July 15, 2024
Department of Human Services
2nd Floor Donaghey Plaza South Building
7th and Main Streets
Little Rock, AR 72203-1437

RE: Medicaid Sustainability Report

To Whom It May Concern,

The Arkansas Center for Health Improvement ("ACHI") values the opportunity to provide comment on the draft Medicaid Sustainability Report published by the Department of Human Services ("DHS") on March 29, 2024. An independent, nonpartisan health policy organization dedicated to improving the health of Arkansans, ACHI recognizes that Medicaid is a vital piece of the coverage patchwork in Arkansas as the primary source of healthcare coverage for roughly 1 in 3 low-income Arkansans. First implemented in Arkansas in 1970, Medicaid has served as a safety net for millions of Arkansans for more than 50 years, and its sustainability is critical to serve millions more Arkansans for the next 50 years.

We appreciate the generally balanced nature of the proposed policy options in the report, and we look forward to engaging in future discussions about the options, as well as other aspects of Medicaid not directly addressed in the report. We are particularly interested in DHS' approach to provider rate updates, given that the report considers substantial changes to supplemental and access payments and cost settlements, which, if implemented, would considerably reduce overall payments to certain providers. Review of provider rates should occur routinely, transparently, and collaboratively with the provider community. Review of provider rates should also include comparisons to rates offered by other public programs and private insurers to enable sufficient monitoring of compliance with Medicaid equal access requirements in 42 U.S.C. Sec. 1396a(a)(30)(A).

Regarding the current Medicaid expansion program, Arkansas Health and Opportunity for Me (ARHOME), the core of the model — individual premium assistance — has proven to be quite beneficial to the state for more than a decade as a bipartisan solution. The Medicaid expansion program has served 718,500 low-income adult Arkansans — nearly one-fourth of the state's population — throughout its existence. The program has also stabilized individual market insurance premiums. Arkansas has had lower average marketplace premiums than any of the surrounding states every year since 2017, and only 11 states in the nation currently have lower average marketplace premiums than Arkansas. The program has served as a lifeline for the state's healthcare providers, with no rural Arkansas hospital having closed, without being reopened or replaced, in over a decade. This is especially notable in contrast with the six states surrounding Arkansas, where 58 rural hospitals have permanently closed since 2012.

Caution is urged against applying different policies to qualified health plans (QHPs) serving Medicaid expansion-eligible individuals, such as removing agent commission fees or shifting advanced cost-sharing reduction payments into premiums. As the report notes, application of different policies would disrupt the operation of the individual market and effectively segment the Medicaid expansion risk pool from the rest of the individual market. Shared market operations

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and the risk pool were key features of the original premium assistance model and continue to be key features of the current model. Because the auto-assignment process does not have similar disruptive effects, however, it could be ripe for change if the policy goal is no longer to strengthen market competition through a formula that provides a foothold for smaller players in the individual insurance market.

Shifting the Medicaid expansion population would result in similar disruption of the individual insurance market. However, should the state decide to pursue a transition to Medicaid managed care — regardless of the population — Medicaid officials should invest in staff and processes, including contractual obligations, to ensure strong oversight of managed care organizations (MCOs) serving Arkansans. The Department of Human Services (DHS) should ensure, at a minimum, that MCOs:

- Provide prompt payment with independent review of claims and an appeals process that ensures due process;
- Comply with the state's "any willing provider" law;
- Include safety net providers in networks;
- Have clear and understandable processes for facilitation of care and coverage transitions; and
- Offer payment rates that are transparent, regularly monitored, and sufficient to ensure network participation.

DHS should have frequent and consistent monitoring of care quality and access, patient experience, and MCO responsiveness. Enrollees should also be able to avail themselves of a strong "bill of rights" that is incorporated into MCO contract language. The bill of rights should be enforceable by multiple parties through multiple mechanisms and should include without limitation participation in community advisory committees, prohibitions on increasing cost sharing amounts, and the right to choose a primary care provider. Finally, DHS should leverage MCO participation in Arkansas to promote competition in other markets with Insurance Department oversight.

As noted in the report, the Provider-Led Arkansas Shared Savings Entity (PASSE) program is highly unique, "one of only two such provider-led solutions nationwide." As such, the program should undergo a scientifically rigorous, independent evaluation prior to its expansion. The report notes an estimated $67 million in savings from the program's inception through fiscal year 2021. However, there is no mention of any assessment of whether those program savings have been to the detriment of enrollee experience, access to services or providers, or quality of care. Caution is urged against transitioning high service utilizers of any type (e.g., those undergoing cancer or other intensive treatment) into the PASSE program, given that the program was designed to serve a segment of the Medicaid population with intellectual, developmental, and behavioral health needs. Thus, specialist availability, care coordination, and other services may not be adequate for those populations.

We are pleased to see options to enhance Medicaid access to home- and community-based services (HCBS) and to identify ways to expedite and streamline the eligibility process. Many elderly Arkansans prefer to age in place, and the emergence of new technologies including

remote patient monitoring offer the potential to reduce reliance on the home health aides and nurses, an already strained workforce presenting a barrier to expansion of HCBS services, and unpaid caregivers. Aside from an enhancement to HCBS services in isolation, an in-depth assessment of transitioning all long-term care services and supports for enrollees into one program is warranted, as it could support efforts to achieve a more equitable balance between spending and utilization in home- and community-based settings and institutional settings.

The state should further explore allowing extended-day supplies for certain maintenance medications. Many Arkansans, particularly in rural parts of the state, lack the transportation needed to frequent their pharmacies, and the evidence noted in the report shows that extended-day policies lead to better outcomes and potential savings. At a minimum, a demonstration project to assess these policies in Arkansas is warranted. While pharmacy value-based payment (VBP) arrangements are intriguing, both evidence- and outcomes-based measures should be used to assess value. Moreover, consistent with federal guidance, drugs purchased through VBP arrangements should be made "available to all Medicaid patients regardless of their health status, not be used as a way to further clinically test drugs in certain populations, and not result in health disparities for any select population."

With respect to the remaining programmatic areas covered in the report, we offer the following comments.

- In recent years, state policy has shifted away from onerous prior authorization (PA) requirements by private insurers to reduce the administrative burden on providers and expedite access to care. To ensure consistent protocols for providers across payers and equal access for Medicaid enrollees, we would urge the state to examine PA requirements and criteria for therapies prior to changing policies.

- We appreciate the accomplishments thus far to develop a continuum of care for youth with behavioral health needs and are pleased with the options in the report to invest in step-down and therapeutic foster care services.

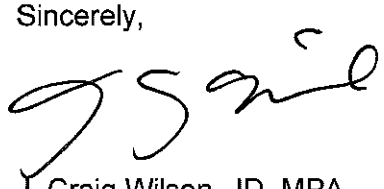
- Should DHS opt to merge the primary care case management (PCCM) and patient-centered medical home (PCMH) programs, providers who have not yet participated in the PCMH program should be offered a tiered approach to participation, so that they can meet milestones toward more advanced activities and quality targets.

- We support the Arkansas Maternal Mortality Review Committee's recommendation to increase the use of Alliance for Innovation on Maternal Health safety bundles and the report's suggestion to develop a value-based payment model for maternal health. Implementation of safety bundles should be incorporated into a statewide system of care like the trauma system, and birthing hospitals should be supported to participate in such a system. We are hopeful that the latter can be achieved via the recent federal funding opportunity to participate in the Transforming Maternal Health model, but we urge the state to invest in more immediate actions to support Arkansas moms in their birthing journey, including covering community-based supports such as doulas, preventing gaps in care and coverage, and ensuring sufficient provider payment rates to safeguard access points.

Finally, an assessment of sustainability for Medicaid programs should account for inflationary measures. The price of medical care inflation has increased by nearly 120% since 2000, an average of 5% annually, while prices for all goods and services have increased by 85% over the same period, an average of 3.5% annually. Cost containment for public programs including Medicaid is important and necessary for sustainability, but state budgets should be cognizant of and account for inflationary pressures that operate under the normal forces of supply and demand and that are not within the control of patients and providers. Disregarding these market impacts will ultimately lead to programmatic trade-offs on quality of care and access to services and providers.

Again, we appreciate the opportunity to provide comment on the report, and we look forward to working with DHS and stakeholders across the state to continue to provide critical support for Arkansans through the Medicaid program.

Sincerely,



J. Craig Wilson, JD, MPA
Health Policy Director

ARKANSAS HOSPITAL ASSOCIATION

July 14, 2024

Arkansas Department of Human Services
Medicaid Sustainability Review Team
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RE: Arkansas Hospital Association Comments on March 2024 Department of Human Services Guidehouse Medicaid Sustainability Review Report

Medicaid Sustainability Review Team:

The Arkansas Hospital Association (AHA), on behalf of its member organizations and their more than 57,000 employees, is grateful for the opportunity to provide feedback on the Guidehouse Medicaid Sustainability Review Report (Guidehouse Report) commissioned by the Arkansas Department of Human Services (DHS). The AHA sincerely appreciates the time and effort that Governor Sanders and her DHS team are investing in studying the state's Medicaid program and ensuring that any necessary changes protect not only Arkansans who rely on the program benefits – as well as the clinicians, health care providers, and community providers of those essential services – but also Arkansas's taxpayers.

Hospital Inpatient and Outpatient Rates

As a membership organization with a mission to safeguard hospitals' operational effectiveness in advancing the health and well-being of their communities, the AHA has significant concerns about the adequacy and sufficiency of the reimbursement rates Arkansas Medicaid pays to Arkansas's hospitals. Traditional fee-for-service per diem rates for hospital inpatient services last improved in 2007, when the daily rate rose from $675 to $850. Unfortunately, hospital outpatient service rates (which include emergency department care) were last modified in 1992 – those rates were a cut from the 1991 fee schedules.

Hospitals do not argue that inpatient, outpatient, and emergency services are expensive; however, hospitals do attest that reimbursements are inadequate to maintain the level of

services that hospitals have historically provided to their communities. Not only does Medicaid fail to cover the costs of hospital care, hospitals are underpaid by Medicare due to federal Area Wage Index policies. Added to that, according to the Rand study on hospital prices, Arkansas is reimbursed lower than all other states from commercial insurance companies[1].

Arkansas has been fortunate that the two communities that experienced hospital closures[2] after Medicaid Expansion was passed have rebuilt new facilities. Unfortunately, the number of Arkansas hospitals that are currently operating a labor and delivery department has dwindled to 35, which leaves 49 of Arkansas's 75 counties without birthing services. In addition, five Arkansas hospitals[3] have now converted to Rural Emergency Hospitals and can no longer provide inpatient services.

The AHA recognizes that this Guidehouse Report did not cover the general revenue investment in inpatient and outpatient rates outside of supplemental, cost settlement, and access payments. The AHA understands that DHS may be exploring options related to hospitals separately, and hospitals are long overdue for reimbursement improvements.

Medicaid Expansion – Qualified Health Plan Model

The Guidehouse Report contemplates alternatives to the Qualified Health Plan Model. It is worth noting that when the Medicaid Expansion program was created in 2013, Arkansas legislators and executive branch leaders considered only expanding the Medicaid population into the fee-for-service program. In focus groups with health care providers and stakeholders, the policymakers recognized that the fee-for-service program woefully underfunded providers. Simply adding beneficiaries to the Medicaid rolls under that reimbursement methodology would not improve access to care because many providers would refuse to accept those patients.

Further, policymakers considered expanding the Medicaid population in a Medicaid Managed Care model. Other states were reporting that Medicaid Managed Care Organizations (MCO) were siphoning funds intended to pay providers for their services, rationing care for patients, and even bankrupting themselves and leaving the state to scramble for other MCOs to take on the responsibility for the patients enrolled in the bankrupted plan. In addition, DHS shared concerns that the hospital assessment program and the nursing home quality assurance program – that

[1] https://doi.org/10.7249/RRA1144-2 "Prices Paid to Hospitals by Private Health Plans" May 13, 2024.
[2] Crittenden Regional Hospital in West Memphis closed in 2014 following a June 6, 2014 fire. Baptist Memorial Hospital in West Memphis opened on December 13, 2018. DeQueen Medical Center in DeQueen closed May 3, 2019. Sevier County Medical Center in DeQueen opened on December 4, 2022.
[3] Five Rivers Medical Center (Pocohontas 9/1/2023); Eureka Springs Hospital (Eureka Springs 12/1/2023); Progressive Health (Helena 12/5/2023); South Mississippi County Regional Medical Center (Osceola 5/1/2024); and DeWitt Hospital and Nursing Home (DeWitt 5/27/2024)

offset the state's financial responsibility for funding federal match – are federally disallowed in a Medicaid Managed Care model. Dissolving those programs would require a state general revenue financial investment to replace the assessment and quality assurance revenues.

Policymakers were not only grappling with how to ensure that newly eligible Medicaid beneficiaries would have access to providers, they were also diligently working to comply with the federal mandate for individuals to attain health insurance and for each state to create access to government-subsidized insurance through an insurance marketplace. Insurance companies were sounding alarms to employers about the premium increases that would be required to maintain plan solvency under the new mandates. The Qualified Health Plan proposal offered an opportunity for insurance companies to spread risk and limit premium increases on off-marketplace plans by using government paid premiums to marketplace plans made on behalf of Medicaid beneficiaries. This stabilized the insurance market in Arkansas while simultaneously funding more reasonable reimbursements to health care providers caring for Medicaid patients.

The federal financial incentive to states to expand Medicaid eligibility was an enhanced match rate that capped the state's responsibility at 10% of the cost of expansion. The Qualified Health Plan model also enabled some of Arkansas's previously expanded Medicaid services (like expanded coverage for pregnant women who were living at over 17% of the federal poverty level) to cost-shift the state's required general revenue matching investment from the approximate 30/70 ratio for those expanded services to 0/100 for the first three years – declining to the maximum of 10/90 over time.

The AHA applauds the policymakers who created the Qualified Health Plan model. While hospitals struggle to negotiate adequate reimbursement with insurance companies, there is no doubt that the program has been good for the health care system, overall, and for Arkansas's economy. The policymakers were thoughtful about the state's financial responsibility for Medicaid beneficiaries, the financial viability of health care providers, and the financial viability of employers as they offset insurance premiums for their employees.

Hospital Assessment Program

The Guidehouse Report does discuss private hospital access payments, which began under Act 562 of 2009. Working with DHS and hospital supporters in the legislature, the AHA spearheaded the creation of the Hospital Assessment Program that enabled Arkansas's private hospitals to begin participating in an upper payment limit (UPL) program authorized under the Centers for Medicare and Medicaid Services.[4] The program allows hospitals to pay the non-federal share of

[4] Ark. Code Ann. § 20-77-1901 et. seq.

the state's match to enhance payments for hospital services to Medicaid patients. There is **no negative impact on the general revenue budget** for this program. Currently, hospitals are assessed only the amount to generate the non-federal share that maximizes the federal match. While the Guidehouse Report suggests increasing the assessment on hospitals in Option 3.5, doing so would penalize hospitals and serve as a reduction in the value of the program.

Hospital Cost Settlement/Supplemental Payment Programs

Section 5 of the Guidehouse Report outlines various cost settlement/supplemental payment processes required by the Arkansas Medicaid State Plan to ensure that hospitals are reimbursed for services provided to Medicaid patients. Medicaid pays interim payments to hospitals for providing services to Medicaid patients. The cost settlement process is designed to make additional payments to providers up to their allowable costs or to recoup overpayments made to providers. Supplemental payments are payments to providers that are separate from and in addition to base payments. An example of supplemental payments is the inpatient quality initiative (IQI) program that awards quality initiatives like lowering a C-section rate.

Hospitals agree with the Guidehouse Report that cost settlements and supplemental payments are administratively burdensome. The AHA does not oppose a change to methodology that is less administratively burdensome on both DHS and hospitals provided that (1) individual hospital rates are not negatively impacted; (2) the result is not merely a redistribution payment model among the state's hospitals of an already significantly inadequate funding amount; (3) adjustments for graduate medical education programs are made to avoid exacerbating the state's health care workforce shortage; (4) adequate implementation time and a phased-in approach that is designed to accommodate hospitals of all sizes and levels of sophistication is provided; and (5) any expenses, such as electronic health record modifications, specialized staff training, improving coding expertise, etc., are reimbursed.

