

EXECUTIVE SUMMARY

In an speech to the Arkansas Legislative Health Reform Task Force, Governor Asa Hutchinson stated that he would like to see \$232 million in savings over the next five years from Medicaid programs for the developmentally disabled (“DD”). He commented that, to date, DD providers had not proposed enough credible savings to meet his target.

Any proposal made by providers or the Task Force should be based on the principles of strategic planning, which involve defining a goal and developing a set of objectives designed to achieve the goal. An example of a goal is; Arkansas will provide long term services and supports (“LTSS”) in an effective and efficient manner to its aged, blind and disabled citizens such that each individual will be able to achieve their full potential and enjoy the quality of life they desire. To achieve the goal, the objectives should be to provide the right services and supports, to the right people, at the right time, in the right amount, in the right place, and at the least cost possible.

UNDERSTANDING THE OBJECTIVES

To the right people:

The State can define the groups of individuals to whom LTSS should be furnished, e.g., the elderly and the disabled, and then determine which individuals meet the eligibility definition for inclusion in those groups.

The right services and supports are furnished at the right time and in the right amount:

The State can utilize a comprehensive and well designed assessment process. Each eligible individual is administered an assessment questionnaire designed to identify their specific functional deficits in performing activities of daily living. The results of the assessment are used to develop an individualized plan of care which identifies the specific types, amounts and timing of the services and supports needed by the individual. All individuals are assessed, and plans of care developed, on a consistent basis. This helps to control overutilization and provides a basis for measuring outcomes.

In the right place:

The “right place” refers to the setting in which services and supports are provided. Currently, the Arkansas DD program utilizes two settings. The first is in an institutional setting such as a Human Development Center (“HDC”). The second is in a home and community based (“HCB”) setting through the Alternatives for Community Services Waiver program. Because the reimbursement rate paid to an HDC is based on the level of services available to a resident, whether or not the services are actually needed or utilized by the resident, the average annual cost per person receiving care in an HDC is more than twice the average cost of HCB care.

At the least cost possible:

Every service or support can be assigned a specific reimbursement rate. The rate should be based on the amount of money that is determined to be adequate compensation for the average provider capable of furnishing the specific service or support. The rate should be set at a level that rewards the low cost providers, and penalizes the high cost providers.

COMPONENTS OF A CREDIBLE PLAN

A credible plan is one that is designed to accomplish all of the objectives. Specific strategies to accomplish the objectives include:

Utilization of a universal assessment process:

The process ensures that utilization of services and supports is both effective and efficient.

Transitioning the provision of care from high cost providers to low cost providers:

There is no justification for paying one provider more than another to furnish the same service or support. Ensure that each provider is paid the same for each necessary service or support furnished.

Rebalance the system away from an overreliance on institutionally provided care:

Arkansas spends a greater percentage of its long term care dollars in institutional settings than most other states. When necessary services and supports can be furnished more cheaply in an HCB setting than in an HDC, the State require that the HCB setting be utilized. In doing so, the number of HDC residents may, or may not, change. What will change is that the expenditures spent on HDC care will decline since they will only be paid for services and supports actually needed by, and furnished to, the residents.

CONSTRAINTS TO DEVELOPING A CREDIBLE PLAN

Developing a credible plan cannot be accomplished if the future structure and operations of the HDCs are not a part of the discussion. HDCs are a high cost provider. To the extent that individuals transition from an HDC to a HCB program, the costs of HCB programs will increase, while HDC costs decrease. Rather than seeking to reduce the costs of operating the HCB related DD program by a set dollar amount, the focus should be on ensuring that an increased amount of money is spent on HCB programs, not less. There can't be a credible solution if the HDCs are not on the table.

Use of a managed care organization ("MCO") is one method of implementing an effective and efficient DD program that achieves the State's defined goal. It is, however, not the only way. All of the policies and procedures that a MCO would utilize to meet the objectives discussed above are currently being utilized. The services and supports they furnish, based on an assessment they administer, are not likely to be any different than the necessary services and supports identified by a State administered assessment process. The only way a MCO can reduce costs is to shift individuals from high cost providers and settings to low cost providers and settings.

