encouraged to similarly structure and integrate their responses to the questions posed in 4.2 below.

C. Coverage models: For each of the programs selected, respondents should identify the corresponding coverage model. Respondents should select one coverage model per program to serve as the basis for their response, but are encouraged to provide the rationale for this selection along with the tradeoffs associated with the various options. The model selected should reflect the respondents' view of the most appropriate model for the given program as well as the respondent's capabilities and strategic goals

- Specialty Services Only
- Select Population-Based Coverage
- Full Population-Based Coverage
- Full Population-Based Coverage with Medicare Integration (e.g., Dual Eligible Special Needs Plans, or D-SNP, demonstration)

D. Approach to Population-Based Coverage. Respondents selecting a Population-Based Coverage model for any of the three special needs program areas should briefly comment on the following:

- 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
- The respondent's capabilities and prior experience implementing similar population-based programs for the special needs program(s) in question
- The respondent's proposed approach to operationalizing population-based coverage, required integration with the traditional Medicaid program, differential treatment of specific sub-populations (including how those sub-populations would be identified) (e.g., providing medical services to high-needs clients while the medical services of other clients continue to be covered by traditional Medicaid).

E. Integration with Medicare. Respondents should elaborate on their decision to select, or not select, a coverage model that requires integration with Medicare for each special needs program. Respondents should briefly comment on the following:

- Opportunities and challenges inherent to pursuing financial or administrative

alignment between Medicaid and Medicare in a managed care setting
- Respondent's capabilities and prior experience in implementing programs that seek to align – financially or administratively – the Medicaid and Medicare programs (e.g., Dual Eligible Special Need Plans demonstration programs).

4.2 PROPOSED APPROACH BY PROGRAM TYPE

Responses to the questions posed in this section should be provided for each program area included in the response (i.e., BH, DD, LTSS). Respondents choosing to address multiple special needs areas, and proposing some degree of integration between these program areas above, are strongly encouraged to structure their responses in a way that reflects this proposed program integration.

Responses to the lettered items in this section (4.2) should be limited to ten pages in total per program area addressed in the response (i.e., up to 30 pages for a response that addresses all three program areas).

4.2.1 Qualifications and approach

F. General Experience. Please describe your organization's expertise with each element of the expectations set forth in Section 3.1, as well as the outcomes that your organization has achieved in other, similar programs.
- Describe in detail the experiences that your organization has had in implementing programs that serve the special needs areas included in your response, clearly delineating between Medicaid and non-Medicaid (e.g., commercial) experience
- Describe in particular any current presence or past experience your organization has had within the state of Arkansas
- Please comment on how you see these potential program areas fitting into your organization's broader business model

G. Innovation. Please elaborate in detail on the approaches and tactics that your organization would pursue to help achieve Arkansas' stated policy objectives, either meeting or going beyond what is specified in the Arkansas payment reform objectives for each program area mentioned in Section 3.2 (e.g., for Behavioral Health, approach to care coordination either including or outside of the Behavioral Health Home model described).
- Please describe in detail the experiences that your organization has had in achieving policy goals similar to those outlined above, providing further detail behind each experience and implementation listed
- For each special needs program area, please comment on the specific programs and initiatives outlined in Sections 3.2.1-3.2.3, elaborating on which ones would be most appropriate to implement in current or modified form, and which alternatives should be considered based on the experiences and capabilities of your organization
- Please briefly comment on any other lessons learned from previous experiences

H. Challenges. What challenges do you anticipate for effective implementation of the Arkansas-specific policy objectives described (e.g., standardized assessments, value-based payments, optimizing setting of care, and Health Homes / other coordinated care models)?

I. Implementation and timeline. Provide a draft timeline for implementation including time required between contract award and go-live, as well as any additional time that may be required following go-live to meet specific policy objectives.