The AHA is confident that DHS and Arkansas hospitals share the goal of promoting access to quality inpatient and outpatient hospital services and ensuring that Arkansas's hospitals remain viable and continue to serve efficiently and effectively as the safety net for our health care system.

Non-Hospital Providers

Hospitals throughout Arkansas provide a plethora of non-acute services like primary care clinics, specialty clinics, home health, habilitation and rehabilitation services, skilled nursing care, mental and behavioral health services, ambulatory surgery services, urgent care services, pre-hospital emergency medical services, imaging services, laboratory services, and more. The Guidehouse Report offers Medicaid options for non-acute care providers. As the backbone of the health care delivery system, hospitals are steadfast supporters of adequate reimbursement for all

other health care providers and community services, too. If any part of the health care delivery system fails, hospitals are expected to fill those gaps. In fact, many "value-based" payment models are built on financial incentives to reduce hospitalizations. The AHA and its members support initiatives that promote efficiency and improve patient access to care at the right time, in an appropriate setting. If those options fail or patients choose to use hospital services over other care settings, hospitals should not be underfunded or penalized.

The Guidehouse Report explores the Provider-Led Arkansas Shared Savings Entity (PASSE) Medicaid Managed Care program designed for MCOs – owned by health care providers, themselves – to integrate physical health, behavioral health, and specialized developmental services for Medicaid individuals diagnosed with complex behavioral health, developmental, and/or intellectual disabilities. While most of the beneficiaries of the PASSE program are children, hospitals routinely complain that adults assigned to the PASSEs who seek hospital care are among the most difficult patients to discharge. The PASSEs do not pay for hospital care after the PASSE determines that the patient no longer meets medical necessity, so hospitals are left absorbing the cost of serving as an extremely expensive hotel for complex patients that are taking up beds needed for other acute patients.

In addition to PASSE patients, hospitals also experience difficulty in discharging patients who need long-term services and supports. The Guidehouse Report offers options to transition this population into the PASSE program or to another Medicaid Managed Care program. Given the current hospital experiences with the PASSEs and the historical experiences relayed by sister states of MCO behavior, in general, the AHA has strong reservations about transitioning this population or any other Medicaid population into Medicaid Managed Care.

As stated earlier, the Hospital Assessment Program is not permitted under a Medicaid Managed Care program. Should the state consider any population transitioning into Medicaid Managed Care, while the AHA maintains strong reservations, the AHA would work diligently with DHS and other stakeholders to create increased reimbursement for hospital services.

Lastly, Section 13 of the Guidehouse Report specifically discusses cutting hospital reimbursement for services provided to dual eligible Medicare-Medicaid beneficiaries. Arkansas hospitals are already subjected to poor Medicare reimbursement because of the federal Area Wage Index policies and the increased prevalence of Arkansans enrolling in Medicare Advantage plans that are not subject to the same provider protections as traditional Medicare. Penalizing hospitals that provide care in good faith to deserving patients – care that is already not adequately reimbursed – only threatens the financial viability of hospitals. With the costs of personnel and

supplies and inflation at an all-time high, hospitals simply cannot sustain any more cuts from any payer.

The AHA is so appreciative of the opportunity to add these comments to the Guidehouse Report and continues to stand ready to work in partnership with Governor Sanders's team, DHS, the health care community, and other stakeholders to care for Medicaid patients. Thank you, again, for your time and attention to this important endeavor.

Sincerely,

Bo Ryall

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July 18, 2024

Elizabeth Pitman, MPH, JD

Division of Medical Services Director

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Little Rock, AR 72203-1437

RE: Medicaid Sustainability Review-Comments regarding Community Paramedicine's potential positive impact for cost savings and target care and resources for Medicaid patients.

Dear Ms. Pitman,

In 2023, Community Paramedicine representatives of Arkansas worked with the Arkansas Division of Medicaid Services attempting to develop a reimbursement/payment model where Arkansas licensed Community Paramedic EMS services would be paid for home visits provided to Arkansas Medicaid members. This initiative was delayed due to the need for a Medicaid Sustainability Review.

The goal of Arkansas Community Paramedicine and Mobile Integrated Healthcare (MIH) is to provide access to hospital level care in the community, particularly for individuals who face barriers in accessing traditional healthcare facilities, such as the elderly, homebound individuals and those with mobility challenges.

By providing care at the patients' location in community, this model seeks to reduce unnecessary 911 calls, ambulance responses, emergency department visits, hospital admissions, and healthcare costs while improving patient outcomes and overall health.

Community Paramedicine is an innovative concept that is emerging across the United States. It expands on the success and proven ability of Paramedics to provide safe, timely, mobile medical care in the community setting. Community Paramedics are specially trained to provide short-term treatment for low-acuity illnesses. Community Paramedics have additional training and Education which focuses on:

- Advanced pharmacology
- Advanced respiratory and cardiopulmonary assessments
- Communication
- Dementia, delirium & and depression
- Gerontology
- Health records management and information technology tools
- Increase scope of practice

- Palliative care
- Public health
- Social determinants of health
- Transfusion medicine
- Understanding of existing community healthcare resources and responsibilities

One of the challenges is the lack of reimbursement to Emergency Medical Services (EMS) agencies for services provided by Arkansas Community Paramedics. Today's Arkansas EMS systems are struggling to continue to provide 911 response to communities due to the increasing cost of doing business, recruitment/retention challenges, delayed turn times at hospitals (eating up valuable Unit Hour Utilization) and reimbursement shortfalls. Implementation of a CP program without reimbursement is not possible.

How would Community Paramedicine (CP) potentially improve the overall healthcare provided for Arkansans and positively impact Arkansas Medicaid Sustainability?

EMS services who offer Community Paramedicine to their service area citizens and hospital would be an overall benefit to Medicaid Sustainability.

- Arkansas Community Paramedics make house calls!
    - Allows patients to go home sooner and keep them home
    - Patient progress can be monitored from the patient's home
- Reduces high utilization of 911 calls
    - Finds alternative resources for patient when the ER is not the correct utility
- Prevents ER visits and reduces the pressure on the Emergency Rooms.
    - A Calgary CP program prevented 4500 emergency room visits in a year alone!
- Develop care plans and finds resources specific to the patient's needs
    - Locating a PCP
    - Transportation to appointments
    - Prescriptions
    - Durable medical equipment
- Demonstrate cost savings
    - Reducing short-term readmission rates
    - Servicing high system utilizers
    - Getting behavioral patients directly to behavioral hospitals
    - Addressing substance abuse and other specific social needs

Some Arkansas Community Paramedic services are currently participating in a transition of care (TOC) study with funding by the CDC Coverdell Grant that was received by the Arkansas Department of Health. CPs follow stroke patients at time of discharge after receiving care for an acute stroke or TIA. CPs work directly with hospital discharge planning / case managers. Community Paramedics visit these patients in their home assuring they have the needed resources to continue them on a plan of healing, rehabilitation and prevent readmission to the hospital. This TOC study is already showing positive results for these patients.

CP is proposed as a restructuring of care, not a new way to spend additional health care money. In fact, most experimental initiatives in mobile care arena have demonstrated a consistent inability to establish economic sustainability because they operate as "additions" to health care spending. In contrast, the strategy is designed to support and augment other patient-centered delivery models including the Patient Centered Medical Home, the Chronic Care Model and the Accountable Care Organization by providing an optimized mix of care, likely at costs lower than traditional models. In most cases, it is likely that CP could be funded within one of these 4 Mobile Integrated Healthcare Practice: A Healthcare Delivery Strategy to Improve Access, Outcomes, and Value models as a cost-optimization strategy based on shared savings.

Arkansas Community Paramedicine programs would be a positive contributor to helping sustain Arkansas Medicaid directly by decreasing overall health care costs. Community Paramedicine will offer a framework that is structured to provide patient-centered care, with every effort made to ensure patients receive the right care, by the right provider, at the right place, in the right time and at the right cost. CP is a strategy for improving population health indexed to meaningful and measurable clinical and patient experience goals.

References:

Mobile Integrated Health Care and Community Paramedicine: An Emerging Emergency Medical Services Concept. Bryan Y Choi, MD; Charles Blumberg, BS; Kenneth Williams MD 2015 American College of Emergency Physicians

Mobile Integrated Healthcare Practice: A Healthcare Delivery Strategy to Improve Access, Outcomes, and Value. Eric Beck, DO, NREMT-P; Alan Craig, MScPI, ACP; Jeffrey Beeson, DO, RN, EMT-P; Scott Bourn, PhD, RN, EMT-P; Jeffrey Goodloe, MD, NREMT-P; Hawnwan Philip Moy, MD; Brent Myers, MD, MPH; Edward Racht, MD; David Tan, MD; Lynn White, MS

Alberta Health Services

Thank you for your consideration and accepting my comments.

Sincerely,

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HOSPITALS · RESEARCH · FOUNDATION

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July 12, 2024

Via Email: msr@dhs.arkansas.gov

Kristi Putnam, Secretary
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Little Rock, AR 72203

Re: Comments Regarding Medicaid Sustainability Review Report ("MSR" or "Report")

Secretary Putnam,

Please allow this letter to serve as the comments of Arkansas Children's Hospital and Arkansas Children's Northwest ("Arkansas Children's") to the Medicaid Sustainability Review Report. We appreciate the opportunity to respond and further engage with DHS and the State to improve the health of the next generation of Arkansans. Considering the State's increased focus on maternal health, we are hopeful that we are on the brink of an inflection point for the state of health in Arkansas. Arkansas Children's is supportive of efforts to positively affect maternal health, as it is directly connected to the health of our children and mission. While this will be a generational undertaking, it is a way to make a transformative impact on the health and future of children in Arkansas. We stand ready to work with DHS, Medicaid and the State to be an important part of improving the health of mothers and children.

Arkansas Children's has a long history of working with the Arkansas Medicaid program and the State of Arkansas to deliver life-saving care to generations of patients and families, the majority of whom rely on Medicaid to cover the cost of that care. The state of the art care and facilities provided by Arkansas Children's is the result of that long-standing relationship and commitment to the children of Arkansas. Our senior leadership team regularly meets with Medicaid leadership and Secretary Putnam to discuss issues we both face. In more recent meetings, Arkansas Children's leaders inquired about the opportunity to meet with and provide information to the consultants that prepared the Report prior to its completion or release. Unfortunately, we were not provided that opportunity. The result is a Report that lacks critical context related to the cost settlement with Arkansas Children's. The Report also contains inaccuracies and misleading statements. Arkansas Children's could have provided important information about the care we provide, the size and scope of services offered, as well as key national, regional and state pediatric data. Better engagement likely would have resulted in more robust and impactful options in the Report. Options that could actually drive improvements in child health with a focus on outcomes, value and quality and not singularly focused on cost savings. More globally, meaningful engagement with all provider stakeholders in the State is necessary to truly transform programs to support improvement of health. This cannot happen without robust dialogue with the provider community. As the sole pediatric health system in the State, we hope to experience an

even more meaningful level of transparency and engagement with DHS and Medicaid going forward.

ABOUT ARKANSAS CHILDREN'S

For more than a century, Arkansas Children's has continuously evolved to meet the unique needs of the children of Arkansas and beyond. Today, we are more than just a hospital treating sick kids – our system includes two hospitals, a pediatric research institute, a foundation, clinics, education and outreach, all with an unyielding commitment to making children better today and healthier tomorrow. Arkansas Children's, in affiliation with UAMS, is engaged in training the next generation of pediatricians and pediatric subspecialists through residencies and fellowships as a part of the Children's Hospital Graduate Medical Education (CHGME) program. While the program is federally funded, that funding is about one-half of the funding provided to adult graduate medical education programs. The cost of pediatric training, residencies and fellowships is borne by Arkansas Children's.

We continue to invest in the latest technology and physicians to deliver innovative care. Arkansas Children's Hospital is ranked in the top 50 nationally in seven pediatric specialties. On our Arkansas Children's Hospital campus, we provide the highest level of care available in our Neonatal Intensive Care Unit (NICU), Trauma Center and Burn Unit. Our physical sites of care include Little Rock, Springdale, Jonesboro and Pine Bluff. We continue to expand to meet existing and growing demand for pediatric specialty and subspecialty care - including improving timely access to high quality care, while providing a home for general pediatric care for thousands of children on Medicaid - more than 3 times any other pediatric primary care provider in the state. In addition, we are engaging in pilot programs to address the pediatric and adolescent mental health crisis. While we continue to make significant investments in central, northwest and northeast Arkansas, we are considering strategic investment in other regions of the State where anticipated growth may support it. It is imperative that we continue to find ways to provide care close to where children and families live when practical.

We do not do this work alone. For instance, we partner with hospital nurseries across the state to support quality care in those nurseries; and primary care providers that serve children across the state through our clinically integrated network, which impacts approximately 250,000 children, to deliver high quality, cost-effective, and coordinated care, leading to better outcomes. Much of this work is uncompensated by Medicaid and other payors, but it is consistent with our mission and vision to improve child health statewide.

It is not possible for all of this work and growth to continue if the State materially reduces overall reimbursement for pediatric care in the State. We believe investment in children is truly an investment in the future of this State, and children are our best opportunity to change the trajectory of the health of Arkansans.

SECTION 5: SUPPLEMENTAL, COST SETTLEMENT AND ACCESS PAYMENTS (INPATIENT AND OUTPATIENT)

This section of the Report provides an overview of various supplemental, cost settlement and access payments, but key facts are either missing or inaccurate, and important context regarding the delivery of medical care to children is absent. For instance, the Report correctly states:

> "[C]ost settlements are lump sum payments to a hospital provider to "shore up" the difference between what it costs to provide services to Medicaid FFS beneficiaries versus how much the hospital received from the Medicaid FFS rate payment program. These hospitals are paid FFS rates, often equating to less than 100% of hospital costs."

It fails to state or acknowledge the following:

- The Arkansas Medicaid FFS outpatient fee schedule, has not been adjusted for more than thirty (30) years, and is inconsistent current with market rates;
- Medicaid outpatient FFS rates, even if appropriately increased in Arkansas, are the lowest in the market and significantly below the cost of care;
- The national shift of care from the higher cost inpatient setting to lower cost outpatient setting, which has caused a corresponding impact to the overall amount paid in outpatient cost settlements;
- "Outpatient" costs include a broad spectrum of services, including primary care and specialty clinic visits, emergency department visits, outpatient surgeries and ancillary outpatient testing;
- Extremely high cost pharmaceutical infusions and therapies, which are saving or materially changing the lives of chronic and acutely ill children every day, are delivered in the outpatient setting;
- Long-standing national data establishes that delivery of pediatric care is more expensive than delivery of care to adults;
- The payor mix for Arkansas Children's is markedly different than other hospitals in the State, with 65% Medicaid, compared to about 30% for other hospitals; and
- Increases in both inpatient and outpatient volume (unique patients and patient visits/admissions) at Arkansas Children's.

These critical missing facts are clear drivers of the outpatient cost settlement amounts paid to Arkansas Children's and other cost-settled providers mentioned in the Report.[1]

Throughout Section 5, both in text and "Figures", DHS and it's consultant inappropriately limited the data set to a six year period (SFY 2018 – 2023). This skews based on multiple factors, including: pandemic response over multiple SFYs, which drove higher labor and supply costs due to shortages; growth of the Medicaid population due to the public health emergency and Maintenance of Effort requirements; and increased federal share during certain SFYs. While the Report notes increases in cost settlement payments to Arkansas Children's during the above-stated period, it is inappropriate to focus solely on the cost settlement amounts. Instead, one should consider the allowable costs based on service date and total Medicaid dollars paid over a longer period to account for the impact of the pandemic. The average increase in total allowable costs paid to Arkansas Children's Hospital for inpatient and outpatient services from FY 2014 through projected FY 2024 is less than the average Hospital Consumer Price Index (CPI) for that same period. Arkansas Children's maintained this modest year-over-year average increase in allowable costs, despite the impact of the pandemic, while providing care to more children, including Medicaid beneficiaries, and delivering the high cost therapies mentioned herein. Our growth is reflected in the following FY 2024 statistics across all of our locations (with approximately 65% of each Medicaid):

[1] Arkansas Children's is unsure whether the cost settlement amounts, including all "Figures" in this section and providers identified, are complete, as UAMS is cost settled but not included in this section of the Report.

