



**STATE OF ARKANSAS**  
ASA HUTCHINSON  
GOVERNOR

**Governor's Advisory Council on Medicaid Reform**  
Freeway Medical Building, Boardroom.  
November 9, 2015

Feedback Provided on The Stephen Group Report and the Governor's  
letter to the Health Reform Task Force

# AR Dept Health's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
1 "rewarding healthy living"	▪The ADH strongly supports the Governor's comments on "rewarding healthy living." The Governor rightly identifies healthy living as a key driver of health outcomes and costs. As the Governor has pointed out, promoting and incentivizing healthy lifestyles ties together very well with his "Healthy Active Arkansas" initiative.
2 Addressing health care needs early	▪The ADH strongly supports the Governor's comment that "While fiscal responsibility is important, it is even more important that we keep the people of our state healthy and by addressing their health care needs before they require expensive medical interventions."
3 Selective use of managed care	▪We agree with the Governor's assessment of the potential benefits of utilizing managed care, "but only for limited and targeted populations." As TSG Report notes, most of the potential savings from managed Medicaid comes from selected high cost populations. We agree with the Governor that the episodes of care and PCMHs are very promising for both controlling costs and improving quality of care; these should continue to be supported.
4 Organizational changes	▪We agree with TSG Report that strong consideration should be made to restructuring the Arkansas Medicaid program and moving it to a cabinet level position. I have attached a recent article that explores this issue in greater detail by former Arkansas Medicaid Director Andy Allison.
5 Additional considerations	▪The ADH generally supports the improvements in vendor management suggested in TSG Report. Specifically, we would welcome streamlining the procurement timeline, improving the recruiting processes to attract more highest-quality new hires, sharing vendor performance data between agencies, and capping indirect costs.

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# AR Dept Health's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
6 Telemedicine	▪We strongly support the use and expansion of telemedicine as an effective approach to both improving access to specialized care and controlling costs. Telemedicine is still relatively new in Arkansas, but there are already a number of excellent examples of its application to the benefit of Arkansas residents.
7 Centers for population health improvement	▪We strongly support incentivizing the establishment of centers for health improvement at Arkansas colleges and universities and developing a Center for Health Excellence along the lines described in TSG Report (vol. II, pp 69-73). Building technical and professional capacity within the state should be a high priority.

# UAMS's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
<p>1 ...</p>	<p><b>•Preventive care should be available to all and encouraged by appropriate financial incentives for patients and providers (Patient Centered Medical Homes, or PCMH)</b>            Assistance with development of IM programs in community hospitals through the UAMS COM Department of Medicine and Office of GME.</p>
<p>2 ...</p>	<p><b>Healthy life style promotion should be incorporated into plans and payment models.</b>            Dr. Dan Rahn, Chancellor of UAMS has been a key proponent of the Healthy Active Arkansas proposal that was recently endorsed by the Arkansas Hospital Association. Hospitals are being asked to champion the campaign to fight obesity in their communities.</p>
<p>3 ...</p>	<p><b>Payment should be directed toward higher quality outcomes not quantity of billable services provided. Payment should encourage high performance health care teams in which a every team member functions to the highest level of their training and competency and should be focused on outcomes. (Episode based payments and PCMH)</b>            The UAMS Regional Programs is already a leader in the adoption of the PCMH model and success in population health management. Expanding and enhancing the work already being done by this group to the rest of the state would provide a mechanism to manage the burden of chronic disease. UAMS Imaging Services is working toward the adoption of ACRSelect, a software system that identifies appropriate utilization of imaging studies. Third party payers are interested in the solution and are willing to consider removal of prior authorization if the system is in use at health care facilities. Following a successful implementation at UAMS, this could be adopted statewide.</p>
<p>4 ...</p>	<p><b>Chronic disease management should be coordinated with primary care, based on best available evidence and should reward outcomes (best outcomes, lowest amount of avoidable events – hospitalizations, and lowest cost.) Payment should be designed to incent the achievement of these goals through episode-based payments</b>            Extend antibiotic stewardship to other hospitals and LTAC's.</p>

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# UAMS's Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

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**The appropriate use of Distance Health technology incorporating best available evidence in the development of care guidelines should be incorporated into chronic disease state management and payment.**

The Center for Distance Health proposes that their resources could be used as the tool to support actionable items proposed in the Arkansas Health Care Reform Task Force report. ED-to-ED transfers. Reducing unnecessary (and costly) transfers could be avoided through targeted triage provided by nurses and specialists through the existing UAMS toll-free Physician Call Center. It will include collaboration with the Arkansas Trauma Communication Center and the Emergency Medical System. (Appendix A)

Image Repository. UAMS helped create and currently operates the statewide Trauma Image Repository and the Stroke Image Repository. Other image dependent transfers such as orthopedics could be facilitated through this same technology.

Correctional facilities specialty support. Decreasing the transport of offenders outside prison walls would save money through avoiding transportation costs and payment for additional guards. It is also an improvement in public safety. UAMS is already providing these services to Wrightsville Prison.

Tele-medical diagnosis of diabetic retinopathy

Neonatal airway management support from UAMS neonatologists (Appendix B)

Hep C care (New Mexico Project Echo)

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**Special high cost populations should be approached with a statewide strategy similar to the statewide trauma system. Specific special populations for which very large opportunities exist include individuals with intellectual and developmental delay (ID/DD) population. UAMS has the capacity to manage this program statewide. We also have prepared and provided a specific recommendation for a three tiered system for behavioral health transformation.**

Kent's proposal for the population with developmental disabilities. (Appendix C)

Bio-repository at JEI for patients with genetic ocular disease (Dr. Westfall will have to provide more detail)

# UAMS's Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

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**The UAMS College of Pharmacy's Evidence Prescription Drug Program (EBRx) has the capacity to design a comprehensive prescription drug program for all state health benefit programs. We believe this holds significant potential for cost savings.**

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**A systemic approach to health education of the entire population should be undertaken to improve health literacy.**

Statewide implementation of screening question for health literacy.