The continued existence of a waiting list of DD individuals in need of long term services and supports is incompatible with the achievement of the State's goals and objectives. The individuals on the waiting list are the right people. The right services and supports, in the right amount, have already been identified. The individuals have chosen their home and community as the right place. The cost of furnishing them the needed services is the lowest cost possible. The only objective not being achieved is having services and supports provided at the right time. Any DD program administered by the State that puts DD individuals at an increased risk of institutionalization by placing qualified individuals on a waiting list to receive services, and the waiting list does not move at a reasonable pace, violates the Americans with Disabilities Act. A credible plan must address the waiting list issue.

REFORMING ARKANSAS' MEDICAID LONG TERM CARE PROGRAM

In an address to the Arkansas Legislative Health Reform Task Force, Governor Asa Hutchinson stated that the traditional Medicaid program must come up with \$835 million in savings over the next five years. He also indicated that the programs for the developmentally disabled (“DD”) would need to produce \$232 million of those expected savings. He stated that, to date, DD providers had not proposed enough “credible” savings to meet the objective. He also stated that the Human Development Centers (“HDCs”) are not a part of the DD savings target.

The primary reason that DD providers have not proposed a credible plan is that, with the HDCs off of the table, there is no credible plan that can be proposed. The dictionary definition of “credible” is; worthy of belief or confidence, or considered capable of achieving a goal. The main synonym for credible is plausible. There is simply no proposal that can be put forward to lower DD program costs that might be considered credible or plausible if the HDCs are not on the table. This is true whether or not the administration of the DD program is converted to capitated managed care by a private entity.

Will Rogers once asked the question, “If stupidity got us into this mess, then why can’t it get us out?” Albert Einstein was a little more subtle in saying, “The significant problems we face today cannot be solved at the same level of thinking we were at when we created them”. No one will dispute that there are problems with the State’s Medicaid program. We will not be able to solve the problems unless we are willing to address the issues in a logical and intelligent manner that is different from how things have been done in the past. A credible plan is the result of a process. The process is known as strategic planning.

Strategic planning focuses on goals, objectives and strategies. A goal defines what an organization desires to achieve. Goals are aspirations. Objectives are the measurable and quantifiable steps to be taken in achieving the goal. They define *what* the organization must accomplish in order to fulfill its mission, or achieve its goal. Strategies are specific actions that are developed to achieve the objectives. They are *how* the organization will be administered on a day to day basis to achieve its objectives. Strategic planning is not a static process. It is a dynamic process that must be reviewed and updated on a constant basis. It is the antithesis of maintaining the status quo. While it is not unmindful of the past, it seeks to apply a new level of thinking to solving current challenges.

There are challenges to be addressed in the entire Arkansas Medicaid program, but this paper will focus solely on the challenges faced by the long term care component of the program. In that long term care costs represent a significant portion of the total Medicaid budget, it is an area that could benefit from strategic planning. How might strategic planning be applied to this challenge? First, the State must define a goal. An example of a goal is, “Arkansas will provide long term services and supports (“LTSS”) in an effective and efficient manner to its aged, blind and disabled citizens such that each individual will be able to achieve their full potential and enjoy the quality of life they desire”. The goal of the State is to assist its citizens in achieving their individual aspirations.

Arkansas has long had a goal of providing LTSS to the aged, blind and disabled citizens of the State. However, it is difficult to ascertain if the State now has, or has ever had, a coherent and comprehensive set of objectives designed to achieve its goal. Once the State has adopted as a goal the provision of any service, across the full spectrum of services that a government can provide, there is one simple set of objectives that should be applied to every goal. The objectives should be to

provide the right services and supports, to the right people, at the right time, in the right amount, in the right place, and at the least cost possible.

Administrative and Legislative officials have indicated that they want to continue to provide LTSS to the aged, blind and disabled population. They have also indicated that they wish to reduce the costs of furnishing LTSS. The former is a goal. The latter is not. Reduced costs are the result of achieving the part of the goal that references “in an efficient manner”. Providing LTSS costs money. As such, it is an exercise in futility to try and analyze or control costs without first having a full understanding of what one is trying to accomplish in administering the programs that give rise to the costs incurred.

When the objectives of a program are defined in a comprehensive and rational manner, the strategies that will lead to the effective and efficient achievement of the goals and objectives are much easier to develop. Anything less is just throwing random strategies at the problem in the hopes that something might work. Each objective listed above is interrelated with the other objectives. Strategies that provide the wrong services and supports, in the wrong amount, may be less expensive in the short-term, but it will not further the achievement of the objective or goal, and may end up leading to higher costs in the long-term. Unless a strategy is effective in achieving the stated objective, it cannot, by definition, be considered the most efficient strategy.