- Approximately 180,000 unique patients were cared for at Arkansas Children's;
- Over 31,500 inpatient discharges (including with observation);
- Over 350,000 outpatient visits, including:
    - Over 110,500 Emergency Department visits

Option 5.1: End inpatient cost settlement process for in-state hospitals

Arkansas Children's Hospital has the only Level 4 Neonatal Intensive Care Unit (NICU), a Pediatric Intensive Care Unit (PICU) and Pediatric Cardiovascular Intensive Care Unit (CVICU). Elimination of the inpatient cost settlement for patients under the age of one would adversely affect the important intensive care and specialty services provided solely or primarily at Arkansas Children's Hospital. This option is inconsistent with the State's long standing policy to ensure delivery high quality neonatal care. It would also further strain the health care delivery system's ability to care for newborns and reduce infant mortality.

The Report states that ending this program would eliminate the administrative costs of calculating and recalculating cost settlement payments. There is no data or information provided to support this statement, including the amount of estimated cost savings.

Option 5.3: Shift hospital outpatient cost settlement for Arkansas Children's Hospital to an Upper Payment Limit payment

Despite making written and verbal requests of DHS for additional data and information upon which each option in Section 5 was based, we have not received a meaningful response to those requests. Since Option 5.3 includes only summary information, it is not possible for us to evaluate the potential impact to Arkansas Children's, or the delivery of care and services to the children we care for. Consequently, we reserve the right to provide an additional response or comment after receiving the information necessary to fully evaluate this option.

The sole support stated for this option is to "save on expensive administrative efforts to cost-settle Medicaid payments to Arkansas Children's Hospital." There is no data or information provided to support this statement, including evidence supporting the specific administrative costs expended each year to cost-settle Arkansas Children's Hospital. We cannot explain the significant delay that caused DHS to be three years in arrears paying final cost settlement amounts to Arkansas Children's Hospital. We have proposed less burdensome cost settlement processes to DHS over the past several years, but those proposals were not accepted.

A statement on page 52 of the Report suggests paying Arkansas Children's Hospital a set dollar amount each year in lieu of cost settlement to "cap" reimbursement for services provided to Medicaid beneficiaries. This statement is concerning, as it does not account for growth in volume, services, rapidly developing, but high cost, standard of care treatments for children, or typical CPI increases.

Option 5.4 Require Arkansas Children's Hospital to fund the non-federal share of the Upper Payment Limit payment as other hospitals do

Despite making written and verbal requests of DHS for additional data and information upon which each option in Section 5 was based, we have not received a meaningful response to those

requests. Since Option 5.4 includes only summary information, it is not possible for us to fully evaluate the potential impact to Arkansas Children's, or the delivery of care and services to the children we care for. Consequently, we reserve the right to provide an additional response or comment after receiving the information necessary to fully evaluate this option.

Although not mentioned in the Report, it should be noted that Arkansas Children's Hospital currently and historically has funded the non-federal share of its inpatient UPL payment. Neither Arkansas Children's Hospital, nor Arkansas Children's Northwest receive an outpatient UPL payment.

Figure 17 is misleading. This Figure, as well as others, is based on the date DHS paid Arkansas Children's a cost settlement payment, not the date of service. Date of service is the period upon which annual cost reports are based. As a result, the information in Figure 17 does not reconcile with each year's cost report or the transmittal of payment issued by DHS to Arkansas Children's. As previously stated, DHS made payments to Arkansas Children's in 2023 that covered three different SFYs. Utilizing the paid date in the Report misrepresents the actual increase or decrease in year over year allowable costs. When considering the date of service and utilizing audited cost report data, the average increase in total allowable costs paid to Arkansas Children's Hospital for inpatient and outpatient services from FY 2014 through projected FY 2024 is less than the average Hospital Consumer Price Index (CPI) for that same period.

The statement in the "Timeline" portion of page 53 is incorrect. Existing Arkansas statutory provisions are implicated.

Overall, Option 5.4 is concerning, as it suggests materially affecting total reimbursement for care provided to Medicaid beneficiaries by Arkansas Children's. While we don't believe that DHS intends to limit or reduce care or services needed by children insured by Arkansas Medicaid, a material reduction in overall Medicaid reimbursement for services provided by Arkansas Children's would likely result in a corresponding reduction in services that Arkansas Children's is able to provide to Medicaid beneficiaries.

CONCLUSION

Arkansas Children's believes healthy children engaged in the system of healthcare leads to healthy adults and a healthy workforce. Improving child health is the first step in the generational effort to improve the health of all Arkansans. We believe we can be an important part of the work and solutions needed to transform the health of children and adults in Arkansas, with the continued financial investment and even more meaningful engagement with DHS and other State agencies.

Sincerely,

Brent L. Thompson
Executive Vice-President
Chief Legal Officer

Arkansas Chapter

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Arkansas Chapter
P.O. Box 251182
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Phone: 501-626-5777
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July 16, 2024

Arkansas Department of Human Services
Medicaid Sustainability Report Team
msr@dhs.arkansas.gov

Dear Medicaid Sustainability Report Team,

The Arkansas Chapter, American Academy of Pediatrics is the state's membership organization for pediatricians and represents nearly 500 pediatricians, pediatric subspecialists, and pediatric trainees across the state. We appreciate the detailed analyses of the Arkansas Medicaid program that Governor Sanders' administration has requested and are encouraged by the innovative ideas included in this report. We are grateful for the opportunity to provide feedback on the Arkansas Medicaid Sustainability Review released in March 2024 on behalf of our members and the hundreds of thousands of children they serve.

More than half of Arkansas's children, and approximately two-thirds of infants and toddlers, receive health services paid for by Medicaid, which makes this program integral to the work of pediatricians. While children represent only 23% of Arkansas's population, they are 47% of Medicaid enrollees.[i] Pediatricians are deeply committed to their patients despite the challenges associated with practicing in a health care system designed for adults. Alarmingly, pediatric residencies across the country have been struggling to fill their trainee slots in recent years, in part due to the pay imbalance between children's health care services and those provided to their adult caregivers.[ii] **Across all areas of feedback, a review of reimbursement that moves toward pay parity for pediatrics should be prioritized.**

In short, Medicaid is a program that serves children and should be designed to optimize outcomes for children. With Arkansas falling near the bottom of state rankings in most measures of child health, now is the time to invest in our children's futures by ensuring that the health care they receive is comprehensive, high-quality, accessible, and child-centered.

Further feedback on the report is organized by the sections of the report.

Section 12 - Patient Centered Medical Homes

Nearly all pediatric primary care physicians participate in the Patient-Centered Medical Home (PCMH) program. Arkansas has a large percentage of physician-owned practices,

and many physician leaders are actively engaged in efforts to exceed quality metrics, achieve annual focus measures, and improve pediatric outcomes.

First and foremost, any changes to the PCMH program should prioritize meaningful pediatric provider engagement. The input and buy-in of those delivering care is vital to the long-term success of any value-based program. The current PCMH program, while it includes a subset of pediatric metrics, is still designed for adults. Value-based primary care programs designed for children, such as the Arkansas Blue Cross Blue Shield Pediatric Primary Care First program, include metrics, services, attribution, and incentives that capture the "unique value proposition of pediatric preventive care" (a proposition more fully outlined by the American Academy of Pediatrics Committee on Health Care Financing).[iii] Additionally, alignment in payment strategies across payers can improve outcomes and may help to reduce physician burnout.

As changes to the PCMH program are considered, improvements to the attribution process should ensure that every child has a medical home *and* that medical homes are responsible for children actually receiving care within their assigned primary care team. Balancing targeted attribution with payment models focused on *pediatric* risk models, *pediatric* metrics, and *pediatric* incentives such as the approach taken with the HealthySteps program can drive practice transformation, enhance prevention/early intervention, and make long-term improvements in outcomes. In addition to practice transformation programs like HealthySteps, integrated behavioral health and support for additional resource navigation, such as community health workers, can address the complex behavioral and social factors that can impact child health in the short term and adult health in the longer term. These supplemental programs should be compensated in ways that cover program costs and incentivize uptake, including in small and rural practices with lower volumes of pediatric patients.

Finally, pediatricians know that maternal and infant outcomes are intrinsically linked and support improvements in maternal outcomes. Pediatricians will continue to center family needs in the care they provide to families after babies are born. Pediatricians are increasingly called upon to address maternal and family needs and should be compensated appropriately for services provided to the family unit, including maternal mental health care screening and navigation, lactation support in the outpatient setting, substance use system navigation, and care coordination.

<u>Section 5 - Supplemental/Cost Settlement/Access payments</u>
ARAAP does not represent health care systems, hospitals, or other business entities, but the health of the pediatric health care system is integral to the ability of its members to ensure primary, tertiary, and specialty care to the children they care for. Pediatric care is significantly underpaid compared to adult and senior payer reimbursement for similar specialties. A 2021 study in the journal Pediatrics stated, "Lifetime earning potential was higher for adult physicians than for pediatric physicians across all comparable areas of both general and subspecialty academic practice. The lifetime earning potentials for adult physicians averaged 25% more, or $1.2 million higher, than those of the corresponding pediatric physicians." Maintaining a strong pediatric workforce in Arkansas is vital, and as stated earlier, pay parity is of concern for pediatricians.

As changes are considered to supplemental, cost settlement, and access payments at hospitals that provide nursery, NICU, outpatient and inpatient care to pediatric patients, ARAAP encourages Arkansas Medicaid not to disinvest in children.

Section 4 - PASSE Managed Care Programs

Comments on the potential PASSE changes focus on sections 4.3 and 4.4, which would expand PASSE eligibility criteria to include more patients. As in section 1, changes to the PASSE should prioritize meaningful pediatric provider engagement as these populations are defined to ensure that children's unique needs are considered. PCPs report that they are generally supportive of the care coordination PASSEs provide, but they are not clear of the benefits they provide beyond what PCMH care coordination offers. With any changes, pediatricians should see no net loss as the structure of reimbursement changes.

Section 11 - Federally Qualified Heath Centers and Rural Health Clinics

ARAAP does not represent FQHC or RHC entities, but the health of the pediatric health care system includes a robust safety net that incorporates pediatric providers and cares for pediatric patients. Adding incentives available, or potentially available, in other pediatric settings, such as supplemental payments for HealthySteps, community health workers, and pediatric-focused behavioral health care models, should carry over to FQHCs and RHCs.

Section 10 - Transportation

Transportation barriers are immense. In thinking about new ways of structuring this service, ARAAP encourages DHS to consider, and seek waivers if necessary, for strategies that allow for the following family-centered approaches to health care.

- Allow multiple children per family to ride to an appointment so families do not have the additional burden of child care.
- Allow infants and children to ride with mothers to maternity and postpartum health care visits.
- With any rideshare model, an expectation for following child passenger safety recommendations must be considered. Requiring rideshare providers to offer infant, toddler, and booster seats would ensure children are protected in motor vehicle accidents, one of the leading causes of death for children.

Section 7 - Pharmacy

Pediatricians are not pharmacists, but they feel the impacts of access barriers and drug shortages. Access to needed medication should be prioritized in pediatrics; for example, covering biosimilar drugs for children with Attention Deficit Hyperactivity Disorder during shortages is a better alternative than forcing children to go without needed medication, even if it is a more costly option at face value.

Section 8 - Habilitative/Rehabilitative Services

Pediatricians understand the value that habilitative therapies bring to children. Early intervention for developmental delays can help children thrive physically, academically, and socially. These services are commonly recommended and prescribed by pediatricians. Pediatricians oppose the suggestion 8.1.A requiring all therapies to be submitted for prior authorization. Increasing the paperwork load of physicians does not improve access to these important services, and the

likelihood that it would generate significant cost savings from reducing needed therapies, rather than access barriers, is low. Pediatricians agree that a potential negative outcome is the public perception of program changes that impede access to needed care.

Section 9 - Psychiatric Residential Treatment

Pediatricians are providing an increasing amount of behavioral health care and often fill in the gaps for youth who fall through the cracks. Of particular concern among members is the continuum of care for patients entering and exiting psychiatric treatment facilities. Pediatricians support improved access to an effective behavioral health care system that coordinates care well among providers, including improved record-sharing among primary care, specialty care, behavioral health care, foster care, juvenile justice providers, and other systems collaborating to improve outcomes.

Again, thank you for the opportunity to provide input into future strategies. Pediatricians look forward to the conversations ahead as the team at Arkansas Medicaid plans for the future.

Sincerely,

Anna Strong
Executive Director
Arkansas Chapter, American Academy of Pediatrics

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[i] https://humanservices.arkansas.gov/wp-content/uploads/Monthly-Enrollment-and-Expenditure-Report_April-2024-.pdf

[ii] https://publications.aap.org/aapnews/news/29175/Match-results-a-wakeup-call-on-need-for-payment

[iii] https://publications.aap.org/pediatrics/article/151/2/e2022060681/190498/The-Unique-Value-Proposition-of-Pediatric-Health

July 11, 2024

Via Email – msr@dhs.arkansas.gov

The Honorable Kristi Putnam
Secretary
Arkansas Department of Human Services
Donaghey Plaza
P.O. Box 1437
Little Rock, AR 72203

In re: Department of Human Services Arkansas Medicaid Sustainability Review Draft

Dear Secretary Putnam:

Thank you for the opportunity to provide comments on the Department of Human Services Arkansas Medicaid Sustainability Review Draft ("Draft"). The below comments are on behalf of the Arkansas Home Based Services Association (AHBSA), made up of the largest W2 home care Medicaid providers in the state. Our organizations provide top-quality, in-home care services for patients across Arkansas, including in many rural communities.

We support many of the options outlined in the Draft. However, there are some proposed provisions that we oppose, or believe need additional clarification. We appreciate your consideration of the below comments, and we are glad to discuss further, if helpful.

Sincerely,
Matt McClure, Ed.D
President of the Board
Arkansas Home Based Services Association

Section 3.7: Eliminate the ARHOME Qualified Health Plan model and transition eligible beneficiaries to the FFS program.
We oppose this option because of the negative fiscal impact of losing the higher Medicaid match rate when moving these individuals back to traditional Medicaid. Further, the significant impact to the Medicaid budget would likely result in reduced services.

Section 4.2: Transition LTSS programs and beneficiaries, excluding nursing facility services, to the PASSE program.
We oppose transitioning all LTSS programs to the PASSE program while excluding long-term care facilities. However, depending on implementation, we are open to transitioning LTSS to the PASSE program if the entire aging population is included, as outlined in Section 4.1 of the Draft.

Section 6: Long-Term Services and Supports (Facility/Home and Community Based Services)
Overall, the aging research and data show that the aging population is and will continue to grow. Therefore, it is imperative that Arkansas DHS and providers work together to identify solutions to mitigate implications on costs and resources. The Draft explains that, as the demand for LTSS is growing, there have also been increasing workforce shortages among LTSS providers – a trend that will continue. However, the Draft does not describe any best practices or strategies for recruitment and retention, as have been employed in other states.

We agree with the Draft's assertion that there is a pressing need to review and streamline eligibility processes across the HCBS programs, to address the "extra layer" HCBS programs currently face, and to ensure the process is efficient and consistent.