UAMS wholesale adoption of the teach-back method then offer classes in teach-back method around the state (via distance health infrastructure)

Beyond the initiatives and recommendations described in the "We Can Do Better, Let's Do Better" brief prepared by Dr. Dan Rahn, Chancellor at UAMS and in response to the events that have taken place since the Stephen Group presented their report to the Legislative Task Force on Health Care Reform, UAMS has taken a closer look at their opportunities to participate in improving the health and health care of Arkansans. No single health care entity in the state possesses all of the needed services to care for the population. However, in the recent collaboration announced by UAMS, ABCBS, Baptist Health, Washing Regional and St. Barnard's Health System, a platform has been created to develop the necessary relationships and affiliations that encompass the entire continuum of care. Innovative ideas coupled with traditional care will be required to move the needle and bring Arkansas up from its health ranking of 49th in the country.

In order to assure that citizens take advantage of the opportunity for expanded health care coverage, UAMS will continue to provide financial counseling, in-person assistors and certified navigators at points of entry in the system. The data at UAMS, during the first 18 months of implementation of insurance expansion demonstrate the desired outcome of exponential growth in outpatient clinic visits coupled with flat to decreased emergency room visits. However, the acuity of the care being provided in the emergency department continues to increase. This tells us that patients are receiving their care in more appropriate and more cost effective settings.

# Arkansas Children’s Hospital’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>1</b> Support Value-Based Payment Systems</p>	<p>Value-Based Payment Systems incentivize health care systems to balance the costs of providing care with quality and patient outcomes. ACH recognizes Arkansas’s need to improve the financial sustainability of the Medicaid program. We also recognize our shared responsibility in providing the highest quality of healthcare and the best health outcomes for Arkansans. We believe that the best way to achieve this is continued direct partnership with the Medicaid program to improve the payment system by transitioning to a value-based payment methodology.</p>
<p><b>2</b> Continued Support for Current Reforms</p>	<p>PCMH has been extraordinarily successful and has already produced savings. Episodes of Care have had lesser financial impact, however, the targeted quality outcomes have improved, and it has been a relatively short time period. The vision and financial impact of the Episodes of Care model cannot be measured until the program has been brought to scale. As Medicaid gains experience and builds expertise and infrastructure, development costs will go down. Additionally, as other States, the federal government, and private payers move in this direction, payers can share costs of development and the full return on investment can be realized.</p>
<p><b>3</b> Managed Care is not a Synonym for Value Based</p>	<p>Managed care is not the same thing as value-based payment reform. The former is a contractual arrangement with the State Medicaid program, while the latter seeks to truly transform the healthcare delivery system by placing the financial incentives on outcomes rather than volume. TSG has noted that both Episodes of Care and PCMH can be continued within a managed care environment, however, a managed care environment would also interject additional complexities to the multi-payer process already in place. Providers would face additional contracting issues, reporting systems, metrics and standards, and payment methodologies. Conversely, continued direct interaction with the State Medicaid Agency minimizes complexities, and ultimately reduces costs to the State by avoiding the administrative fees paid to the managed care companies.</p>
<p><b>4</b> Improve Alignment with Eligibility &amp; Payment</p>	<p>ACH considers DHS a partner in championing children. Specifically related to Arkansas Medicaid, we recognize that not only are they ACH’s largest payer by far, they are also one of the fastest payers. They are always willing to take phone calls, assist us with complicated patient transfers, hear our concerns, listen to the latest clinical evidence, and in general, work with ACH to ensure that DHS clients and ACH patients get the care they need. However, ACH also recognizes the need for, and supports alignment between eligibility and enrollment operations and fiscal and medical operations and aligned information systems. For example, AR Kids eligibility determinations are delayed and the process fragmented which creates delayed payments; improved alignment and infrastructure could resolve issues such as these.</p>
<p><b>5</b> Support Telemedicine &amp; Increased Collaboration</p>	<p>ACH believes telemedicine presents an opportunity to ensure that every child in Arkansas has access to pediatric subspecialists without traveling for extended time periods. As discussed in our Strategic Plan, ACH is committed to reaching the four corners of the state, and telemedicine is a core component of this strategy. It is critical that reimbursement models also support the development and use of telemedicine within Arkansas.</p> <p>ACH is the pediatric teaching affiliate of UAMS and also operates the Arkansas Children’s Hospital Research Institute. As part of our Strategic Plan, ACH is investing in data analytic capabilities, policy development, and advocacy. ACH welcomes the opportunity to collaborate with the State Medicaid Agency in any capacity related to children’s health. Potential examples are policy analysis, data analytics, or assessments of clinical evidence.</p>

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# Arkansas Minority Health Commission’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
1 ...	Develop a system-wide Arkansas health improvement dashboard.- The Agency for Healthcare Research and Quality <a href="http://nhqrnet.ahrq.gov/inhqrdr/Arkansas/dashboard">http://nhqrnet.ahrq.gov/inhqrdr/Arkansas/dashboard</a> provides an excellent overview of the health status of Arkansans by various categories. Arkansas could begin working with the U.S. Department of Health & Human Services to establish measures for areas where there are none. Additionally, this site could be used to compare Arkansas to other states.
2 ...	Establish commission on the future of the Human Development Centers - The Arkansas Minority Health Commission concurs with TSGs assessment in establishing a diverse commission to seek ways to effectively and efficiently increase the quality of life for those with development disabilities.
3 ...	Telemedicine – The Arkansas Minority Health Commission supports TSGs recommendation on reviewing measures to increase the utilization of telemedicine as on mechanism of increasing access to care.
4 ...	Collaborations- The Arkansas Minority Health Commissions supports TSGs assessment of increasing health care leaders capacity within Arkansas. The University of Arkansas for Medical Sciences College of Public Health has Masters Degree programs in Public Health and Health Administration as well as Doctoral Degree Programs (Public Health Leadership, Epidemiology, and Health Systems and Services Research that fit with the example provided by TSG.
5 ...	Building on the concept of SB 827 of 2015 – The Arkansas Minority Health Commission supports the expansion of the “Health Arkansas Educational Program” to include items outlined in the TSGs report, specifically around nutrition, health, wellness and prevention. SB827 in collaboration with the “Healthy Active Arkansas” campaign could have a synergistic effect on the health and well-being of Arkansans. This aspect is core to the mission, vision, and goal of the Arkansas Minority Health Commission.