Let’s look at each objective. Being able to ensure that the right people receive the right services and supports, at the right time and in the right amount is relatively easy to accomplish. To ensure that LTSS is provided to the right people, the State can define the groups of individuals to whom LTSS should be furnished, e.g., the elderly and the disabled, and then determine which individuals meet the eligibility definition for inclusion in those groups. To ensure that the right services and supports are furnished at the right time and in the right amount, the State can utilize a comprehensive and well designed assessment process. Each eligible individual is administered an assessment questionnaire designed to identify their specific functional deficits in performing activities of daily living.

Based on the results of the assessment, a case manager will work with the individual to develop a person-centered service plan that identifies the specific services and supports needed by the person to assist them in meeting their activities of daily living. Utilizing a properly designed and administered assessment process ensures that each individual only receives those services and supports necessary to achieve their full potential and enjoy the quality of life they desire . All similarly situated individuals receive the same level of services and supports. This addresses the issue of some people over-utilizing services. It also ensures against under-utilization.

The “right place” refers to the setting in which LTSS is received. Settings for LTSS include institutions such as private and public nursing homes, private intermediate care facilities for individuals with intellectual disabilities (“ICF/IIDs”) and HDCs, and home or community based (“HCB”) locations. Providing LTSS in the right place is a little more complicated because of its interrelationship with the other objectives. While HCB providers are generally capable of furnishing the full range of services and supports needed by any LTSS recipient, there are still some instances when an institution may be the most appropriate, and least restrictive, setting in which an individual can receive the right services and supports, in the right amount and at the right time.

The last objective to be discussed is ensuring that LTSS are furnished at the least cost possible. To develop strategies to achieve this objective, one must first understand the interrelationship between this objective and the other objectives, especially the objective regarding the right setting. Within the overall Arkansas Medicaid program, there are several individual programs that may rightly be

considered “high cost”. One such area is long term care. The LTSS program provides services and supports to the State’s aged and disabled population. The largest component of the LTSS program is care for the aged. In State Fiscal Year 2014, a little over \$800 million of state and federal dollars were spent for public and private nursing home care. A relatively small amount is spent on home and community based services (“HCBS”) for the aged. The other major component of LTSS spending is for care for the DD population. Within this component is spending on the HDCs and the private ICF/IIDs of around \$174 million, and \$190 million on the Alternative Community Services (“ACS”) Waiver, which provides HCBS care to DD individuals.

As described above, long term care in Arkansas is provided in both institutional and home and community settings. Both settings are generally capable of providing for all of an individual’s needs relating to activities of daily living. It has been consistently shown that the vast majority of the people needing long term care would prefer to receive their services and supports in their own home and community. Despite the demonstrated capability of HCBS providers, and the expressed desires of most people, the percentage of people in Arkansas that receive LTSS in an institutional setting is much greater than the average of the other states in the country. This is the major factor influencing the total cost of long term care in the State.

There is substantial evidence available that shows that the average annual cost of providing LTSS in an institutional setting is significantly higher than what is incurred in a HCB setting. Nursing homes and HDCs are generally structured such that they provide a specific level of care to all of their residents. Little consideration is given to the objectives of providing the right services and supports, in the right amount and at the right time on an individualized basis. It is a one size fits all model, and it is an expensive model. Nursing home and HDC supporters like to point out that the cost of institutional care is not always more expensive than home and community based care. They are correct. For every individual, there is a correct set of services and supports needed, that are furnished in the right amount and at the right time. There is always a cost for providing these services and supports that can be determined. For a person with extensive needs, the cost of providing for those needs in a HCB setting may be higher, lower or the same as the costs incurred in an institution.

The issue is that the cost per person receiving care in a nursing home or HDC is based on the setting itself, rather than the individual’s need for, or utilization of, the services and supports available in the institution. There is no direct correlation between the costs incurred in an institutional setting and the actual needs of the individual. The assessment process discussed above can address this issue. Based on an individual’s assessment results, a plan of care can be developed that identifies the specific types and amounts of LTSS the person needs. A “cost” can be assigned to each service and support. As a result, the total cost of implementing a plan of care is determinable in advance.