OPTION 6.A.1: Enhance Access to HCBS and "equalize the front door" by identifying opportunities to streamline the eligibility process and exploring expedited eligibility pathways.
We have seen firsthand the burdensome delays in care caused by the "extra layer" requiring HCBS to complete independent assessments before delivery of service. We support efforts to "equalize the front door" through expedited and streamlined eligibility pathways. This will also create significant cost savings. Programs like Hospital to Home give clients a choice. However, please consider situations where clients are not transitioning from a hospital. In addition, this may be limited only to "217 Group." What about those outside that waiver program?

OPTION 6.A.2 Incorporate Value-Based Payment in HCBS reimbursement
We are open to this structure if it is implemented with the right framework, and we request the opportunity to submit specific recommendations. For example, if implementing more PCA training, we would urge DHS to follow innovative models that have proven to work well in other states.

OPTION 6.A.3: Review Medicaid program entry points to ensure correct program placement and appropriate service delivery in alignment with "no wrong door" philosophies, which promote a single, coordinated system to access services.
Similar to Option 6.A.1 to "Equalize the Front Door," we support the idea of "No Wrong Door." However, we respectfully request inclusion in discussions to decide specific guidelines for how the program would work. For example, while the Contact Center will be helpful, there is a critical need for program navigation. Again, AHBSA would like to provide input in the planning stage if implemented. (For example, if program navigation incudes provider choice, the patient needs educated on options based on star rating and other metrics.)

OPTION 6.B.1 Develop a monitoring system for State Plan personal care services.
We support this option if it involves eliminating Optum. Requiring a physician signature, referral, or prescription for personal care services for clients in the PASSE programs is not in the Guidehouse Report. In previous meetings, it has been mentioned this should be required for all SSI and not only PASSE clients.

OPTION 6.C.1 Incorporate value-based payment into nursing facility payment methodology to support value and quality of care.
If DHS chooses to implement this option, home and community based service providers request an opportunity to collaborate on implementation.

OPTION 6.C.2 Assess Arkansas's nursing facility landscape to understand the current state and identify opportunities for improvement
AHBSA supports an assessment of the nursing facility landscape, and we urge DHS to explore innovative options, such as allowing nursing homes to use unoccupied beds for a different level of care, such as independent or assisted living (which we recognize would require a licensing change).

Arkansas DHS Medicaid Sustainability Review March 2024
Public Comment
Comments by: Central Arkansas Area Agency on Aging, dba CareLink

CareLink agrees that the sustainability of Medicaid is a significant issue for the aging community in Arkansas. The 60+ population will increase from approximately 17.6% today to approximately 26% of the total Arkansas population by 2030. 65+ poverty in Arkansas has risen from approximately 11% to 12.8% in 2022, increasing the need for Medicaid services.

However, to remain sustainable the conversation must be about more than containing costs. Medicaid rate structures, whether fee for service or managed care, in HCBS State Plan Personal Care and the ARCHOICES waiver program are inadequate and need substantial review. Sustainability also means supporting a labor force that will support Home and Community Based Services. Workforce wages, benefit structures and a career ladder are essential components of ensuring Medicaid sustainability for those Arkansans needing HCBS.

Section 3 ARHOME

- Agreed that the ARHOME program needs to be continued for Arkansans and CareLink supports continuation of the program.

Option 3.7 Eliminate the ARHOME Qualified Health Plan model

- Oppose due to negative economic impact to the overall Medicaid budget as specified in the narrative.

Section 4 Provider-LED Arkansas Shared Savings

Option 4.1 Transition LTSS to PASSE Program

- CareLink remains neutral on the concept of placing all LTSS services into managed care.

Option 4.2 Transition LTSS to PASSE program but exclude NF

- CareLink adamantly opposes Option 4.2, the exclusion of nursing facility services. The facility category accounts for the majority of expenditures in the LTSS system. Placing HCBS in managed care without the funding spent on

facilities, prevents the PASSE or Managed Care Insurance entity from making substantial change in the paradigm and does not contribute to sustainability.

Section 6 LTSS

- Medicaid reimbursement rates for HCBS State Plan Personal Care and ARCHOICES waiver services are inadequate to recruit and retain qualified staff.

Option 6.A.1 Equalize the front door

- CareLink strongly supports initiatives to equalize the front door making HCBS eligibility and entry into waiver programs faster and easier while maintaining eligibility controls. It is our opinion that this option has the potential to impact Medicaid sustainability far greater than any other option. Making the less expensive option of care, HCBS, equally as assessable as facility care will reduce costs and enhance the experience and lives of care recipients.

Option 6.A.2 Value Based Payment

- CareLink supports value-based payments and increased quality of services. However, these payments must be an opportunity for providers to earn higher reimbursement than the current fee structure. Must be in addition to, not taken away from. Again, current rates for State Plan Personal Care and ARCHOICES waiver programs are abysmal and need significant review. Rates need to be increased **AND** a value-based system needs to be implemented.

Option 6.A.3 No wrong door.

- Implemented properly, this is a great idea.

Option 6.B.1 Develop a monitoring system for State Plan personal care.

- Consolidating oversight with state agencies could prove beneficial to the state, provider and care recipients.

- However, this section taken at face value implies that there is insufficient monitoring occurring within the Personal Care service. Larger providers would argue that there is substantial monitoring occurring, albeit from numerous state departments and agencies and from contracted third parties. If the revised streamlined monitoring enables the state to more fully monitor all providers to ensure policies, procedures and rule and regulations are followed and that

available data is routinely analyzed to monitor and enhance the system – then CareLink is supportive of the initiative.

Baptist Health

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July 14, 2024

Kristi Putnam
Cabinet Secretary
Arkansas Department of Human Services
Donaghey Plaza,
P.O. Box 1437,
Little Rock, AR 72203
Email: msr@dhs.arkansas.gov

Dear Ms. Putnam,

On behalf of Baptist Health, I would like to extend our sincere gratitude for your unwavering dedication to improving the lives of Arkansans. Your efforts and those of the Department of Human Services (DHS) provide significant support to our community which helps enable Baptist Health to pursue our mission of providing quality patient-centered services and responding to the changing health needs of Arkansans with Christian compassion.

Thank you for the opportunity to provide feedback on the Medicaid Sustainability Review (MSR) report. We are grateful for DHS's collaborative efforts and the opportunity to contribute our insights. The purpose of this letter is to offer Baptist Health's feedback on the options outlined in the MSR. Below are our comments regarding the various program design options, addressed in order of the sections that carry the highest importance from our perspective.

GENERAL COMMENTS - HEALTHCARE FUNDING CRISIS IN ARKANSAS

Publicly available studies from trusted sources (including the federal government, national employer groups, and national insurance companies) show irrefutably that Arkansas hospitals are already reimbursed at nationally-low levels, largely due to local funding that is well below the national average, which in turn has resulted in federal reimbursement for Arkansas providers (including non-hospital providers) that is well below the national average. In addition, Arkansas hospitals are increasingly being relied on to address physician shortages caused by increased demand, limited supply, and stagnant reimbursement. Finally, Arkansas hospitals and other providers are experiencing significant reductions in already nationally-low federal reimbursement levels due the increase in privatized Medicare (aka Medicare Advantage) which has resulted in financial resources being siphoned away from direct patient care through increased denials and increasingly burdensome administrative requirements.

Any changes that cause Arkansas reimbursement to fall further behind national levels only exacerbates the situation, digging a deeper hole that Arkansans will be forced to reconcile in future. We do not believe the current path is sustainable for Arkansas providers and the end

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result will be reduced access and quality of care for most Arkansans. Helping Arkansas address this crisis is top of mind at Baptist Health and reflected in our comments below.

SECTION 3: ARHOME QUALIFIED HEALTH PLAN MODEL

Baptist Health is very supportive of Medicaid expansion and believes Arkansas' use of the Qualified Health Plans has improved healthcare access for Arkansans and generated much needed additional financial resources for Arkansas hospitals, physicians, and other providers. While we recognize that a program of this magnitude will inherently have opportunities for improvement, we believe future plan revisions should focus on the expansion of these programs to more Arkansans that lack sufficient healthcare insurance, while also better utilizing federal matching funds to improve the financial resources available for providers to meet the needs of Arkansans in a sustainable manner. On the contrary, we believe revisions that restrict coverage for core healthcare needs or reduce already nationally-low reimbursement to providers will ultimately delay care, compound the severity of the underlying healthcare needs, and force providers to seek other funding sources such as higher commercial reimbursement and local tax support to subsidize the uncompensated cost of care that our society has deemed necessary through laws such as EMTALA.

Option: **3.4 (move QHP to PASSE); 3.7 (move QHP to Medicaid FFS)**
Impact: ***NEGATIVE***
Both of these options would significantly reduce reimbursement for Arkansas providers which would be detrimental for healthcare in Arkansas for reasons noted above.

Option: **3.5 (increase hospital fees)**
Impact: ***NEGATIVE*** *as presented*; however, ***POTENTIAL POSITIVE*** *if pursued differently*
This option as presented would significantly reduce reimbursement for Arkansas hospitals which would be detrimental for healthcare in Arkansas for reasons noted above. However, if this option was part of a broader plan to actually expand QHP coverage for Arkansans and drive down the uninsured rate, this could generate more funding for Arkansas providers (net of additional fees) in a way that is sustainable from a state budget perspective.

Option: **3.6 (move QHP to Medicaid managed care)**
Impact: ***NEGATIVE*** *as presented*; however, ***POTENTIAL POSITIVE*** *if pursued differently*
This option as presented does not result in improved federal match and would result in activity similar to what is happening with the privatization of Medicare through Medicare Advantage. As presented, this would significantly reduce reimbursement for Arkansas hospitals which would be detrimental for healthcare in Arkansas for reasons noted above.

However, some states have recently been successful in significantly increasing overall funds available for all Medicaid services (including FFS, QHP, etc) by using an average commercial rate benchmark in lieu of a Medicare benchmark. This still leaves the risk of private

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companies siphoning funds away from direct care as they managed the state's Medicaid plan; however, we believe that this could be mitigated if state leaders worked with a provider-led committee to help design the overall plan in a way that encourages quality care, and disincentivizes arbitrary denials and administrative cost.

While providers have serious reservations regarding the Medicaid managed care option, we believe the need in Arkansas is great and if this option was part of a broader plan to actually expand coverage for Arkansans and drive down the uninsured rate, this could result in more funding for Arkansas providers in a way that is sustainable from a state budget perspective. Therefore, we believe it should be explored further via a committee involving key leaders from the state government and provider community.

Option: **3.1 (strengthen controls); Option 3.3 (reward QHP performance)**
Impact: ***POSITIVE***
We believe both of these options could be implemented in a way that is positive and sustainable for patients, providers and plans. Focusing more resources on direct patient care, coupled with incentives for QHPs to design programs that meet the core health needs for Arkansans in a positive way makes sense. While designing incentives for QHPs, we encourage DHS to include incentives for plans to work with providers in developing clinically-focused care pathways to ensure appropriate care, and penalties for plans that arbitrarily deny access to care, or deny payment after care has been given in good faith. We also encourage DHS to consider a meaningful incentive for QHPs based on a provider experience score. We believe this would reduce friction between plans and providers in the longer-term which is imperative for truly improving outcomes and use of limited resources in a sustainable manner.

Option: **3.2 (shift premium cost share dollars)**
Impact: ***POTENTIAL NEGATIVE***
If this option were implemented on its own, we believe QHPs would largely rely on reductions in provider reimbursement to offset the negative impact from the higher premium tax. As noted above, further reductions in reimbursement for Arkansas providers would be detrimental for healthcare in Arkansas. If this option were coupled with another option such as Option 3.3 (reward QHP performance) and/or ideas such as a meaningful provider-experience incentive for QHPs, the negative impact from this option could be largely mitigated from a provider perspective.

SECTION 5: SUPPLEMENTAL, COST SETTLEMENT, AND ACCESS PAYMENTS (INPATIENT AND OUTPATIENT)

Option: **5.1 (cost settle in-state hospitals) and 5.2 (cost settle out-of-state hospitals)**
Impact: ***NEGATIVE***

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We understand and support the broader goal to reduce administrative burden and improve predictability for all involved. However, we believe that this change poses a higher risk to hospitals that provide vital and limited labor & delivery and NICU services throughout the state. That said, if this option were pursued, we strongly encourage DHS to utilize a method that ensures reasonable reimbursement for these services (both in-state and in key border towns) so Arkansas residents do not lose access to these highly important services.

Option: **5.3 (ACH outpatient UPL) and 5.4 (ACH fund non-federal share UPL)**
Impact: ***CONSISTENT WITH OTHER ARKANSAS HOSPITAL PROVIDERS***
Commenting on an option that directly impacts another provider can be complicated; however, we believe the concepts presented under these two options already exist for all other non-CAH/REH Arkansas hospitals; therefore, we believe consistent treatment for a larger and financially stable provider such as ACH makes sense when it comes to allocating limited state resources.

SECTION 13: CROSSOVER CLAIMS

Option: **13.1 (Medicare Part B "lesser of" policy)**
Impact: ***NEGATIVE***
As presented, this option would significantly reduce reimbursement for Arkansas providers which would be detrimental for healthcare in Arkansas for reasons noted above. If there were a way to significantly reduce the administrative burden associated with filing these claims, and to use the savings to improve provider reimbursement in other areas, there could be something beneficial in this area for all parties involved.

SECTION 4: PROVIDER-LED ARKANSAS SHARED SAVINGS ENTITY MANAGED CARE PROGRAM

Impact: ***POTENTIAL POSITIVE*** *and* ***POTENTIAL NEGATIVE***
We recognize that certain Arkansans have higher medical needs and in these complex medical situations we support programs that focus on beneficiary needs as they can improve quality of life, while better utilizing limited resources throughout the healthcare system. When done successfully, this is truly positive for all involved (beneficiaries, providers, ultimate funding source which is often Arkansas taxpayers). To the extent that these options help achieve this broader goal, we are supportive.

That said, we cannot tell if these options would impact the Program of All-Inclusive Care for the Elderly (PACE) and would strongly encourage DHS to exclude PACE programs from any of the changes noted in this section as it is already an innovative care model designed to provide complete and coordinated beneficiary-centric care for Arkansas residents with

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complex medical needs. In fact, there are options in other sections that we believe would expand access to the PACE programs which we are very supportive of.

SECTION 6: LONG-TERM SERVICES AND SUPPORTS (FACILITY / HOME AND COMMUNITY-BASED SERVICES)

Option: **6.A.1 (streamline eligibility process); 6.A.3 ("no wrong door" approach)**
Impact: ***POSITIVE***
The way we interpret these options, we believe they would simplify the eligibility process and provide beneficiaries with a wider range of options on the front end that could better meet their needs. We are supportive of efforts in this area and believe it would improve access to alternative programs such as PACE (mentioned above). Currently, there are different eligibility processes for PACE and nursing home services, and it is harder to get a beneficiary qualified for PACE which seems counterintuitive since PACE helps a beneficiary stay in their own home longer and is lower cost from the state's perspective. Having a streamlined process that identifies eligibility for all available programs on the front end would be better for all involved (beneficiary, state, and providers).

Option: **6.C.2 (Assess Arkansas' nursing facility landscape)**
Impact: ***NEED FOR AWARENESS***
Nursing homes are an important part of the overall healthcare delivery system and we are supportive of assessing Arkansas' nursing facility landscape to identify opportunities for improvement. Unfortunately, the nursing home industry is an area where large private equity firms have invested heavily from a national perspective, and they will often use complex ownership structures involving multiple subsidiary entities that provide related-party services to multiple wholly-owned/controlled nursing homes. While there are many legitimate reasons to have multiple legal entities owned by a single corporate parent, it can also be used to hide financial results and to limit accountability to the public by limiting the amount of assets that are exposed to legal liability.

Brendan Ballou (a federal prosecutor that served at the U.S. Department of Justice) published a book on this topic in 2023 called *Plunder: Private Equity's Plan to Pillage America*. It is an eye-opening read and we believe offers a perspective that would be helpful in shaping how DHS would approach a study of the nursing home industry in Arkansas. For example, if DHS relies solely on publicly filed cost reports to assess the financial performance of nursing homes in the state, the assessment would only reflect the financial performance of the nursing home itself, but for any nursing homes owned by a larger private-equity investment group, it would exclude any financial benefit derived from providing services through related-party subsidiaries that ultimately have shared ownership further upstream. The final chapter of the book even offers action steps for various stakeholders, including state and local governments.