## Arkansas Waiver Association’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<b>1</b> HDC Population	▪The most striking recommendation in TSG report from the AWA point of view is the statement on our state’s institutional bias. We agree that our state has depended on the HDC’s for far too long, and this isn’t financially sustainable. We will work with the legislature and the Governor’s office to provide quality community supports for individuals who have disabilities.
<b>2</b> MCO for Aged and Disabled	▪While we understand the need to manage costs in Medicaid, we have serious concerns about the implementation of a Managed Care option for these populations. We have followed the discussion about MCO’s in other states, and while for some, there have been good outcomes, others have seen lessened quality of supports, and therefore, quality of life.
<b>3</b> Healthy Living	▪AWA is very supportive of this recommendation, and would strongly support all efforts to increase healthy living. Because we support individuals who have developmental disabilities, we recognize the value of health and wellness programs, and will work to implement them in our programs.
<b>4</b> Episodes of care/Patient Centered Medical Homes	▪We agree with the Governor’s assessment of these principles. They have been and will continue to be effective.

# Arkansas Advocates for Children and Families' Feedback on TSG Report and the Governor's Letter

Summary	Explanation
<b>1</b> Wellness Program without Premiums and Cost-sharing	<p>▪AACF supports incentivizing healthy behaviors and encouraging regular preventative care. However, the TSG recommendation ties healthy behavior activities to additional cost-sharing and premiums for failure to meet requirements. Premiums have been shown to limit enrollment and reduce access to care in numerous studies. Premiums also may negatively impact the state budget because the high administrative costs can outweigh the premiums collected. We've already experienced this scenario with the implementation of the Independence Accounts in Arkansas. Act 1005 of 2015 created the Healthy Arkansas Educational Program, which provides incentives for Medicaid beneficiaries to participate in training classes that include health and wellness education. Funding this type of approach would better support the goal of improving the health literacy and healthy behaviors of Arkansans enrolled in Medicaid.</p> <hr/>
<b>2</b> Medicaid Eligibility Should not be Linked to Work Requirements	<p>▪While the TSG recommendations focus on a work training referral, it ties ongoing eligibility to meeting this requirement (i.e. lock-out periods). To date, no state has received approval to tie work requirements to a change in eligibility or reduction in benefits. Also, work requirements are not necessary since research shows about 75 percent of uninsured adults live in a family with at least one full or part-time worker and over half of individuals actually work full or part-time. Research shows that for those individuals not working, about 20 percent report caring for a family member, looking for work, being in school, or being ill or disabled. Medicaid can actually help people obtain and keep a job by helping them stay healthy enough to work, and the best way to encourage work is to make sure the workforce is healthy. Finally, this would be administratively burdensome to the state and create an intrusive process to determine eligibility.</p> <hr/>
<b>3</b> Protect Children's Coverage and ARKids First	<p>▪The low rate of uninsured children, under 5 percent, in the state is due to the success of the Arkansas Medicaid and ARKids First programs. Any changes to the costs, benefit package, and structure of ARKids First jeopardizes this progress. Full-family coverage is an important policy goal, but making children more susceptible to coverage loss, reduced benefits, or poor continuity of care is not worth the risk. Any proposal to move children into a private plan, whether marketplace or employer sponsored should be avoided. Also, Medicaid and CHIP are designed with kids health needs in mind and include important benefits like EPSDT. A recent study shows that parents are more concerned with the affordability and benefits package for children than having all family members in the same plan.</p>

# Arkansas Advocates for Children and Families' Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

### 4 Managed Care Considerations

■Despite the TSG projected cost-savings, the data on the costs, access, and quality of care for managed care in Medicaid are mixed. The great majority of MCO models in states involve children, pregnant women and parents, and disabled and aged beneficiaries are far less likely to be in managed care. Some of the challenges for states when considering high needs and high costs populations are:

- Establishing appropriate capitation rates because fee-for-service data is not always the most accurate due to variations in enrollees' health status and service needs and the difficulty of refining risk adjustment methodologies.
- Managed care for persons with disabilities is not likely to generate short-term savings because high capitation rates are often needed to entice managed care plans to the market due and there are up-front administrative costs.

Furthermore, planning and implementing this type of structural change must be done in a consumer-friendly manner. Public engagement and feedback from the families receiving services must be a part of the process. There must be some assurance of a smooth transition from a fee-for-service model to avoid disrupting any existing patient-provider relationships. Protecting consumers' rights must also be a priority to ensure they are aware of changes and there is not a negative impact on access to care and quality.

### 5 Fully Implement HCPII and Monitor Progress

■Prior to implementing full risk managed care for all or select populations, the state should move forward with full implementation of the AR Health Care Payment Improvement Initiative (HCPII) by expanding PCMH and implementing health homes. With the full implementation of the Payment Improvement Initiative and 2-3 years of data to measure the impact on access to care, quality of care, and cost containment, the state will have sufficient data to determine if more sweeping structural changes are necessary. This approach will also require the state to invest in data monitoring, which could be achieved by creating the *Health Improvement Dashboard* as TSG recommends.

### 6 Implement Health Homes for High Needs Populations

■By implementing meaningful care management of high cost, high need populations through health homes, the state would improve the quality of care for our most vulnerable Arkansans and more effectively manage costs. States receive a 90 percent enhanced Federal Medical Assistance Percentage (FMAP) for the specific health home services for the first 8 quarters and a few years of work has already occurred to develop health homes models for LTC, DDS, and DBHS. Also, the state currently has effective models to build on, including Community Health Workers (CHWs). Additional analyses should be conducted on the financial impact of implementing this type of intensive care management model under the current fee-for-service structure, along with PCMH and the current Episodes of Care (EOCs).

# Arkansas Advocates for Children and Families' Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

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Assess Admin  
Costs &  
Consumer  
Impact of  
Restructuring

While increasing the efficiency of the agency has been identified as a high priority, it will be critically important to ensure a structural redesign of the agency does not shift state Medicaid dollars away from health care services for children and families or health care providers to pay for the costs of changing the agency structure and staffing. Also, the benefits of a single agency include cross-divisional work to meet the health care needs of our most vulnerable children, such as those with involvement in the juvenile justice and child welfare systems. Any agency restructuring should ensure staff positions exist to continue cross-divisional collaborative work to better support all children and families.