- Responses should outline the amount of time that would be required for activities such as developing the necessary infrastructure; hiring staff and building systems and protocols; engaging with stakeholders; building the provider network; and educating clients and their families
- Respondents should comment on their proposed approach to ensuring continuity of care and seamless care plans transitions for clients, including but not limited to clients who may be transitioned to community-based services for the first time

4.2.2 Opportunity sizing

J. Improving quality and other key outcomes. Drawing on the data that we have provided in the Data Appendix, please comment on the impact that the proposed program can be expected to achieve by providing the following:

- Overall view of areas of opportunity and potential impact within each, with reference to specific data points or indicators where possible (e.g., expected shift in the share of total LTSS spend in home and community based settings by X%)
- Conditions or assumptions that would need to be in place in order to achieve the impact described above
- Any relevant information on historical impact for programs that you have led in other states, on comparable metrics or others deemed to be relevant
- Additional metrics that you believe the proposed program would impact and that are important for ongoing program calibration

K. Slowing spending growth. Based on the data and information that we have provided, what do you believe the size of the opportunity is in Arkansas to reduce spending or affect the trend on spending growth while maintaining quality and access? Please provide the following:

- Your perspective on the overall opportunity and the time to capture (e.g., what can be achieved in the first year; what is achievable over a five-year period), as it relates to both overall program spending and the trend rate of spending growth
- Conditions that would need to be in place in order to achieve this impact
- Information on impact that your organization has achieved in similar programs

4.3 PERSPECTIVES BY PROGRAM TYPE

This section is designed to gather potential partners' perspectives on other aspects related to the potential design and implementation of managed care programs in the state of Arkansas. Responses should provide detail on rationale and potential alternatives. Separate responses should be provided to the items below for each area of the Populations and Services Matrix to be pursued. Responses to the lettered items in this section should be limited to five pages in total per program addressed in the response (i.e., up to 15 pages for a response that addresses all three program areas).

4.3.1 Market Structure

Responses to the following questions should address your perspectives on the main options and alternatives to be considered, and rationale for each.

L. Geography: What are the challenges and opportunities associated with the following geographic contracting options?

- Statewide contracts covering a given population or set of services across Arkansas
- Two regionalized contracts covering a given population or set of services under the auspices of a single program
- More than two regionalized contracts under the auspices of a single program

M. Choice and Competition: What are the challenges and opportunities for patients, providers, MCOs, and the State in contracting with multiple vendors for each market segment to instill patient choice and competition between managed care plans?

N. Enrollment: What are the considerations in deciding between a mandatory enrollment model and a voluntary enrollment model for a managed Medicaid program for a special needs population? What processes and criteria for auto-enrollment should the state consider, especially in markets where multiple competing plans exist?

O. Waiver requirements: Based on your organization's experience in other settings, what would be the waiver or state plan amendment requirements associated with implementing managed care for the special needs areas covered in your response? In covering waiver services, based on your experience, which activities and functions would be best delegated to the MCO versus retained by DHS?

4.3.2 Partnership Terms

P. Contract Length: What are the challenges and opportunities associated with the following Terms of Contract?

- Three years subject to one additional successive period of 24 months
- Five years subject to one additional successive period of 24 months
- Three years subject to two additional successive periods of 24 months each

What alternative Terms of Contract should be considered?

Q. Rate Setting: What processes, criteria and considerations are important to the rate setting process for the populations/services covered in your response? What role should competition or negotiation over rates ultimately play in a Request for Proposal (RFP) process?

R. Visibility into future terms: What contractual terms for future years would be most helpful to know in advance, and why? (e.g., rates)

S. Additional terms: What other terms should the state consider for managed care contract(s)?

T. Quality improvement: What opportunities exist for measuring, reporting and ultimately improving quality for the populations/services covered in your response? What are the obstacles to doing so and how can these obstacles be addressed?

U. Delivery system: What are the challenges and opportunities in Arkansas' current delivery system for the populations/services covered in your response? What role can managed care play in working with the provider network to collaboratively build capabilities? (e.g., building capabilities in provider organizations for adoption of EHR/HIT solutions)

4.3.3 Additional information

V. What additional approaches, tools, or experiences do you bring that go beyond the questions asked above?