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Please note, we are not saying that we are aware of specific situations where the issues identified in Mr. Ballou's book applies to any of the nursing homes in Arkansas; however, we recognize the complexity that can exist within this industry and believe that it could have material and important implications for a statewide assessment such as the one being contemplated, hence the comment and recommended reading.

SECTION 7: PHARMACY

Impact: ***POSITIVE***
We recognize the pressure that rising drug costs have on the overall healthcare system, and support efforts to better manage pharmaceutical utilization and costs amongst the Medicaid population. We also believe that health plans and employers (such as Baptist Health) could benefit greatly from the information generated specifically under Option 7.4 (pharmacoeconomic specialist). It makes sense for the state to lead a coordinated effort to review the implications of high-cost drugs on the overall Arkansas healthcare system. Should this option be implemented, we would encourage DHS to incorporate a panel of active providers for feedback and input as part of these reviews.

SECTION 8: HABILITATIVE AND REHABILITATIVE SERVICES

Option: **8.A.1 (prior-auth for all therapy services)**
Impact: ***POTENTIAL NEGATIVE***
We recognize prior authorization is appropriate in some situations; however, we are also supportive of the statewide efforts to reduce the overall number of prior authorizations as it has become overutilized and administratively burdensome. Under this option, a prior authorization would be required for all therapy services which we believe will cause unnecessary administrative burden. For our own health plan, we only require prior authorization in situations where the provider believes an extended period of therapy is necessary. Should DHS pursue this option further, we would encourage DHS to consider a similar approach to minimize the added administrative burden and increase the effectiveness of such a program.

SECTION 11: FEDERALLY QUALIFIED HEALTH CENTERS AND RURAL HEALTH CLINICS

Impact: ***POTENTIAL POSITIVE*** *and* ***POTENTIAL NEGATIVE***
FQHCs and RHCs are safety net providers and extremely important in delivering healthcare throughout Arkansas, especially in rural areas. While we support efforts to reduce administrative burden and improve predictability for all involved, we encourage DHS to

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approach any changes to these models cautiously, and to make sure that changes do not negatively impact care delivered under these models.

SECTION 12: PRIMARY CARE CASE MANAGEMENT, PATIENT CENTERED MEDICAL HOMES, AND EVIDENCE-BASED MATERNAL HEALTH MODELS

Impact: ***POSITIVE***
We believe the options in this section align with Baptist Health's primary care value-based efforts, and are supportive of improving and expanding primary care value-based programs for Medicaid-covered lives. As noted above, state reimbursement rates are already at a nationally-low level, so longer-term savings from these programs should be reinvested back into the local healthcare system to help address the broader crisis noted above.

In closing, Baptist Health appreciates your thoughtful collaboration and willingness to receive our feedback on the MSR report. We look forward to continued collaboration with DHS to improve the lives of Arkansans. Thank you for your time and consideration.

Sincerely,

Troy Wells
President and CEO

July 12, 2024

Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

Cabinet Secretary Kristi Putnam
Arkansas Department of Human Services
700 Main St.
Little Rock, AR 72203-1437

Re: Comments on the Arkansas Medicaid Sustainability Review

COMMUNITY
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SYSTEMS

4000 Meridian Boulevard
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P.O. Box 689020
Franklin, TN 37068-9020

Dear Cabinet Secretary Putnam,

We want to express our appreciation on behalf of Community Health Systems ("CHS") for your willingness to explore all options to improve the stability of the Arkansas Department of Human Services' Medicaid program. CHS operates five hospitals and numerous clinics that play a crucial role in the State's Medicaid program by providing valued services to patients. We believe that the Medicaid program's financial sustainability is at risk due to the growing gap between available funding and rapidly rising costs. Pursuing new financing solutions to alleviate this cost gap will be critical to preserving access to services for Arkansas residents. Therefore, we are grateful for the opportunity to provide our feedback on the Arkansas Medicaid Sustainability Review (the "Report") draft at the beginning of your planning process.

Transitioning Beneficiaries to Medicaid Managed Care

The managed care options presented in the Report would partially address State budget concerns by shifting more of the financial burden to providers that already receive payments below their costs for serving the Medicaid population. Rather than transferring this problem to other key stakeholders within the State, which would be, at best, net-neutral for Arkansas residents, the State should consider broader managed care financing solutions that better leverage federal dollars for the benefit of all stakeholders. Many other states have successfully implemented such solutions, achieving both (a) a reduction in the net cost of Medicaid to the State General Fund and (b) an increase in federal funding available for Medicaid services. If Arkansas does not adopt a similar approach soon, the quality and availability of services for its residents will significantly decline due to potential hospital closures and physician shortages in the long term.

Below is our feedback on the proposed managed care options and recommendations on how the State can effectively utilize managed care to enhance the long-term sustainability of the Medicaid program.

We oppose options 3.4 and 3.6 in their current form, which propose shifting coverage of the Adult Expansion population from commercial payors to Medicaid managed care payors. This transition would lead to significant base rate reductions for providers serving this population, particularly impacting hospitals with potential cuts of 25% to 50% below current levels. Additionally, the State's anticipated savings from these options are expected to be minimal and uncertain, due to the availability of a 90% enhanced federal match for this population and potential reductions in premium tax revenue.

Despite our opposition to options 3.4 and 3.6 as currently proposed, we recognize the potential benefits of managed care when implemented under the right strategy and conditions. For instance, a managed care system covering the majority of Arkansas's Medicaid population could not only achieve State savings but also increase the State's premium tax revenue and enable support for providers through innovative payment models.

Transitioning most Medicaid members from fee-for-service to managed care has the potential to increase annual premium tax revenue to the State by up to $120 million. Moreover, in the context of hospitals, a broader adoption of managed care could facilitate the implementation of a directed payment program up to average commercial rates. This approach could enhance access to care for Medicaid patients without additional costs to the State General Fund, as it could be entirely financed through intergovernmental transfers and hospital assessments.

To fully realize these benefits, however, a more comprehensive transition of Medicaid beneficiaries to managed care than what is currently proposed in the Report would be necessary. Therefore, we would support options 3.4 and 3.6 if the State simultaneously (a) implements managed care for a larger portion of Arkansas's Medicaid population, including children, pregnant women, elderly adults, and people with disabilities, and (b) adopts a directed payment program that reimburses hospitals up to commercial rates.

In conclusion, the State should reconsider options 3.4 and 3.6 in their current form and instead focus on a comprehensive managed care strategy that balances fiscal responsibility with provider support. We are committed to collaborating with all key stakeholders to ensure that any changes to Medicaid managed care in Arkansas align with these principles and maximize benefits for all involved parties.

Shifting State Costs of Adult Expansion to Private Hospitals

We oppose option 3.5, which proposes increasing assessments on private hospitals to cover some or all of the State's Adult Expansion costs. This proposal unfairly places a disproportionate burden on private hospitals already facing significant financial challenges, potentially leading to adverse impacts on healthcare access and quality across the State.

This option would intensify the financial pressures confronting private hospitals, including rising operational costs, workforce shortages, and the ongoing challenges of providing uncompensated care. The added strain could force hospitals to make difficult decisions, such as reducing services, deferring investments in technology and facility upgrades, or implementing staff layoffs. These measures would affect vulnerable populations reliant on Medicaid for essential services, potentially worsening health disparities and overall healthcare outcomes in our communities.

Moreover, shifting the responsibility for the State's Adult Expansion costs solely to private hospitals undermines the equity and sustainability of broader-based taxation systems intended to support public services. Instead of burdening private hospitals, it is imperative to explore alternative funding strategies that distribute financial

obligations more fairly across all stakeholders. This approach would ensure that Medicaid Expansion remains financially viable while preserving access to care.

Transitioning Beneficiaries to Fee-For-Service

CHS opposes option 3.7, which would shift coverage of the Adult Expansion population from commercial payors to Medicaid fee-for-service. This option would not only lead to base rate reductions for providers, as under options 3.4 and 3.6 discussed above, but it would also significantly reduce premium tax revenue available to fund Medicaid programs.

Eliminating and Replacing Hospital Cost Settlement Payments

We support the version of option 5.1 that replaces the current inpatient cost settlement process for in-state private hospitals with a budget-neutral base rate increase funded by State General Fund. We agree with the Report's assessment that this approach would eliminate costly administrative burdens for both the State and hospitals while maintaining current reimbursement levels and access to care.

We oppose option 5.4, which would shift the outpatient cost settlement for Arkansas Children's Hospital ("ACH") to a UPL payment program financed with new hospital assessments levied on ACH. Based on our experience in other states, we believe it could be challenging to demonstrate that such a non-uniform tax model meets the redistributive criteria under the B1/B2 statistical test. Alternatively, if the State were to increase the current uniform tax rate to finance ACH's UPL payments, it could inadvertently impose higher assessment rates on other private hospitals.

Incentive Payments for Patient-Centered Medical Homes

CHS supports option 12.A.1, which proposes maintaining the Patient-Centered Medical Home model and enhancing incentive payments to providers. We acknowledge the critical role of incentive payments in driving providers to improve member care. To allow providers sufficient time to achieve these improvements, we recommend that the State gradually progress from linking additional incentive payments to participation and quality reporting to linking additional incentive payments to performance on quality measures.

We appreciate your consideration.

Sincerely,

Nathaniel K. Summar
Senior Vice President, Revenue Management

July 12, 2024

Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

Cabinet Secretary Kristi Putnam
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We appreciate your consideration.

Sincerely,

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Senior Vice President, Revenue Management

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July 12, 2024

Arkansas Department of Human Services
Medicaid Sustainability Review Team
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Little Rock, Arkansas 72203-1437
Email: msr@dhs.arkansas.gov

Re: Comments of the Arkansas Health Care Association to the Arkansas Medicaid Sustainability Review

Medicaid Sustainability Review Team:

The Arkansas Health Care Association ("AHCA") is the state's largest organization of long-term care providers, representing more than 90% of the licensed long-term care facilities in Arkansas. Its responsibilities are to educate, inform and represent members before government agencies, elected officials, other trade associations and related industries. Additionally, AHCA provides training, education and assistance to facilities across the state, promoting high-quality care for patients and strict professional standards for staff.

AHCA is taking this opportunity to provide comments and feedback to the Arkansas Medicaid Sustainability Review ("AMSR") that was released in March of 2024. These comments are directed at the portions of the AMSR related to long-term services and support. ("LTSS")

Skilled Nursing Facilities ("SNF") versus Home and Community Based Services ("HCBS")

In discussing LTSS, the AMSR contains an overt theme.[1] That being that many of the individuals that reside in a SNF could actually receive services in a HCBS setting, such as assisted living or home care. By placing those people in a HCBS setting instead of a SNF, the AMSR concludes the State will save money. This assumption is flawed as illustrated by the following:

- First and foremost, a person CANNOT legally reside in a nursing home unless they meet the criteria showing a need for SNF placement. The procedure for determining that need is set forth by the Department of Human Services ("DHS") and requires completion of a "Form DMS-703." (https://humanservices.arkansas.gov/wp-content/uploads/016.06.06-003F-8364_Procedures_for_Determination_of_Medical_Need_for_Nursing_Home_Services_.pdf) The DHS policy plainly states: "A thorough and complete evaluation must be conducted to ensure that individuals who do not require nursing home services are not admitted to nursing facilities." Ultimately, the Office of Long Term Care, housed at DHS, decides if someone qualifies for SNF placement. If someone can live in a HCBS

[1] Sections 4 and 6 of the AMSR contain the bulk of the discussion regarding LTSS.

setting, it is highly unlikely they meet the criteria for nursing home placement. Moreover, that decision is ultimately made by DHS – not the provider.

- The AMSR cites the AARP estimate that approximately 14% of Arkansas SNF residents could be supported in the community. (p. 67) This number is misleading. Most of the individuals in the 14% figure are short-term Medicare post-acute admissions (not Medicaid patients) who are receiving rehabilitation services with the intent of returning home.

- From 2008 through 2020, Arkansas participated in the federally funded Money Follows the Person ("MFP") grant program, designed to help Medicaid beneficiaries living in inpatient institutions (hospitals, SNFs, and ICFs/IIDs) for more than 60 days transition into family homes, group homes, or other residential settings in the community. Over that time, the MFP program transitioned 923 Medicaid beneficiaries from inpatient settings to the community. However, each year, an average of only 14 people aged 65 and older were successfully transitioned to the community despite the extra federal MFP funding designed to identify those residents.

- Through DHS, the State has in place what is known as the Options Counseling Program. This program requires SNFs to provide new admissions with information on care options and the availability of HCBS options, such as assisted living and home care.

- HCBS is optional, not mandatory, and federal law prohibits a state from imposing HCBS on any Medicaid beneficiary who qualifies for and chooses SNF care (42 U.S.C. § 1396n(c)(2)(C)).

- The U.S. Supreme Court decision in Olmstead v L.C. (1999) is often misinterpreted on this issue. In particular, the Court emphasized that nothing in the Americans with Disabilities Act (ADA) condones terminating a SNF setting "for persons unable to handle or benefit from community settings." The Court's opinion also noted that there is no federal requirement "that community-based treatment be imposed on patients who do not desire it."

- While the cost to take care of someone in the community may be cheaper, that doesn't automatically equate to savings for Medicaid. SNF operators in Arkansas pay a Quality Assurance Fee of 6% gross receipts tax on all Medicare, Medicaid, and private pay. Those dollars are substitutes for general revenue that would otherwise be needed to receive the federal match. In other words, SNF operators are paying a large portion of the state match themselves. For HCBS, no such mechanism exists.

- Finally, nobody wants to be in a nursing home. HCBS is always going to be the preferred option. Unfortunately, people become too sick and frail to be properly cared for in the community and are left with no choice but to reside in a SNF. In short, there is neither a carrot nor a stick driving people into a nursing home. They are there because they have to be.

The AMSR suggests that it is too difficult to access HCBS services by stating that "[t]he main difference between HCBS and nursing facility initial program entry is that the HCBS programs have an 'extra layer.'" That simply isn't the case.

- Federal law requires assessments for both populations. Federal SNF regulations require a more elaborate and data-driven process, including pre-admission screening, assessment and re-assessment using federal instruments, and a comprehensive care planning process for each SNF patient. Nothing remotely as rigorous is required of HCBS entry.

- For each person seeking HCBS coverage, federal regulations and waiver instructions require the state to provide an independent RN assessment using an instrument selected by the state. This determines the need for non-skilled supportive services, while financial eligibility is determined separately in the same manner as SNF financial eligibility.

- In most cases, a person that seeks admission to a nursing home is admitted immediately. This makes sense because those individuals are very sick and/or in need of immediate rehabilitation. That doesn't mean, however, that they are Medicaid approved immediately. That process can take months and, if they are denied, the SNF operator is likely to bear that loss.

- While there may be frustration with the timeliness of independent assessments and financial eligibility determinations associated with entry into an HCBS program, that is an operational issue. It is no basis for expanding HCBS eligibility and spending.

The AMSR suggests expanding HCBS in Arkansas, including lowering eligibility criteria. But it fails to mention the following:

- A substantial general revenue spend would be required to increase Medicaid enrollment through the HCBS pathway. HCBS waiver enrollees receive HCBS as well as full Medicaid coverage.

- There is no shortage of HCBS for adults 65 or older or persons with physical disabilities. There are no waiting lists in Arkansas.

- There would be no offsetting savings on SNF benefit spending from increasing HCBS spending and eligibility. As discussed above, people that are in SNF's are there because they need those enhanced services as determined by the State.

- Arkansas LTSS spending is already more than "balanced." Spending on HCBS and the myriad of other non-skilled support services covered by Arkansas Medicaid exceeds SNF spending by about two to one.