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Improve  
Current Annual  
Renewal  
Process

The TSG report reported that about 43,000 people in traditional Medicaid and Private Option had out of town addresses causing them to be flagged as high risk as part of a Lexis Nexis analysis. We now know that many of these individuals were terminated through the regular renewal process and others were actually eligible because they are still AR residents. This suggests that the state is not any more likely to flag more cases of fraud or abuse by implementing more frequent verification checks, but would incur the costs associated with this type of process without any benefit. At this stage of implementing a new eligibility system, it is expected that additional work will be necessary to refine and improve the current eligibility process. AACF supports making those improvements to ensure Arkansans that are legitimately eligible are enrolled in the program, but not spending additional resources that yield low results. Continued system enhancement and better outreach to consumers would achieve the needed improvements to the annual renewal process.

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# Mental Health Council of AR's Feedback on TSG Report and the Governor's Letter

## Summary

**1** We do not support managed care for behavioral health

## Explanation

- There is no protection for these Arkansans as they will be competing for the same services as the general population in a managed care system. The Community Mental Health Centers serve all counties in the state. Developing supports in the community provides less intrusive, less expensive and less restrictive care.
- Contracting with an out of state management company automatically reduces available funds for direct services. There are other options for reducing costs without a managed care company; we assert that we can manage and enhance services with community supports in place

**2** ...Support the existing public mental health system through the development & enhancement of the following priority services.

- MHCA supports and agrees with TSG to establish crisis units. We have such a Task Force in place that includes the community groups listed. We have toured Oklahoma, Bexar County Texas and scheduled to tour a state run crisis unit in Mississippi. We have conducted a pilot process of CIT training. Bexar County: In the first year, nearly 1,000 people with mental illness were directed away from jail to a more appropriate treatment facility. Since that time, our program has quadrupled, diverting more than 4,000 individuals with mental illness from incarceration to treatment & saving the county at least \$5 million annually for jail costs & \$4 million annually for inappropriate admissions to the emergency room.
- We recommend the Sequential Intercept Model by the CJTF in its planning efforts for improved access to community base behavioral health services.

**3** Treatment Compliance

- (Further explanation in handout.) Funding for community treatment (ACT Teams); care coordination, enhanced substance abuse treatment ( needs to be reimbursed by Medicaid) ; enhance the level of intensive community based services.

# Mental Health Council of AR's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
4 Implement the Payment Improvement Initiative	▪The P.I.I. cost millions of tax dollars to develop and should be implemented with the three Tier System. We do not agree with using the Inter-RAI. No other specialty must first have a screening to determine services. This results not only in a barrier to, and delay in treatment , but leaves out the fundamental clinical judgement of a professional.
5 Support & Develop telemedicine policies & procedures to benefit access to care.	▪The shortage of psychiatrists is well documented throughout the country. Many CMHCs have developed this capability to serve mentally ill in jails & remote counties. Telemedicine is a critical component of the Mental Health Crisis Units.
6 Collect meaningful data to be used in analysis of services/costs.	▪As part of the public mental health system, the Community Mental Health Centers billing & other pertinent data is included with the Arkansas State Hospital and Arkansas Health Services. We suggest this data be separated ASH/AHS, inpatient, and CMHC's outpatient for meaningful analysis of Medicaid services provided by the Mental Health Centers.

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# Arkansas Medical Society's Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

### 1 Managed Care...

The AMS is opposed to placing physician services in a capitated managed care program. Arkansas physicians have been actively involved in helping DHS develop and adopt other methods of reform to reduce cost and improve quality. These include the patient centered medical home and episodes of care. Additionally, AMS and other physician organizations have submitted a letter to the task force offering to support and help develop other reforms addressing misuse of emergency rooms and high cost, complex patients. A copy of that document will be attached.

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### 2 TSG Additional Considerations

We have reviewed the suggestions and recommendations from TSG under the heading "additional considerations". Many of these recommendations call for further study of certain issues. Others are more formal recommendations. Some recognize that work is already being done on the issue, i.e. telemedicine. We would however, be opposed to circumventing the licensing boards on issues like telemedicine, given that they are best suited to fully understand the ramifications of various methods and modalities of delivering care, while at the same time being legally charged with the responsibility to protect the public.

# AFMC's Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

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Evidence of managed care cost savings is much more mixed than reported in the Stephen report. Dr. Michael Sparer of Columbia University has studied this and finds little or no savings, aside from cutting provider fees in the first year. Missouri, which has Medicaid managed care in 2/3 of the state and managed FFS in the remaining rural areas finds at best 1.7% savings...and advises me no difference in Quality metric outcomes between the managed care areas and FFS. Iowa moved forward on managed care recently with the promise of \$51 million in annual savings but when required to show the documentation of that they had none, apparently it was a manufactured number, pretty much made up.

Our advice is more research is needed to validate the claim of substantial cost savings ...

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Some managed care firms have behaved badly and the consultants report and the Task Force didn't look much at this. For example just among those who presented to the Task Force there is one that lost a breach of contract suit (and lost again on appeal) to KY because they walked away from a 100,000 Medicaid patients. A large managed care firm in Missouri paid a multi million dollar fine for failing to cover services for autistic children and for paying for routine abortions in violation of Missouri law. If Arkansas does any managed care it will be important to have a good monitoring system in place, and we would suggest not allowing firms with poor performance/substantial penalties in other states to bid in Arkansas....Lets use the companies with the best track records.

## Arkansas Association of Area Agencies on Aging’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>1</b> REBALANCING: Key to LTSS Reform</p>	<ul style="list-style-type: none"> <li>As discussed in detail in TSG Finding 14 and Recommendation 14, Arkansas’ LTSS remains unbalanced, with about two-thirds of LTSS spending going to nursing homes.</li> </ul>
<p><b>2</b> People prefer HCBS</p>	<ul style="list-style-type: none"> <li>According to a 2014 AARP survey of likely voters over age 50, three-fourths of those surveyed would prefer to receive care at home than be admitted to a nursing home. Three-fourths of respondents want their elected officials to make availability of at-home care a priority.</li> </ul>
<p><b>3</b> HCBS are Cheaper</p>	<ul style="list-style-type: none"> <li>Recommendation 14.2 of TSG Report calculates savings of over <b>one-half billion dollars</b> over 2017-2021 if LTSS are balanced 50/50.</li> </ul>
<p><b>4</b> Rebalancing should be part of any system</p>	<ul style="list-style-type: none"> <li>No matter which option the state chooses regarding managed care, LTSS rebalancing should be a focus. Accomplishing rebalancing requires reforms that remove barriers to HCBS placement and that allow HCBS providers to provide efficient, quality care. These reforms can be implemented independently of the managed care decision and result in immediate savings through rebalancing.</li> </ul>
<p><b>5</b> Timely Financial and Medical Eligibility Determinations</p>	<ul style="list-style-type: none"> <li>Currently, HCBS applicants require financial and medical eligibility determination before services can commence. Delays in either determination result in delays in receiving care and increase the likelihood of nursing home admission.</li> </ul>