There are methodologies under consideration in which the assessment can be used to determine a specific budget available to the individual. The assigned budget is based on the cost of furnishing the identified service or support by the low cost provider. It is completely indifferent as to the setting in which the service or support is furnished. It is the same concept that is behind the Payment Improvement Initiative. There is one rate that is applicable to a given service, regardless of the service provider. A person may choose to receive all of their services from a nursing home or an HDC, but the institution’s reimbursement level from the Medicaid program will be limited to what the person’s individualized budget is. In this manner, the objective of providing services and supports at the least cost possible is satisfied.

Short of reducing the number of individuals eligible to receive LTSS, there is only one credible method of reducing overall program costs. Within each high cost component of the LTSS program,

there are high cost providers and low cost providers. In most cases, the setting in which services are provided has a direct correlation to the cost of service provision. For LTSS to the aged, nursing home care is significantly more expensive than equivalent care furnished in a HCB setting. For LTSS furnished to the IID, institutionally based care in an HDC or ICF/IID is significantly more expensive than the cost of care furnished in a HCB setting. For certain individuals with a high level of need for supports and services, there may not be much difference in the cost of institutional care compared to HCB care. However, for many individuals, the right care, at the right time and in the right amount can be furnished at significantly less cost in a HCB setting.

A credible plan to reduce total LTSS spending must be based on transitioning the provision of care from the high cost providers to the low cost providers. This concept was covered in depth by the Stephen Group Report to the task force. They identified substantial savings that could be realized by “rebalancing” the LTSS program to reduce the level of institutionally based service provision in favor of an increased level of HCB service. Apart from any other changes that might be made to the LTSS program, simply transitioning the provision of services and supports from the high cost institutionally based providers to the lower cost HCB based providers was estimated to result in \$500 million in savings over a five year period. Explicit in The Stephen Group presentation was the notion that as expenditures for institutionally based care were reduced, the expenditures for HCB care would increase as a result of more individuals being served by the HCBS program. The projected savings were net of the decreased and increased spending within the separate settings.

The proposal made to the Governor by the nursing home industry is based on this very concept. Their proposal calls for a “smart rebalancing” between institutions and HCBS. This will, by definition, increase the total cost of HCBS provided care. The way that savings might be achieved is that for every \$2 in reduced nursing home placement costs, \$1 more is spent on HCBS care for each person transitioned from a nursing home. On a net basis, total costs are reduced, despite the fact that total HCBS costs will have increased.

What is true for the nursing home industry will also be true for the DD program. By only paying for needed services and supports on the basis of utilizing the lowest cost provider capable of furnishing the identified services and supports, it is very likely that there will be a substantial decrease in the number of people utilizing HDC-based services. Whether or not this “rebalancing” in the number of people utilizing a given setting actually occurs is immaterial. If people are transitioned from receiving LTSS at an institutional setting rate, into receiving LTSS at a rate based on HCBS provided care, the State will be assured that it is providing LTSS at the lowest cost possible.

Such a process that seeks to ensure that LTSS is provided to the DD population in the most effective and cost efficient manner possible cannot be successful if the HDCs are “off the table”. The ACS Waiver program exists to prevent the unnecessary institutionalization of disabled individuals in need of LTSS. If the funding for HCB services is reduced, the result is that more individuals will be forced into utilizing the services provided by the highest cost provider. Furthermore, the U.S. Supreme Court, in its Olmstead ruling declared that unnecessary institutionalization was a form of discrimination prohibited by the Americans with Disabilities Act. If unnecessary institutionalization is to be avoided, and the total costs for furnishing LTSS to the DD population is to be reduced, then the number of people using HCBS care versus HDC based care must increase. This means that for *total* spending for LTSS to the DD population to decrease, spending on programs such as the ACS Waiver must increase, and spending on HDC based care must decrease.

Any thought that the issue of DD program related costs can be addressed without considering the HDC system is misguided. There is one program for care for the DD population. It is unreasonable,

and unproductive, to analyze the program in any other manner. The program currently utilizes two different settings. No person has a “right” to receive services in an HDC. The only “right” a person has is to receive the right services and supports, in the right amount, at the right time, in the right place and at the least cost possible. An HDC might be the right place.

Rebalancing does not explicitly require that HDCs be eliminated. The premise is that provision of LTSS for the DD population should transition from high cost providers to low cost providers. More accurately, it envisions that all providers will “cost” the same. It is likely that there will be a greater reliance on HCB care versus institutional care, but whether or not such a move actually happens is immaterial. What matters is that the system gets “rebalanced” such that all LTSS is furnished by the lowest cost provider. If the overutilization of high cost HDCs is what got us into this mess, than taking HDCs off of the table won’t help us get out of the mess.