Managed Care

Section 4 of the AMSR proposes putting LTSS into Arkansas's managed care program, known as the PASSE (Provider-Led Arkansas Shared Savings Entity). AHCA opposes the addition of LTSS into the PASSE, or managed care generally.

The commentary and analysis of managed care programs is vast and spans the spectrum of "it's the greatest thing ever" to "this is a disaster." AHCA won't get bogged down in that debate in this comment, but will make the following observations:

- In Section 4, in trying to project the savings the State will realize from placing LTSS into managed care, the AMSR states "savings are generally driven primarily by delivering services to beneficiaries in more home-like settings, which is financially advantageous to the State and usually better for the individuals." (p. 34) This is in line with the theme identified at the outset of this comment and, as discussed above, it simply isn't true. There are not droves of people in nursing homes that can be treated in the community. As noted already, the State isn't going to allow it. In that case, there are no savings.

- The AMSR notes that the State would have to spend more money initially to start this program due to additional administrative costs. (p. 35) It goes on to state it could take as long as nine years to generate net savings. (p. 35). AHCA submits such projections – which are subject to great question in the first instance - hardly justify undertaking such a drastic measure.

- The AMSR states that "[s]avings are **unlikely** to be achieved for HCBS under managed care . . . ." (p. 37)

- The AMSR cites a 2021 study from the Advancing States MLTSS Institute and the Center for Health Care Strategies that found "inadequate data exist to conclude that MLTSS programs are cost-effective." (p. 37, FN 37). Again, it would seem that the prospect of any costs savings associated with placing LTSS in managed care is guesswork, at best.

- Finally, bundling LTSS into a managed care program will necessarily result in the diversion of the SNF paid Quality Assurance Fee to cover administration of the program and reimbursement of other provider types. That's fundamentally unfair.

There may be a time and place for managed care. For the reasons discussed herein, this is not the time and place for it. There are many other measures that can be taken to slow growth, create savings and efficiencies. AHCA is actively working with DHS on a number of those measures and expects implementation of them in the near future.

AHCA appreciates the time and effort that went into the creation of the AMSR. It is also appreciative of the dialogue with DHS since its release and looks forward to continuing that discussion.

Sincerely,

Rachel Bunch
Executive Director

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July 12, 2024

Arkansas Department of Human Services
Medicaid Sustainability Review Team
Post Office Box 1437, Slot S401
Little Rock, Arkansas 72203-1437
Email: msr@dhs.arkansas.gov

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The AMSR suggests that it is too difficult to access HCBS services by stating that "[t]he main difference between HCBS and nursing facility initial program entry is that the HCBS programs have an 'extra layer.'" That simply isn't the case.

- Federal law requires assessments for both populations. Federal SNF regulations require a more elaborate and data-driven process, including pre-admission screening, assessment and re-assessment using federal instruments, and a comprehensive care planning process for each SNF patient. Nothing remotely as rigorous is required of HCBS entry.

- For each person seeking HCBS coverage, federal regulations and waiver instructions require the state to provide an independent RN assessment using an instrument selected by the state. This determines the need for non-skilled supportive services, while financial eligibility is determined separately in the same manner as SNF financial eligibility.

- In most cases, a person that seeks admission to a nursing home is admitted immediately. This makes sense because those individuals are very sick and/or in need of immediate rehabilitation. That doesn't mean, however, that they are Medicaid approved immediately. That process can take months and, if they are denied, the SNF operator is likely to bear that loss.

- While there may be frustration with the timeliness of independent assessments and financial eligibility determinations associated with entry into an HCBS program, that is an operational issue. It is no basis for expanding HCBS eligibility and spending.

The AMSR suggests expanding HCBS in Arkansas, including lowering eligibility criteria. But it fails to mention the following:

- A substantial general revenue spend would be required to increase Medicaid enrollment through the HCBS pathway. HCBS waiver enrollees receive HCBS as well as full Medicaid coverage.

- There is no shortage of HCBS for adults 65 or older or persons with physical disabilities. There are no waiting lists in Arkansas.

- There would be no offsetting savings on SNF benefit spending from increasing HCBS spending and eligibility. As discussed above, people that are in SNF's are there because they need those enhanced services as determined by the State.

- Arkansas LTSS spending is already more than "balanced." Spending on HCBS and the myriad of other non-skilled support services covered by Arkansas Medicaid exceeds SNF spending by about two to one.

Managed Care

Section 4 of the AMSR proposes putting LTSS into Arkansas's managed care program, known as the PASSE (Provider-Led Arkansas Shared Savings Entity). AHCA opposes the addition of LTSS into the PASSE, or managed care generally.

The commentary and analysis of managed care programs is vast and spans the spectrum of "it's the greatest thing ever" to "this is a disaster." AHCA won't get bogged down in that debate in this comment, but will make the following observations:

- In Section 4, in trying to project the savings the State will realize from placing LTSS into managed care, the AMSR states "savings are generally driven primarily by delivering services to beneficiaries in more home-like settings, which is financially advantageous to the State and usually better for the individuals." (p. 34) This is in line with the theme identified at the outset of this comment and, as discussed above, it simply isn't true. There are not droves of people in nursing homes that can be treated in the community. As noted already, the State isn't going to allow it. In that case, there are no savings.

- The AMSR notes that the State would have to spend more money initially to start this program due to additional administrative costs. (p. 35) It goes on to state it could take as long as nine years to generate net savings. (p. 35). AHCA submits such projections – which are subject to great question in the first instance - hardly justify undertaking such a drastic measure.

- The AMSR states that "[s]avings are **unlikely** to be achieved for HCBS under managed care . . . ." (p. 37)

- The AMSR cites a 2021 study from the Advancing States MLTSS Institute and the Center for Health Care Strategies that found "inadequate data exist to conclude that MLTSS programs are cost-effective." (p. 37, FN 37). Again, it would seem that the prospect of any costs savings associated with placing LTSS in managed care is guesswork, at best.

- Finally, bundling LTSS into a managed care program will necessarily result in the diversion of the SNF paid Quality Assurance Fee to cover administration of the program and reimbursement of other provider types. That's fundamentally unfair.

There may be a time and place for managed care. For the reasons discussed herein, this is not the time and place for it. There are many other measures that can be taken to slow growth, create savings and efficiencies. AHCA is actively working with DHS on a number of those measures and expects implementation of them in the near future.

AHCA appreciates the time and effort that went into the creation of the AMSR. It is also appreciative of the dialogue with DHS since its release and looks forward to continuing that discussion.

Sincerely,

Rachel Bunch
Executive Director

July 15, 2024

Department of Human Services
P.O. Box 1437
Little Rock, AR 72203

RE: Medicaid Sustainability Review

Dear Sir or Madam:

Thank you for the opportunity to comment on the Arkansas Medicaid Sustainability Review. We appreciate the state's efforts to ensure the long-term viability of the program.

We would like to offer our perspective on a few of the recommendations outlined in the report:

8.A.1 – Enhanced Utilization Management (UM) Processes for PT/OT/ST

Rehab Net agrees with the need to strengthen the Prior Authorization (PA) requirements for therapy services. However, the recommendation to require PAs for all therapy, not just those exceeding 90 minutes a week, raises concerns. A physician's prescription already signifies a medical necessity. Requiring additional PAs for baseline care seems redundant and will only increase the administrative burden for providers and reviewers.

The projected savings of $500,000 annually need to be weighed against the potential cost burden on providers implementing these additional PA processes. We believe focusing on more robust Utilization Management criteria for extended care (beyond 90 minutes) would achieve cost reduction without imposing an undue burden on providers.

8.A.2 – Adult Medicaid Coverage in Outpatient Settings

We strongly support the recommendation for expanded adult Medicaid coverage in outpatient settings. We believe readily available care reduces downstream costs and can provide supporting evidence upon request. In addition to the research cited in the Medicaid Sustainability review, there is substantial evidence in the literature to demonstrate downstream cost savings.

P.O. BOX 202 • CONWAY, AR • 72033
PHONE: 501-548-6003 • FAX: 844-209-1709

We appreciate your consideration of our feedback. We remain committed to working collaboratively towards a sustainable Medicaid program that prioritizes quality care in a cost-effective manner for all beneficiaries.

Sincerely,

Becky A. Crenshaw, MRC, CRC
Executive Director

BAC

Arkansas Medicaid Dental Program

To	**:**	DHS Medicaid Sustainability Report Response
From	**:**	Kristin Merlo, Delta Dental of Arkansas
Date	**:**	**July 12th, 2024**
Re	**:**	**DDAR Perspective on Arkansas Medicaid Sustainability Review**

Delta Dental of Arkansas (DDAR) is appreciative of the opportunity to review and provide our organization's perspective on the Arkansas Medicaid Sustainability Review. Since the inception of the Dental Managed Care Program in Arkansas in 2018, Delta Dental of Arkansas has proudly partnered with DHS to serve our state and advance our mission to improve the oral health for all Arkansans. Our response to the state's assessment is rooted in our organization's continued commitment to the oral health of our state's Medicaid beneficiaries and the success our organization has supported in partnership with DHS and other Medicaid stakeholders. Our comments and perspectives are intended to emphasize the successes of the managed care program while highlighting perceived opportunities to continue the trend of improving oral health outcomes for beneficiaries while driving value for the state.

Over the last 6+ years, Delta Dental of Arkansas has managed benefits for an average of 325,000 beneficiaries, handling over 2.2 million dental claims while serving as a trusted partner for state beneficiaries, dentists and program leaders. This includes acting as a steward for the program and DHS through above-and-beyond outreach, education, community service for our beneficiaries.

As a result of the Covid-19 Public Health Emergency and the continuous enrollment provisions, Medicaid enrollment saw significant increases in Arkansas. DDAR experienced enrollment growth to nearly 370k enrollees in 2022, up from 300k before the PHE in 2019. As stated in the Medicaid Sustainability Assessment, the cost of administering the state Medicaid program increased by 41% since FY2018, a trend that can be directly attributed to the increased enrollment since the inception of the PHE. The overall increase in Medicaid spending in Arkansas mirrors trends experienced by the national Medicaid program, which saw an estimated 33% increase in expenditures from 2018 to 2022[1].

While increased enrollment naturally led to greater expenditures for the dental managed care program, DDAR saw a much lower increase compared to other Medicaid programs, with capitated premium payments only increasing by an average of ~1.4% per year between 2018 and 2023, or a total increase of ~7.0%. Furthermore, DDAR received the highest capitated payment amount in 2022 ($78.9M), which represents an increase of ~16.7% since 2018, a lower increase than both the national and Arkansas average for Medicaid programs.

1. Kaiser Family Foundation

In addition to help mitigate expenditures, DDAR has supported Fraud, Waste, and Abuse (FWA) initiatives that actively identify and recapture state funds that were utilized for unnecessary or fraudulent care. As a Managed Care Organization, DDAR's FWA capabilities are bolstered by our processes deployed for commercial lines of business to identify fraudulent providers, and helped to recover hundreds of thousands of dollars over the life of the contract

While total capitated payments rose at a modest rate, the **per enrollee capitated rate decreased over the duration of the managed care contract**. The per enrollee capitated rate for the dental managed care program began at $235.54 in 2018, and reached the highest amount in 2019 at $239.84. However, the capitation rate in 2023 was down to $224.07.

Despite the challenges facing state dental Medicaid programs nationwide and the dental industry as a whole following the Covid-19 pandemic, the Arkansas Dental Managed Care Medicaid program led to significant improvements for dental care in the state. Utilization rates for dental services are not a unique challenge in the state of Arkansas, especially following the Covid-19 pandemic. Notably, utilization rates for the approximately 250k children enrolled in Delta Dental of Arkansas Medicaid plans in 2021 **showed notable improvement since the inception of the managed care contract compared to national commercial plans as well as other state Medicaid populations**.

Utilization Rates of Dental Services for Insured Children[1]			
Population	**2018**	**2021**	**% change**
Commercial National	70%	66%	-4%
Medicaid National	52%	47%	-5%
Medicaid AR	42%	51%	9%

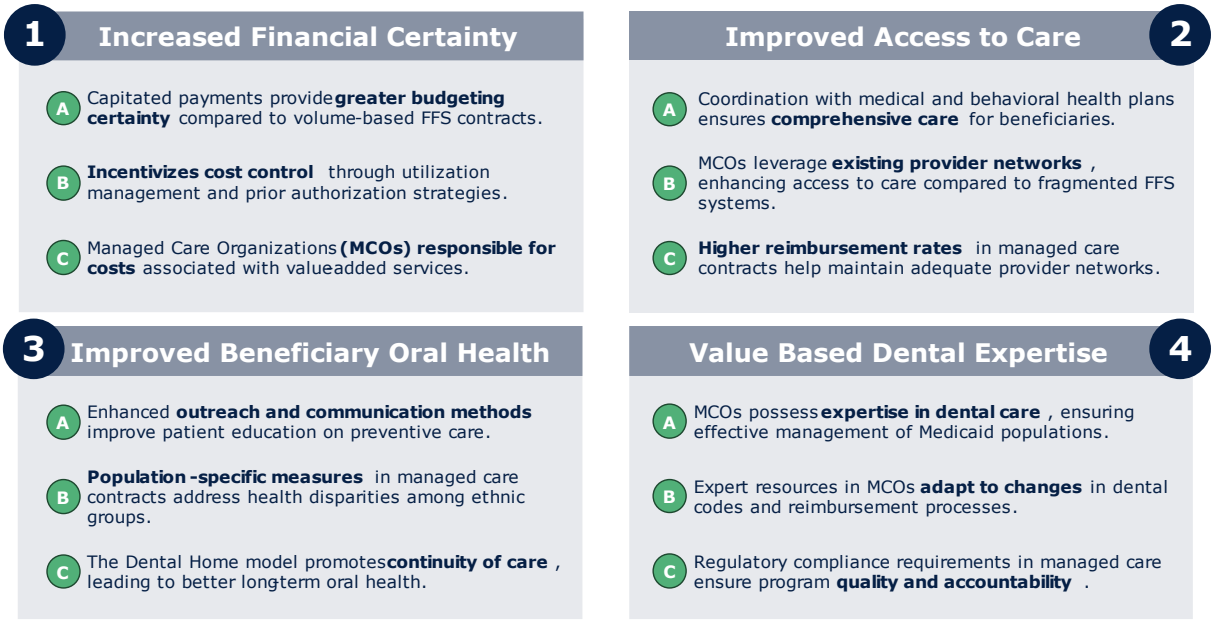
Furthermore, utilization rates across several care categories have **increased** since the start of the managed care in 2018, improving Arkansas' standing nationally for dental utilization[2].

Category of Care	Ranking FFY 2018	Ranking FFY 2021	Improvement
Total Eligibles receiving any dental service	47th	13th	34
Total eligibles receiving preventive dental services	47th	12th	35
Total eligibles receiving dental treatment services	43rd	24th	19
Total eligibles receiving dental sealant ages 6 to 9	50th	46th	4
Total eligibles receiving dental sealants ages 10 to 14	51st	46th	5
Total Eligibles receiving diagnostic services	45th	12th	33

1. American Dental Association; 2. CMS 416 FFY 2018 – 2021

DDAR's partnership with DHS to support the dental Medicaid program in Arkansas represents Delta Dental's ability to monitor and manage the intricacies of dental care while maintaining financial stability through a managed care program. Managed care contracts continue to be the most common form of contract for dental Medicaid programs nationally, with 32 states employing a managed care contract (19 "carve-in" and 13 "carve-out") as of April 2024. According to Kaiser Family Foundation[1], 72% of Medicaid beneficiaries are enrolled in comprehensive managed care organizations.

The growing shift to managed care contracts is a reflection of the value and proven benefits for stakeholders across the Medicaid ecosystem. These benefits compared to FFS enable improved health outcomes, stronger benefits for providers participating in the system, and stronger oversight for state agencies and their managed care partners. A number of peer reviewed studies have analyzed these benefits, and while outcomes for Medicaid programs are largely state and population specific, four main themes emerge: positive impacts to state expenditures, improved access to care for beneficiaries, improved health outcomes for beneficiaries, and industry and contract expertise from managed care partners.