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## Arkansas Association of Area Agencies on Aging’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>6</b> Presumptive Eligibility with Reimbursement</p>	<ul style="list-style-type: none"> <li>Currently, an individual can be admitted into a nursing home at any time, and the nursing home will eventually receive payment after eligibility is approved. A similar mechanism is needed for HCBS providers, who cannot provide services with guarantee of reimbursement until eligibility determination is complete.</li> </ul>
<p><b>7</b> Adequate Rates</p>	<ul style="list-style-type: none"> <li>As reflected in TSG Section 32.4 “Reinvestment Opportunities,” rates for LTSS HCBS providers are inadequate and must be increased in order for rebalancing to occur. Unlike nursing homes, HCBS provider reimbursement is not cost-based; no adjustments have been made for minimum wage, DoL regulations, or the Affordable Care Act. TSG recommended a 10% increase in HCBS services as a place to invest savings resulting from other reforms.</li> </ul>
<p><b>8</b> Annual Rate Rebasing</p>	<ul style="list-style-type: none"> <li>The current rate for attendant care for LTSS HCBS has not been increased since 2009. While an anticipated rate increase as part of a new waiver will help, it will only bring the rate up to the costs reported from three fiscal years ago. As an alternative to nursing homes, LTSS HCBS rate should be increased annually in accordance with increases in costs, as is done with nursing homes.</li> </ul>
<p><b>9</b> Administrative Flexibility</p>	<ul style="list-style-type: none"> <li>Currently, LTSS HCBS direct-care workers must record time spent on specific tasks in the home, and services are billed in 15-minute increments. The proposed waiver will partially address the first issue by combining some services into Attendant Care service; however, Medicaid Personal Care should be included in the Attendant Care service as well. The requirement for RN supervision should also be re-visited, as other programs do not have this requirement.</li> </ul>
<p><b>10</b> Meaningful Care Coordination</p>	<ul style="list-style-type: none"> <li>True HCBS care coordination is more extensive than Targeted Case Management, currently the only option. The state should develop a reasonable model for care coordination and fund the services adequately so that HCBS providers can coordinate with all service providers for each client.</li> </ul>

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## Arkansas Association of Area Agencies on Aging’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>11</b> LTSS HCBS are already managed</p>	<ul style="list-style-type: none"> <li>Both the ElderChoices and Alternatives for Adults with Physical Disabilities waivers are managed. State nurses determine the medical level of need and the quantity and types of services to be provided. The nurses help clients choose the provider. The provider can only receive payment for services provided consistent with the care plan. Care coordination is provided to the extent feasible.</li> </ul>
<p><b>12</b> Managed Care Concerns</p>	<ul style="list-style-type: none"> <li>If the State decides to go to a form of managed care for LTSS services, all of the previously stated concerns apply. In addition, we have additional concerns if the State contracts with one or more Managed Care Organizations.</li> </ul>
<p><b>13</b> State Rate Setting</p>	<ul style="list-style-type: none"> <li>Florida MCOs who made presentations all said that State rate setting was a benefit and avoided their having to negotiate rates with hundreds of providers. In TSG Recommendation 11 for managed care, they recommend that the state set rates for at least the first three years. State Rate setting would prevent MCOs from achieving “savings” by pitting providers against one another in a pricing war.</li> </ul>
<p><b>14</b> Close Oversight of MCO Contracts</p>	<ul style="list-style-type: none"> <li>MCO contracts should contained detailed requirements, included those mentioned here, as well as quality requirements. The State must monitor the MCOs performance closely to ensure that contract requirements are met and that any problems that develop are addressed immediately.</li> </ul>
<p><b>15</b> Provider Viability</p>	<ul style="list-style-type: none"> <li>Existing providers who meet program requirements should continue to participate in the program. Attempts by the MCOs to take over functions (e.g., care coordination) of providers in other states have just led to additional layers of administrative costs and the loss of the value of local providers who know the community.</li> </ul>

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## Arkansas Association of Area Agencies on Aging’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>16</b> Focus on High-Need Services</p>	<ul style="list-style-type: none"> <li>Arkansas has been identified as a high-need state for senior hunger. Part of the ElderChoices service package is home-delivered and congregate meals. Although not a traditional medical service, services such as this that address areas of clear need should be required in any MCO contracts.</li> </ul>
<p><b>17</b> Information Systems</p>	<ul style="list-style-type: none"> <li>All MCOs should be required to use the same software for provider claims submission, reporting, eligibility verification, etc. An individual provider should not have to bear the administrative burden of using two or three different systems if there are multiple MCOs in the area. The State should consider paying for necessary hardware and software, either directly or through rates for services.</li> </ul>
<p><b>18</b> Provider Input in Contracting Process</p>	<ul style="list-style-type: none"> <li>If a decision is made to contract with managed care organizations, provider representatives should be consulted regarding the development of the RFP and the contract. The consultation process should include adequate opportunity for review and feedback.</li> </ul>
<p><b>19</b> Consistent Provider Requirements</p>	<ul style="list-style-type: none"> <li>Any willing and qualified provider should be allowed to participate in the program. All providers should be subject to the same requirements. For example, some home care agencies treat direct care workers as independent contractors, thereby avoiding certain costs, yet they receive the same reimbursement as providers with employee tax and fringe benefit costs.</li> </ul>
<p><b>20</b> Additional Consideration 31</p>	<ul style="list-style-type: none"> <li>As already mentioned, Recommendation 31 is critical in order for applicants to have a true choice in where to receive LTSS. Delays in eligibility verification affect both nursing homes and HCBS providers. The nursing home eventually gets paid for services already provided once eligibility is determined. HCBS providers cannot provide services with certainty of reimbursement until the eligibility decision is made.</li> </ul>