Given the historical success in Arkansas and the growing prevalence of managed care contracts nationally, DDAR believes a managed care contract, either through a carve-in or carve-out model, is more beneficial than traditional fee-for-service contracts, as incentives and financial stability are aligned with the care delivery outcomes.

We look forward to continuing to partner with DHS and other stakeholders throughout the duration of the Dental Medicaid Managed Care Program, and thank DHS again for the opportunity to review and provide feedback on the Arkansas Medicaid Sustainability Report.

Kristin Merlo

Comments in Response to Section 11 of the Arkansas Medicaid Sustainability Review: Federally Qualified Health Centers and Rural Health Clinics

ARcare, and the Community Health Centers of Arkansas, Inc. (CHCA) jointly submit these comments to Section 11 of the Arkansas Medicaid Sustainability Review (AMSR), which contains possible changes to FQHC reimbursement in Arkansas. ARcare is an Arkansas FQHC. CHCA is the association that represents several other Arkansas FQHCs, including 1st Choice Healthcare, Boston Mountain Rural Health Center, Inc., CABUN Rural Health Services, Inc., Community Clinic, East Arkansas Family Health Center, Inc., Healthy Connections Community Health Network, Jefferson Comprehensive Care System, Inc., Lee County Cooperative Clinic, Mainline Health Systems, Inc., Mid-Delta Health System, Inc. and River Valley Primary Care Services. Collectively, these two entities represent all twelve Arkansas-based FQHCs.

A. The Health Center Program in Arkansas

There are 12 independent non-profit Health Centers in Arkansas with over 230 sites across the State. https://www.chc-ar.org/arkansas-chc-map-list. The term federally-qualified health center or "FQHC" is a payment designation for both Medicare and Medicaid purposes. *See, e.g.* 42 U.S.C. §1396a(bb). In order for an organization to receive that designation it must either receive a grant under Section 330 of the Public Health Service Act or meet all of the many Section 330 grant requirements but not actually receive grant funds from the federal agency responsible for administering the Section 330 program, the Health Resources and Services Administration ("HRSA")(often referred to as a "look-alike" FQHC). *See* 42 U.S.C. § 1396d(l)(2).

According to a study commissioned by the National Association of Community Health Centers ("NACHC"), Health Centers nationally create over 500,000 jobs, generate over $85 billion in economic output and more than $37 billion in labor income. Arkansas' Health Centers create over 4,000 jobs, $696 million in economic output, and over $300 million in labor income. https://www.nachc.org/wp-content/uploads/2023/06/Economic-Impact-of-Community-Health-Centers-US_2023_final.pdf. A significant percentage of the funding for Health Centers is federal, either directly through federal grants and Medicare payments or indirectly through Medicaid (for FY 2024, 72% of each payment for Medical services by Arkansas Medicaid is federal "FMAP")[1]. Accordingly, this economic activity is largely generated by federal funds.

Arkansas's Health Centers continue to grow and expand to cover gaps in areas others may not want to locate or deem viable. Currently, Arkansas Health Centers are the medical home for over 300,000 or 10% of the entire Arkansas population. The number of discrete patients served increased by almost 50% from just over 200,000 patients in 2018 to over 300,000 patients in 2022.[2] Just under 40% of the funding for FQHCs in Arkansas comes from Medicaid, 30%

[1] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[2] Arkansas' population in 2022 was just over 3,000,000 meaning that the FQHCs serve 1 and 10 residents of the State. https://www.census.gov/quickfacts/AR

from private insurance, and 15% from Medicare. About 15% of FQHC's patients are uninsured, the funding for which comes from the federal Section 330 grant. https://data.hrsa.gov/tools/data-reporting/program-data/state/AR/table?tableName=Full. The FQHCs in Arkansas serve about 12% of all Medicaid beneficiaries and 21% of Arkansas' uninsured population.

The return on investment of Arkansas' health centers is undeniable. While serving 12% of the Medicaid beneficiaries and 10% of the State's residents overall, the payments to the FQHC's as a percentage of the Medicaid budget is below 1%. https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf.

Finally, in terms of services, while all of the State's FQHCs provide medical services, and most provide behavioral and substance use disorder services, over 80% also provide dental services, fulfilling a dire need (*i.e.* dental providers who accept Medicaid or uninsured) and 50% offer pharmacy.

Health Centers are an essential and cost-effective foundation of the health care safety net of the State.

B. The Law of PPS and Implementation in Arkansas

In 2000, the Medicaid FQHC prospective payment system ("PPS") was created in Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act ("BIPA"). BIPA replaced the then-current system of reimbursing each FQHC for its reasonable cost of providing Medicaid covered services with a system that paid FQHCs, starting on January 1, 2001, on a "per-visit" basis. BIPA required Medicaid agencies to base the per-visit rate for each FQHC on an average of 100 percent of the FQHC's reasonable and related cost of providing Medicaid covered services in FY 1999 and 2000. *See* § 1902(bb)(2) of the Social Security Act ("SSA"), codified at 42 U.S.C. § 1396a(bb). This means that PPS rates are averages, *i.e.,* the total cost of Medicaid covered services divided by total billable visits. This rate must be inclusive of, and account for, the cost of both "FQHC Services" and "any other ambulatory services" included in the State's Medicaid plan. 42 U.S.C. § 1396d(a)(2)(C).

Federal law specifies that for every year following the base year of 2001 the per visit rate is adjusted by an inflation factor known as the Medicare Economic Index ("MEI") and "to take into account any increase or decrease in the scope of such [Medicaid covered] services furnished by the [FQHC] during that fiscal year." 42 U.S.C. § 1396a(bb)(3). This latter provision is often referred to as the change in scope of services requirement.[3]

Instead of paying FQHCs through standard Medicaid PPS, States also have the option of adopting an Alternative Payment Methodology ("APM") in their State Plans that applies to FQHC and other ambulatory services as long as the FQHC expressly agrees to the APM. 42

[3] *See* Section 252.120 of the Arkansas FQHC Provider Manual for how Arkansas has implemented this requirement of federal law.

U.S.C. § 1396a(bb)(6)(A).[4] The APM, however, cannot pay less than what the FQHC would receive under its PPS rate. 42 U.S.C. § 1396a(bb)(6)(B). Inherent in this requirement is the expectation that a state will maintain and update accurate PPS rates in order to make a fair comparison to the APM-level payment.

Consistent with these APM provisions, Arkansas currently allows FQHCs to be reimbursed at the PPS rate or an APM as stated in the Arkansas FQHC Provider manual, https://humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-providers/manuals/fqhc-prov/. Under Section 252.200, if an FQHC signs an agreement with the State showing that the FQHC "choose this alternative method," they will be reimbursed as the higher of cost or PPS:

> (A) In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for dates of service occurring January 1, 2001 and after, FQHCs will be reimbursed an interim per encounter rate for Medicaid covered services with cost settlement at the greater of 100% of reasonable costs or the allowable per encounter rate as determined under the prospective payment system (PPS).

Changes to this "better of cost or PPS" APM are contained in the AMSR.

C. Potential issues with modifications to the existing APM

First, as noted above, an APM must be included in the State Plan and, of course, changes to the APM would also need to be the subject of a State Plan Amendment and subsequent approval by CMS. This process is often challenging and always lengthy.

Second, any savings to the State based on changes to the current Arkansas APM will be modest at best. The State's contribution to FQHC reimbursement is relatively small. Moreover, the State cannot reimburse below the PPS rate. The difference between the current APM and the PPS rate will yield the State very little in terms of savings. Indeed, the AMSR itself states, with regard to suggestions calling for the elimination of the current APM, that "limited upfront costs savings are estimated . . . ."

Changing FQHC payment systems is time consuming, costly and the return on investment is, at best, modest. Focusing on operational efficiencies to improve the current system appears to be more likely to result in positive gains for both the State and the FQHCs in Arkansas.

[4] There are also extensive rules on how to treat FQHCs should a State Medicaid program decide to implement Medicaid managed care. Since Arkansas has not opted for such a model, we will not address the so-called wrap-around provision of 42 U.S.C. § 1396a(bb)(5) and other associated provisions of the Social Security Act here.

Janet Mann
Deputy Secretary for Programs and State Medicaid Director
Arkansas Department of Human Services
PO Box 1437
Little Rock, AR 72203

July 9, 2024

Dear Director Mann,

I am submitting comments regarding the Medicaid Sustainability Review on behalf of Gentiva Personal Care. By way of background Gentiva Personal Care (formerly Kindred) is the entity that purchased the personal care business that was previously owned and operated by the Arkansas Department of Health. We are grateful for the opportunity to serve Medicaid recipients throughout the state and are happy to provide our comments regarding the Home and Community Based Services (HCBS) and Long-Term Services and Support (LTSS) section of the report.

Should you have any questions about our comments below, please do not hesitate to contact us.

Warmest regards,

Kim Steed, RN, BSN

Regional Director Operations – Personal Care

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Gentiva Personal Care Comments

SECTION 6: LTSS and HCBS

Option 6.A.1: Enhance access to HCBS and "equalize the front door"

The federal government does not require particular assessment tools to determine LTSS eligibility. Studies show that most states use more than one tool, usually for different populations. However, to promote efforts for beneficiaries to live in the most appropriate, least restrictive setting, states may choose to implement standardized assessment processes across LTSS programs…Washington uses Section 1115 waiver authority for presumptive eligibility and splits the risk of this eligibility with the federal government to help keep beneficiaries in the least restrictive setting possible.

COMMENT:

We agree that a "Hospital to Home" waiver, could equalize the front door. We believe that HCBS are the least restrictive and most cost-effective way to provide services to patients who do not require full time assistance in a skilled nursing facility. To facilitate an equalized front door, we recommend, trained RNs as case managers who could serve as "liaisons" to use one assessment tool that directs a person's level of care. This assessment tool should be "care" driven rather than timed. The assessment tool should not complicate the purpose of keeping someone clean and safe – albeit in the privacy of their own home, or in a facility.

The result, we believe, is the most appropriate care, in the most cost-effective location, which will lead to a better patient experience. We are cognizant that there may become a time when a patient requires skilled nursing services in a facility, but it should be a progression to reach those services, not a starting point.

Option 6.A.2: Incorporate value-based payment in HCBS reimbursement.

Cost savings are dependent on value-based program design. While there may be a financial outlay in establishing a value-based payment program, using value-based payment may increase the data and knowledge of programs. It will allow the State to make targeted and systematic changes to improve programs and address fiscal challenges, including mis- or overspending on certain services…

Missouri has incorporated nine incentive payments for HCBS waiver providers that focus on workforce retention, direct support professional training, and compliance with electronic visit verification, among other areas. These value-based payments have supported the reduction of overall spending on service delivery and have provided the State with additional data on services that did not previously have adequate data collection processes.

COMMENT:

Value-based payment system may be a reasonable option if the playing field is equal and the reimbursement rate is increased to an appropriate amount. For example, Missouri is referenced as a leading practice in the report and they have implemented a "value based" payment system; it's worth noting that Missouri increased their reimbursement rate to $30.00 +/hour.

If we were to move into a value-based world, we would recommend the following:

1. Provider equality
    a. New policy/procedures
    b. All providers to follow same policy (eg. below)
    c. All providers should be W2 provider
    d. GPS/telephony Electronic Visit Verification (EVV) system should be mandatory, no more paper EVV should be accepted
    e. The State to track PIN #s for overlap with other agencies

Most providers have implemented federally and state mandated EVV systems. However, some providers are still manually entering visit data and verifying the visit. These providers are using the aide notes to verify the visit. Other providers are using telephony and/or GPS apps. to track the visit, which interfaces with the states EVV system (Authenticare.) This is true EVV and is what all provider should be doing.

Additional, some providers are providing transportation during authorized service time and receiving payment. This is not in the policy manual.

In conclusion, all programmatic requirements should be equalized prior to implementing a value-based payment plan.

Option 6.A.3:

Review Medicaid program entry points to ensure correct program placement and appropriate service delivery in alignment with "no wrong door" philosophies, which promote a single, coordinated system to access services.

Comment:

We are in agreement with this philosophy. There should be "no wrong door." We would recommend that a State RN Liaison (via a 800 hotline) for case managers to contact for placement.

Option 6.B.1:

Develop a monitoring system for State Plan personal care services. State plan personal care services serve multiple populations. As a result, several DHS divisions are involved in personal care services operations. Historically, there has not been a clear delineation of responsibilities nor formal oversight of the personal care services program, and the services can be provided in multiple settings, including homes, group homes, and schools. Establishing a monitoring system, including formal oversight processes, could enhance administrative efficiencies, improve the quality of care, and yield cost savings.

Comment:

The State historically has had a monitoring system through the Arkansas Department of Health (ADH), Health Facilities Service Survey every 3 years, and Arkansas Foundation for Medical Care. In addition, the Office of Medicaid Inspector General (OMIG) investigates complaints, suspected fraudulent activity, etc.

We recommend that ADH continue to survey, if licensing is still required through Health Facilities Services; in the alternative if a new surveying/monitoring system is created, then the ADH & AFMC survey/audits should be eliminated.

Additional General Comments:

- The personal care industry in Arkansas struggles through a federal Department of Labor rule that is not being enforced in Arkansas. Today, there are providers who are "W2" providers who employ and control the care workers as employees as required by the Department of Labor. However, there are still a majority of providers in Arkansas who use 1099 providers in defiance of the federal law. Agencies who are not compliant with federal and state laws, should not be allowed to participate in the Medicaid program.

- Certificates of Need should be explored for the personal care industry. The state requires a Certificate of Need for Home Health, Hospice as well as Skilled Nursing Facilities. There are 75

counties in the State of Arkansas, with over 750 active Personal Care Providers. We believe if the requirements are more structured, such as CON or a similar mechanism, for all Personal Care Providers that a value-based payment system could work. In addition, this could cut out exploitation of the elderly, disabled and the behavioral health population – and mitigate the potential for fraud, waste and abuse in the personal care sector.

- The required personal care aide PIN # is not being enforced. We have multiple aides working for more than one agency. The purpose of the PIN is to avoid duplication of billing for the same aide at the same time. We use a GPS EVV system that is interfaced with the state's EVV, Authenticare. However, we often bill and get a rejection because another agency who has submitted manual billing through Authenticare to verify visits, claim that their aide has provided services at the same time that we provided services.

This is unfair to the provider, providing the service through required GPS/telephony method of EVV. If the PIN# is going to be required, then the State needs to ensure the State system is capturing the PIN# use on the same dates/times to prevent this type of unnecessary billing challenge. Additionally, a GPS/telephony EVV should ALWAYS take propriety over a paper submitted claim, which creates the greatest risk of error or inaccurate information.

- If the PASSEs are going to continue providing "Care Coordination" for the client – they should be responsible for obtaining the physician's signature to provide Personal Care Services. This is part of care coordination.
- If the personal care provider will now be responsible for obtaining an order from the PCP (MD, DO, PA, RNP) – all providers should do their own RN assessments and Person-Centered Plan of Care.

The Health Care Transformation Division (HCTD), of the Northwest Arkansas Council was created in response to a 2019 study that analyzed health care in Northwest Arkansas through an economic lens and was established through the execution of a Memorandum of Understanding where the participants agree to work together to address regional health care challenges. Each HCTD member provides time and expertise to address the region's health care challenges. The partners of the HCTD joining on this comment are Mercy Northwest, Northwest Health, Washington Regional, Community Clinic, the University of Arkansas, Highlands Oncology, UAMS Northwest, and Arkansas Children's Northwest. This response is a unified response of these partners, but does not replace individual institutes who wish to submit their own responses.

The HCTD appreciates the report's effort to look at various components of health care financing across providers, and we look forward to engaging in future discussions about the options, as well as other aspects of Medicaid not directly addressed in the report. We are particularly interested in DHS' approach to provider rate updates, given that the report considers substantial changes to supplemental and access payments and cost settlements. Review of provider rates should occur routinely, transparently, and collaboratively with the provider community. Review of provider rates should also include comparisons to rates offered by other public programs and private insurers to enable sufficient monitoring of compliance with Medicaid equal access requirements in 42 U.S.C. Sec. 1396a(a)(30)(A).