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# Ark Pharmacist Association's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
<p><b>1</b> Medicaid is already operating an effective and efficient managed-care pharmacy program within DHS.</p>	<p>▪DHS has employed virtually every managed-care strategy in the operation of the Medicaid Pharmacy Benefit for over a decade. Including the EBRx program at UAMS has acted as a managed care consultant for the program, which has used in-state providers to make data and financial decision to help optimize care and cost for the state. This along with utilization review strategies, use of a fiscal intermediary (not a traditional PBM model), quantity limits, rebating, locally controlled generic pricing, mental health drug age edits and individual reviews to ensure only appropriate services are covered have helped to get the program main relatively flat costs and resulted in their net costs to the program at only approximately 50% of the total cost. Additionally, EBRx and Medicaid pharmacy staff are currently in the works to continue to provide program management and produce greater savings.</p>
<p><b>2</b> <b>Remove Chronic Medication Prescription Limits</b></p>	<p>▪Medicaid has always had a monthly prescription quantity limit, which keeps patients with multiple chronic diseases from being able to have coverage for all of their medications. This limit should be removed for medications used to treat chronic diseases to encourage use of these important medications and to prevent unwarranted hospitalizations and other medical expenses.</p>
<p><b>3</b> <b>Continued Expansion of EBRx Drug Categories</b></p>	<p>▪The UAMS EBRx preferred drug list should continue to add additional categories of medications to the preferred drug list, such as antipsychotics. This ensures the most clinically efficacious drug selection and allows the state to utilize supplemental rebates(of which the state retains full transparency and adequate accounting of the rebate dollars) with manufacturers to leverage a lower net price to the state.</p>
<p><b>4</b> <b>Incentivize Medication Adherence for Patients and Providers</b></p>	<p>▪Appointment-based Medication Synchronization (ABMS) should be used with local pharmacists as a tool to ensure that patients not only fill their prescriptions on a routine basis, but to ensure maximum compliance and avoidance of side effects and other adverse effects. Patients stay healthy and the system saves the most money when patients take their prescribed medications as directed to ensure the best outcome for their disease(s).</p>
<p><b>5</b> <b>Medication Therapy Management Services</b></p>	<p>▪Medication Therapy Management Services (MTM) allows for a twice a year comprehensive medication review to ensure compliance, identify health issues and medication complications, determine other socio-economic barriers to being healthy and review for needed immunizations to ensure maximum health outcomes for patients.</p>

## [Arkansas Academy of Family Physician’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p>1</p> <p>...</p>	<p>▪Local PCPs want the opportunity to provide care management services. Many are providing these services successfully through the PCMH model. Out sourcing will further fragment care. These top 10% patients will default to local MD’s, hospitals, Emer.Depts...</p>
<p>2</p> <p>...</p>	<p>▪We desire a collaborative relationship with Medicaid in which these patients are identified and a local PCMH model can be applied. We do not believe an out of state entity managing their care is the answer.</p>
<p>3</p> <p>...</p>	<p>▪...Our current mental health system is fragmented and poorly supported. We need a system in which PCPs can attain psychiatric assistance for their patients as these unresolved issues play a major role in downstream Medicaid expenses</p>
<p>4</p> <p>...</p>	<p>▪Futile care to patients in their last 6 months of life resulting in multiple procedures &amp; hospitalizations need to be appropriately addressed through hospice &amp; palliative care models. ...</p>
<p>5</p> <p>...</p>	<p>▪We have submitted with other organizations a letter offering support &amp; assist in issues such as misuse of ER’s and high risk patients. We praise the Governor for the Healthy Arkansas Program but concerns over implementation ...</p>

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# Arkansas Hospital Assoc's Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

### 1 Managed Care

Hospitals' major concern with Medicaid managed care is that reimbursement rates will fall. Even a requirement that a MCO pay no less than current rates is not satisfactory, as current Medicaid rates fall far short of covering hospitals' costs of providing care.

Hospitals are already a bargain buy for Medicaid. A new study by the financial services firm BKD shows that Medicaid's rate-based payments for inpatient and outpatient hospital care provided by "private" (i.e. non-governmental) hospitals covered only 52% of hospitals' costs (65%-inpatient care; 33%-outpatient care). Hospitals will experience even greater Medicaid losses beginning January 1, 2016, when Medicaid will no longer pay for the inpatient Medicare deductible amounts owed by Medicare/Medicaid crossover patients. This change in payment policy further reduces hospital payments by approximately \$35 million annually. Hospitals may be able to recover 65% of these additional losses through federal Medicare Bad Debt payments in future years, as long as no cuts are made to these bad debt payments at the federal level.

Medicaid pays for inpatient care based on a per diem rate, with a cap. The per diem limitation was originally established in the early 1990's at the 90<sup>th</sup> percentile of hospital per diem costs. After its initial implementation at \$584 per day, the limit was increased to \$675 in 1996, **and was not increased again until July 1, 2006, to \$850. This per diem limitation remains unchanged as of today, almost 10 years later.**

## Arkansas Hospital Assoc's Feedback on TSG Report and the Governor's Letter

- The Medicaid program pays hospitals for outpatient services based on a fee schedule. **For most services, payment under the fee schedule is equal to the lesser of the amount billed or 64% of the Blue Cross/ Blue Shield fee schedule published in October of 1990. *This fee schedule has not been updated in 25 years.***
- Supplemental Medicaid payments based upon dollars available to private hospitals under federal upper payment limit (UPL) policies brought in an additional \$130 million in SFY 2013 hospital Medicaid payments for which *NO STATE GENERAL REVENUES* were spent. Under the UPL program, hospitals provided the state matching revenues for those dollars through the state's hospital Medicaid assessment fee. Including these UPL payments, Medicaid covered only 78% of costs.
- **Even after considering the approximate \$130 million in supplemental UPL reimbursements, Arkansas hospitals lost over \$109 million in 2013 caring for Arkansas Medicaid patients.**
- For SFY 2015, the state's non-government hospitals shared about \$160 million in UPL payments, net of the assessment fees the hospitals paid to generate these funds, and still experienced substantial Medicaid losses.

## Arkansas Hospital Assoc's Feedback on TSG Report and the Governor's Letter

- There is no guarantee that hospitals will qualify to continue receiving the supplemental UPL-based payments under managed care.
- Under federal policy, UPL calculations only apply to Medicaid fee-for-service spending. If a State with a UPL Program decides to use or expand the use of capitated managed care, it immediately runs into a fiscal and political problem. CMS interprets federal rules as prohibiting a State from directing that a Medicaid health plan pay particular rates or use a certain methodology. Marketplace negotiations are expected to govern provider rates in capitated Medicaid managed care.
- Finally, while Medicaid does not pay hospitals sufficiently, the program does pay claims in a timely manner, markedly better than most other payers. Changing to an intermediary operated by a MCO could result in timely payment issues and create significant cash flow problems for many struggling hospitals.

## Arkansas Hospital Assoc's Feedback on TSG Report and the Governor's Letter

As for an alternative savings model, the Arkansas Health Care Payment Improvement Initiative (PII) has made significant contributions to the current "bending of the cost curve" of the Medicaid program. The initiative has been recognized nationally as innovative and other states are seeking to replicate it for their own.

The Patient Centered Medical Home component of the PII just last week reported a shared savings of **\$34 million to Medicaid** and \$5.3 million to providers for 2014. The Episodes of Care component of the PII has been estimated by The Stephen Group to have annual savings of **\$8.7-\$20.3 million annually. These numbers represent at least \$40 million in annual savings to the Medicaid program at the cost of hospitals and physicians.**

The PII is exactly the type of program that incentivizes providers, improves quality and puts the money back into the Medicaid program. These savings can be ongoing if the PII is continued and expanded. While the Medicaid Managed Care companies make savings promises that will ultimately not be kept, the PII is currently working and saving the state money. As hospitals we care for the patients in our communities daily as the safety net, the Medicaid Managed Care companies' goal is to make money at the expense of Arkansas patients through the rationing of their care.

The hospital and physician communities along with commercial insurance companies and Medicaid program have stepped in to not only reduce the health care costs to government but also to reduce the overall costs of health care to the citizens of Arkansas through the PII.

## Arkansas Hospital Assoc's Feedback on TSG Report and the Governor's Letter Question #2

Moving toward a DRG system for reimbursing hospitals:

There seems to be no compelling reason to change to a DRG system to save on Medicaid hospital costs, which have been flat for several years. The current Medicaid rate structure for inpatient care was last changed in 2006 and outpatient rates in 1992, when they were reduced. The only variable that could increase payments is Medicaid utilization, which is unlikely due to more low-income people being covered via private policies

DRGs in and of themselves will not produce a cost savings for the state. In fact, setting up and administering a DRG system might prove more costly. As it is, the only meaningful variable for most Medicaid inpatient claims today is the number of days covered, which is multiplied by the hospital per diem rate. And the most Medicaid pays for practically any outpatient surgical procedure is around \$300. This is far below what might be the average reimbursement from other payers and hospitals are understandably skeptical that a move toward DRGs would be made with the intent for higher payments.

The key to savings would be setting the hospital base rates and the DRG weights. The easiest would be to tie both to current Medicare rates and weights, which, in theory, are designed to cover costs. Hospitals are concerned that in order to generate savings, the DRG rates would in many cases be insufficient to cover even the 65% of hospital inpatient costs which Medicaid covers now.

# COMMUNITY HEALTH CENTERS –AR’s Feedback on TSG Report and the Governor’s Letter

Summary	Explanation
<p><b>1</b> Governor’s Letter</p>	<p>▪Non-Emergency Transportation – Many Community Health Centers offer transportation services to their facilities as a part of the unique “enabling services” of an FQHC.</p>
<p><b>2</b> Governor’s Letter</p>	<p>▪Work force referrals – Community Health Centers have expressed an interest in providing an area of their facilities to host workforce referral agents.</p>
<p><b>3</b> Governor’s Letter</p>	<p>▪Managed Care – Community Health Centers have experienced successful outcomes when combining behavioral health and primary care. Decision makers are encouraged to continue seeking this combined approach to patient care.</p>
<p><b>4</b> Governor’s Letter</p>	<p>▪Payment Improvement Initiatives – Many Community Health Centers are very interested in participating in the State’s PCMH program as most have been recognized by NCQA’s certification process as a patient centered medical home. ...</p>
<p><b>5</b> Stephen Group - #29</p>	<p>▪Telemedicine – Community Health Centers participated in UAMS’ BTOP program, and are well poised to utilize telemedicine. Community Health Centers know the importance of a patient-provider relationship that includes face to face encounters. Telemedicine has much potential to supplement the quality care already provided to our patients.</p>

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# COMMUNITY HEALTH CENTERS -AR's Feedback on TSG Report and the Governor's Letter

Summary	Explanation
6 Stephen Group - #30.3	▪SB827 – Most Community Health Centers have “community rooms” that could be used in hosting training sessions for Medicaid beneficiaries along with others from the community in learning about healthy food and other wellness programs.
7 Stephen Group – p. 79	▪Pharmacy Services – Community Health Centers have a unique pharmacy program that patients can benefit from -- the 340B Drug program.
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# Arkansas Health Care Association Feedback on TSG Report

Summary	Explanation
<p><b>1</b> Disregard for GR</p>	<ul style="list-style-type: none"> <li>▪ Even with the suggestion of task force members, the report only addresses total dollars without regard for State General Revenue. While there is some federal matching component to all Medicaid programs, some are exponentially greater than others, especially with the Quality Assurance Fee (bed tax). It is important to consider this as we look for savings in the Arkansas Medicaid budget.</li> </ul>
<p><b>2</b> Comparison to States with 50% FMAP</p>	<ul style="list-style-type: none"> <li>▪ When comparisons are made to other states and their Medicaid programs, it is important to consider the FMAP in addition to program expenditures and enrolment. Based on our economy, Arkansas has an FMAP rate of 70%, which is higher than most states. Comparing state budget impact to states with Medicaid Managed Care with 50% FMAP is not a fair comparison.</li> </ul>
<p><b>3</b> Case for Rebalancing</p>	<ul style="list-style-type: none"> <li>▪ The report recommends that the state take action to ‘rebalance’ long term services &amp; supports, while also stating that the state-wide census for NH is 11,958, and the state-wide census for HCBS is 14,847. There are already more people being served in the community – 63% of all LTSS beneficiaries, and many of those receive multiple services. HCBS programs are important to the continuum of care, but are not necessarily replacements for NHs. The health and safety of our elderly must be considered and based on need.</li> </ul>
<p><b>4</b> Growth in NHs vs. HCBS</p>	<ul style="list-style-type: none"> <li>▪ The Stephen Group report references “unsustainable growth” in nursing homes. Looking at Arkansas data, between 2007 – 2014, NH expenditures grew by an annual average of 3%, while HCBS expenditures grew by an average of 9.4%. If “rebalancing” were the answer, we would see a proportional shift in NH numbers with the increase of HCBS.</li> </ul>
<p><b>5</b> Managed Care Savings</p>	<ul style="list-style-type: none"> <li>▪ The report builds the foundation for savings through managed care on the assumption of HCBS programs having an annual growth of 9% and nursing homes having annual decline of 7%. Managed care has not proven cost savings in long term care; oftentimes reduction of NH expenditures are only shown in proportion to growth of HCBS, which creates an unfair comparison.</li> </ul>