The urgent need for sustainability for continued Medicaid funding is our highest priority. Sustainability, by definition, requires budget adjustments for inflation. As inflation continues to rise, the cost to deliver health care has been negatively impacted. The need for continued funding to offset the rise of cost, through inflation, causes a gap in health delivery cost and health delivery reimbursement. While we understand this burden does not solely fall onto Medicaid, it must be part of the solution. The Economic Impact of Medicaid Spending in Arkansas, published in 2010 highlights the fact that for every one dollar withdrawn from Medicaid reimbursement, there is a direct loss of six dollars in the community. We recognize the need to be good stewards of taxpayer dollars, but a budget that does not account for environmental and inflationary pressures will ultimately lead to impacts on access to services and quality of care.

ARKANSAS
HEALTHCARE
ALLIANCE, LLC

July 15, 2024

Arkansas Department of Human Services
P.O. Box 1437, Slot S401
Little Rock, AR 72203
Email: msr@dhs.arkansas.gov

Re: Comments of the Arkansas Healthcare Alliance to the Arkansas Medicaid Sustainability Review

I am writing on behalf of the Arkansas Healthcare Alliance ("Alliance") to provide comments to certain sections of the Arkansas Medicaid Sustainability Review. The Alliance is a coalition of behavioral health and developmental disabilities providers from across Arkansas serving thousands of beneficiaries.

Section 3.4 – Move ARHOME beneficiaries into the PASSE program

We support this option and stand ready to facilitate the process.

Section 4 - PASSE

We support adding populations to the PASSE program. Specifically, we support adding ARHOME, home health, ABA / Autism / OT / PT / SLP, pregnant women and other similar populations. Likewise, we support the pending re-entry Section 1115 waiver. The infrastructure is in place for any addition, depending on size of the new population(s). The PASSEs would need some time to scale, but this can and should be accomplished.

The care coordination needs for ARHOME and the Tier 1 IDD patients would be less than current PASSE beneficiaries such that the care coordinator to beneficiary ratio could be much larger for those clients. Or, clients could opt in to care coordination. Payment could coincide with care coordination enrollment.

EIDT and ADDT could go into PASSE, but the cost to manage on both the provider and the PASSE side seems high for a group of services that are finite and center-based. Outpatient ABA, OT, PT, SLP are more fluid in home and community-based settings and could potentially be managed more effectively by the PASSEs.

If additional populations go in the PASSE, providers and DHS would need to work with PASSEs on eliminating time consuming and burdensome paperwork.

Section 8 - Habilitative and Rehabilitative Services

As for 8.A.1, we are unsure what this would accomplish other than requiring DHS and providers to hire more people and vendors to manage the PA paperwork. It states that less than $500,000 in savings may be achieved by prior authorizing all services. An alternate approach is to strengthen the criteria and systems in place. Adding PA requirements also seems to be counterintuitive to the PA Transparency Act adopted by the General Assembly in 2023.

The State might add eligibility components, but that would only make it more difficult for children to access these services. Under the previous CHMS/medical model, there were two medical components (therapy) as criteria for enrollment. DDTCS had a developmental component only. Then under EIDT, we added the developmental plus one medical component (therapy). The EIDT criteria balances developmental and medical necessities.

Section 10 - Transportation

We have grave concerns regarding this section. The overall consensus is that the transportation infrastructure is too fragmented and urban focused to merge into one contract. This would put rural beneficiaries at a massive disadvantage.

Putting transportation into the PASSEs would create an unmanageable administrative burden for providers without DHS mandating that each PASSE use the same methodology for payment. At that point, why create the burden on PASSEs and providers alike?

Utilizing Ubers and Lyfts is simply not a viable option. Again, this would decimate rural providers and beneficiaries as there are minimal, if any, Ubers and/or Lyfts in the majority of rural counties.

Thank you for consideration of these comments.

Sincerely –

Bess Ginty
Managing Member
Arkansas Healthcare Alliance

DHS,

Please know that I have read the comments from the Arkansas Hospital Association in regards to Medicaid Sustainability as well as the Final Report.

I operate a Critical Access Hospital and while IPPS style hospitals like Baptist and Jefferson Regional Medical Center prefer Qualified Health Plans over traditional Medicaid, Critical Access Hospitals do not.

The State having an active goal of moving 80% of Medicaid into a Qualified Health Plan Model will be detrimental for Critical Access Hospitals.

When speaking with many Critical Access Hospital CEOs, our stance is much different on this point from the Arkansas Hospital Associations stance.

Thank you,

Jeremy D. Capps

Chief Executive Officer

Delta Memorial Hospital

811 Highway 65 South

Dumas, AR 71639

Office: (870)-382-8126

Cell: (870)-307-7620

To whom It May Concern,

I am responding to public comments related to Medicaid Sustainability. I am a Dr of Physical Therapy and own an OP facility in El Dorado. We are Medicaid providers. Medicaid requires we have a PCP referral (even though we supposedly have direct access in this state). Requiring a PA in addition to a PCP referral is going to cause undue hardship and unnecessary administrative burden on you and us – please leave as is. Therapy is one of your lowest cost services – this will only add to the overall expenditures.

Thank You, Jerry Yarborough, PT, DPT 318-548-5882

To Whom It May Concern,

My name is Yukiko Taylor, and I serve as the Executive Director of the Developmental Disabilities Provider Association (DDPA) in Arkansas. Our association represents 68 providers and serves 14,000 individuals with intellectual and developmental disabilities (IDD) across the state.

I am attaching our detailed responses to the Medicaid Sustainability Review (MSR) to this email for your review. As stakeholders deeply invested in the well-being of our clients, we appreciate the opportunity to share our insights and recommendations.

Representing both providers and clients, we are committed to our common goal: the well-being of people with IDD in Arkansas. We hope for opportunities to amplify the voices of the 14,000 individuals who may be affected by this review.

Thank you for your attention to this matter, and I look forward to contributing to the ongoing dialogue around Medicaid sustainability.

If you have any questions, please feel free to contact me.

DDPA MEDICAID SUSTAINABILITY REVIEW COMMENTS 061024 - Copy.docx

Sincerely,

Yukiko Taylor

Yukiko Taylor
Executive Director

Please see below for two comments on the Arkansas Medicaid Sustainability Review from the Arkansas Waiver Association:

Reported Savings:
While the Medicaid Sustainability Review report outlines potential cost-saving options, there are significant concerns about the $67 million in savings reported under the PASSE system of managed care, particularly in relation to the current state of home and community-based services (HCBS). HCBS are underfunded and face significant challenges in meeting the needs of eligible beneficiaries. There is a long-standing, unmet need for HCBS, as well as persistent shortages in the direct support workforce necessary to provide HCBS. These issues have been exacerbated by the COVID-19 pandemic and rising inflation, and the issues continue to worsen. Adequate resources to provide and expand quality HCBS are necessary, and savings actualized in the PASSE system to date have been a further detriment to the service system, not a benefit to those relying on HCBS services. Using the reported savings under PASSE as a foundation to explore further cost savings across Medicaid is inaccurate and detrimental to both existing HCBS recipients and other Medicaid populations.

Quality Care Coordination:
The Medicaid Sustainability Review makes numerous references to the potential benefits of care coordination on both quality of services and long-term cost savings and outlines option scenarios that include realiagning other Medicaid populations to the PASSE model to actualize the benefits of care coordination. While quality care coordination, when implemented effectively, can lead to improved health outcomes, increased beneficiary satisfaction, and more efficient use of healthcare resources, often resulting in better management of chronic conditions, reduced emergency department visits and hospitalizations, and overall improvements in health and well-being, the care coordination service provided to current beneficiaries in the PASSE system is not adequate and does not meet the expectations of care coordination standards. When done effectively, care coordination involves deliberately organizing beneficiary care activities and sharing information among all participants concerned with a beneficiary's care to achieve safer and more effective care. For current Arkansas PASSE beneficiaries, most often PASSE care coordination does not provide proactive coordination of services, resources, and support. It is necessary to address the current inadequacies of care coordination for PASSE beneficiaries before expanding the service to a broader segment of the Medicaid populations.

Thank you,

Syard Evans,

President,
Arkansas Waiver Association

July 15, 2024

Arkansas Department of Human Services
Medicaid Sustainability Review Team
700 Main Street
Little Rock, AR 72201
msr@dhs.arkansas.gov

RE: March 2024 Department of Human Services Guidehouse Medicaid Sustainability Review Report

Medicaid Sustainability Review Team:

Arkansas Advocates for Children and Families appreciates the opportunity to offer comments on the March 2024 Department of Human Services Guidehouse Medicaid Sustainability Review Report. Arkansas Advocates for Children and Families (AACF) is a statewide, non-profit child and family policy research and advocacy organization. Our mission is to ensure that every child has the resources and opportunities to live healthy and productive lives and realize their full potential. We have long been advocates for better public policy that can improve the health of Arkansas families, including supporting a strong Medicaid program.

AACF's primary concern with the report lies with the premise that Medicaid growth is out of control. In fact, Arkansas's Medicaid spending growth is modest compared to many other states. Our state's Medicaid expenditure growth is 33% lower than the national average. At the national level, per-enrollee spending by private insurance grew by 61.6% from 2008 to 2022 – much faster than Medicaid spending growth per enrollee of 21.7% during the same period.

Our ARHOME health insurance program is a vital lifeline for our state, strengthening families and communities. In addition to providing health care coverage to low-income families, the expansion of Medicaid also decreased uncompensated care costs for hospitals, preventing rural hospital closures. In fact, hospital uncompensated care costs are less than half as large in Medicaid expansion states like ours, as compared to non-expansion states.

Section 3: ARHOME Qualified Health Plan Model

The Guidehouse report examines alternatives to the Qualified Health Plan (QHP) Model. When our state's Medicaid expansion program was launched in 2013, Arkansas leaders initially considered expanding Medicaid through the fee-for-service program. However, they realized this model did not improve reimbursement rates for providers, potentially limiting patient access. Policymakers then focused on ensuring access for new Medicaid beneficiaries and complying with federal mandates for health insurance and state-facilitated government-subsidized insurance marketplaces.

If leaders are to reassess the format of our expansion (e.g. the "private option" versus managed care), it must ensure that providers are adequately funded to be able to provide care for the Medicaid population. Shifting ARHOME beneficiaries into a PASSE (Provider Led Arkansas Shared Savings Entities) system would be a significant undertaking and have implications for the insurance marketplace. Additionally, if shifting enrollees out of QHPs into PASSEs or other fee-for-service models utilized lower reimbursement rates than currently in place, access to routine care could be negatively impacted for thousands of vulnerable families in Arkansas.

AACF is concerned that cuts to services, reimbursement rates, and reduced investment in our program would make it more difficult to address severe health outcomes in our state, including our status as 50th in the nation for maternal mortality. This report primarily centers on programmatic changes but does not consider improvements to provider rates, including hospital rates (except for supplemental cost settlement payments). Improvements in provider rates will improve patient access by increasing providers' ability to accept Medicaid patients, particularly fee-for-service patients.

Section 12: Primary Care Case Management and Patient Centered Medical Homes

Medicaid can help to spread and sustain practice changes that improve the mental health of children and address conditions before they become more expensive and complex to

treat later. We support the adoption of HealthySteps, a promising pediatric primary care model that integrates social and emotional development into well-child visits for parents. It has been successfully implemented in several states and shown to be an effective model for addressing social determinants of health through strengthening linkages between primary care, mental health, and social services. Analyses of HealthySteps models have concluded they are cost-effective for Medicaid programs and promote cost savings over time with an average Medicaid return-on-investment of 163%. This means that for every dollar invested, an estimated $2.63 in savings is returned by state Medicaid programs annually. In the long term, this model can promote a lower need for developmental and special education services, reduced incidence of chronic disease, and higher education attainment.

Medicaid is an essential service in Arkansas

An estimated 850,000 Arkansans have access to health services through our Medicaid insurance program, making it the most important health program in the state. Rather than focusing on areas to make short-term cuts to benefits, allocating robust resources to Medicaid will support long-term sustainability of our program and ensure better health for hundreds of thousands of Arkansans.

Feel free to contact us if you have any questions or need clarification about the comments we've included here. You can call our office at (501) 371-9678 or email us at the addresses included below.

Sincerely,

Keesa Smith-Brantley
Executive Director
Arkansas Advocates for Children and Families
ksmith@aradvocates.org

Camille Richoux
Health Policy Director

Arkansas Advocates for Children and Families
crichoux@aradvocates.org

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University of Arkansas for Medical Sciences

Andy Davis, PE
Vice Chancellor of Institutional Relations
Chief Government Affairs Officer

July 14, 2024

Arkansas Department of Human Services
Medicaid Sustainability Review Team
Post Office Box 1437, Slot S401
Little Rock, Arkansas 72203-1437
EMAIL: msr@dhs.arkansas.gov

RE: March 2024 Department of Human Services Medicaid Sustainability Review Report

Medicaid Sustainability Review Team:

The University of Arkansas for Medical Sciences (UAMS) extends its gratitude for the dedication and resources committed to identifying improved solutions for Medicaid funding in Arkansas. We commend the report for clearly presenting the items discussed as options rather than recommendations. UAMS would welcome the opportunity to participate in the further evaluation of these options. As the state's only academic medical center, we offer a unique and valuable perspective to the evaluation process.

Many of the proposed options suggest transitioning certain populations to Medicaid Managed Care. UAMS recognizes that most states have adopted managed care models as the primary mechanism for delivering Medicaid services. We are open to a comprehensive evaluation of how such a transition could be successfully implemented in Arkansas. It is imperative that any shift to managed care be meticulously designed to ensure equitable benefits for Medicaid enrollees, providers, and the state. It is crucial that this process does not create disparities or unintended disadvantages among stakeholders.

It is important to clarify that on Page 43, the report states that the state general fund finances the cost settlements listed. This is not applicable to UAMS. UAMS fully funds the state match requirements for its supplemental payments. Consequently, any modification to UAMS supplemental payments would not yield savings for the state general fund.

Regarding Option 5.1, ending inpatient cost settlements for in-state hospitals would adversely affect UAMS unless there is a corresponding offset in the Fee-for-Service (FFS) rates. UAMS is open to exploring this option but emphasizes the necessity of ensuring that it results in an overall improvement in reimbursement rather than a reduction.

Additionally, the table on Page 45 of the report appears to underestimate UAMS' inpatient cost settlement. If the table is based on a cash accounting method, this discrepancy may be due to the timing of the processing of the FY23 tentative cost settlement. It is also important to reiterate that the state share obligation is entirely funded by UAMS. Therefore, this would not result in state savings.

Provider Name	Total Inpatient Cost Settlement	Estimated State Share Obligation[41]
Arkansas Children's Hospital	$8,126,056	$2,331,365
Baptist Health Little Rock	$5,571,378	$1,598,428
Washington Regional Medical Center	$3,179,379	$912,164
St. Bernards Hospital Inc.	$2,240,301	$642,742
Baptist Health Medical Center North Little Rock	$1,635,561	$469,242
White County Medical Center	$1,617,594	$464,088
White River Medical Center	$1,531,515	$439,392
Mercy Hospital Fort Smith	$1,402,831	$402,472
Jefferson Regional Medical Center	$1,104,682	$316,933
Mercy Hospital Rogers	$1,100,987	$315,873
Leo N. Levi Memorial Hospital	$977,685	$280,498
Chi St Vincent Hospital Hot Springs	$806,953	$231,515
University Hospital of Arkansas	$798,000	$228,946

Figure 14 from the Arkansas Medicaid Sustainability Review Report

We appreciate your consideration of our input and look forward to the opportunity to contribute to this critical discussion.

Sincerely,

Andy Davis, PE
Vice Chancellor of Institutional Relations
University of Arkansas for Medical Sciences