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# Arkansas Behavioral Health Planning and Advisory Council's (ABHPAC) Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

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|--|--|
| <p><b>1</b> Appropriate Care Coordination and Access to Coverage</p>                                       | <ul style="list-style-type: none"> <li>■ Patient-Centered Medical Home (Care Coordination) for adults with high utilization needs.</li> <li>■ Wraparound (Care Coordination) for Arkansans up to 21 years old.</li> <li>■ Continue "Private Option" or put in place coverage for the approximately 250,000 Arkansans linked to the Transitional Health Insurance Program.</li> </ul>   |
| <p><b>2</b> No Fee for Service (FFS), move to Payment For Outcomes.</p>                                    | <ul style="list-style-type: none"> <li>■ Leave the Fee For Services Model for one that <u>pays for quality services and improved outcomes</u>.</li> <li>■ Person-Centered Planning versus Provider-Driven Services</li> </ul>  |
| <p><b>3</b> RSPMI was developed for adults. Need a service array suitable for Children &amp; Youth.</p>    | <ul style="list-style-type: none"> <li>■ Replace RSPMI with Adult &amp; Child/Adolescent Rehabilitation Services that are not Fee For Service (FFS), but rather pays according to outcomes.</li> </ul>   |
| <p><b>4</b> Consumers &amp; Parents of Youth should, and MUST be at the table of any redesign attempt.</p> | <ul style="list-style-type: none"> <li>■ Recovery-Based Services get HUGE Return on Investment (ROI)<br/>"Nothing about us without us"               <ul style="list-style-type: none"> <li>■ Design a system that uses Family Support Partners</li> <li>■ Design a system that uses Youth Support Partners</li> <li>■ Design a system that uses Peer Support Specialists</li> <li>■ The Partners/Specialists will work with the clinical staff</li> </ul> </li> </ul> |
| <p><b>5</b> Use of Functional Assessments to determine services needed at that time.</p>                   | <ul style="list-style-type: none"> <li>■ "right service at the right time"<br/>According to the RFI data:               <ul style="list-style-type: none"> <li>■ Approximately 78,669 Children and Youth are getting Behavior Health services</li> <li>■ Only 20,686 are seen by Community Mental Health Center's (CMHC)</li> <li>■ So, approximately 57,973 children are seen by Private Provider's, with little or no information on outcomes</li> </ul> </li> </ul> |

# Arkansas Behavioral Health Planning and Advisory Council's (ABHPAC) Feedback on TSG Report and the Governor's Letter

## Summary

## Explanation

6

Not a true delivery system for those identified as ID/MI and not on the Medicaid Home and Community Based Waiver.

- Children First Community Option (CFCO) 10,265 Children/Youth
- Community Mental Health Center's served Children/Youth at a cost of \$476,280 per child

# AARP Arkansas' Feedback on TSG Report and the Governor's Letter

Summary	Explanation
1 Enhancing Home and Community Based Care	AARP supports TSG recommendation 14.1 <b>Reforming the Front Door: Assessments and Level of Care</b> . Without independent administration of eligibility assessments instruments the state cannot be assured that individuals are receiving the right service, in the setting of their preference, at the right time and at the right cost.
2 Enhancing Home and Community Based Care	AARP supports TSG recommendation 14.2 <b>Rebalancing the Long-Term Services and Supports (LTSS)</b> for the elderly and adults with physical disabilities. The data in the TSG report is consistent with AARP data and other state's experiences that show a robust LTSS system provides care in the setting preferred by consumers <u>and</u> helps control costs. The availability of family caregivers will decline rapidly in the next couple of decades as baby boomers age out of the caregiving years and into late old age, when their own risks of needing care are much higher. In 2010 the ratio of potential caregivers age 45–64 to those at high risk of needing care (age 80 and older) was 7:1. By 2030, that ratio is projected to decline sharply to 4:1 and to further fall to less than 3:1 in 2050. By that time, all baby boomers will be in the high-risk years of late life. Higher divorce rates and childlessness will further complicate the availability of family care. Filling this void with expensive nursing home care is not a sustainable or preferred strategy.
3 Enhancing Home and Community Based Care	AARP supports TSG recommendation 14.3 <b>Remove Barriers to Enhancing Choice of Community Based Care</b> . While nursing home receive annual rate increases, the state has no organized, rational system to determine and provide rate adjustments for home and community based care services.

# AARP Arkansas' Feedback on TSG Report and the Governor's Letter

Summary	Explanation
4 Managed Care	<p>Medicaid managed care provides many opportunities and challenges in care delivery and financing. AARP does not support or oppose a transition to managed care, but rather seeks to ensure that any changes to the state's health care and Long-Term Services and Supports (LTSS) systems are person and family-centered and allow individuals to live as independently as possible and to exercise control over their own care arrangements. Increased integration of care across the health care delivery system and improvement in quality of care and health outcomes, align with AARP policy principles.</p> <hr/>
5 Managed Care	<p>Areas that AARP would want the state to pay close attention to in any transition to managed care:</p> <ul style="list-style-type: none"><li>•Beneficiary Enrollment processes , opportunities for Choice and self-direction, and Disenrollment</li><li>•Network Adequacy</li><li>•The timeframe for development and implementation</li><li>•The reinvestment of projected savings back into HCBS</li><li>•Necessity for strong state oversight</li><li>•The involvement of family caregivers</li></ul> <hr/>