It has been reported that if the DD providers cannot come up with a credible proposal, the State may turn over the administration of the DD program to a managed care company (“MCO”). What could be expected of a MCO? The MCO would start a client relationship by trying to determine the needs of the client. They would probably administer a functional needs assessment questionnaire to ascertain the client’s need for services and supports to assist in meeting their activities of daily living. The results of the assessment would be turned over to a case manager, who would use it to develop a person-centered service plan. Once the details of the service plan had been worked out, and the cost of implementation had been arrived at, the MCO would arrange for the identified services and supports to be furnished by local providers that have contracted with the MCO.

If this process sounds familiar, it is because it is identical to the process that is currently being used in the State. There is absolutely no step, procedure or action that a MCO would undertake in managing the DD program that is not already being done. The assessment tool used by the MCO might be different from the one used by the State, but if both are equally valid, they should both come up with an identical list of each individual’s functional limitations. This list should be the basis for identical service plans. Actual services and supports would be furnished by the same providers that currently furnish services and supports.

In general, current DD providers are ambivalent about the use of managed care to administer the DD program because the current program already has all of the attributes that a MCO would be expected to bring to the program. Local DD providers do not administer the assessments. They are done by a separate contractor. Whether the State performs the assessments, or the MCO performs them, has no effect on local providers, who by regulations cannot administer assessments to any client they furnish services to. The MCO would assume the task of case management. Since inadequate reimbursement rates result in local providers losing money on providing case management services, they will not mind letting the MCO have this responsibility. Because the MCO cannot provide direct services on its own, it will have to contract with local providers to furnish the actual services and supports. In the end, nothing will have changed except for which specific entity performs what specific task.

It is tough to construct a credible scenario in which a managed care entity can save the State money since they will be doing exactly what is already being done. They will be expected to provide the right services, to the right people, at the right time, in the right amount and in the right place. For this they will receive a capitated payment per client. Because the service plan must be completed before services can begin to be furnished, and the assessment can be used to determine costs in advance, both current providers and a MCO will know exactly how much they will be spending on client services and supports at the beginning of each year. If the assessment has identified a need for a

particular service or support, the MCO may not withhold the provision of them. As a result, there is very little a MCO can do that will impact the cost of services and supports provided. Furthermore, reducing services below the level identified as necessary through the assessment will just force more people into high cost institutions.

A MCO cannot even begin to try to achieve its goals unless the clients covered under its contract includes every single DD person receiving LTSS from the State, regardless of the setting in which services are currently being received. As is the case when a MCO manages a medical benefits program, the MCO must be able to define a plan of care for each client that will achieve a desired outcome. The MCO must be able to set dollar limits on the cost of implementing the plan of care. These dollar limits are based on rates that have been negotiated between the MCO and providers capable of furnishing the specified service. Every medical service or procedure is reimbursed at the same rate to all “in-network” providers. By definition, in-network providers are the “low cost” providers because no one else will be paid more for services furnished than they will be paid.

The same principle should apply to DD services. Every service or support provided should be paid for at the same rate for all clients. It should make no difference who the provider is. All that should matter is that all services and supports are furnished at the lowest cost possible, consistent with the achievement of desired outcomes. The MCO is subject to the same constraints as is the State itself. Only by rebalancing the service settings away from an overreliance on institutional placement, can the MCO hope to achieve meaningful program cost reductions. Given that the provider setting has such a direct correlation with the cost of service, taking the highest cost setting off the table when looking for future cost savings is fiscally irresponsible. Because HDCs are, like HCBS care, an optional benefit under Medicaid, there is no justification for treating them differently. Punishing low cost providers, and denying people the opportunity to live in their community, is not how the State will achieve its budgetary targets.

Another issue of concern to providers and recipients of HCBS is the extensive waiting list for enrollment in the ACS Waiver. There are currently close to 3,000 people on the waiting list, with some people having been waiting for more than eight years. These are people that need the services and supports provided by the Waiver to be able to stay in their local community, find meaningful employment and participate in community activities. For many years, public officials have expressed their concern about the waiting list, and have promised to address the issue. To date, the waiting list has not been eliminated, and continues to grow.

There are some people that oppose any expansion of the ACS Waiver because of a mistaken belief that a large number of people are using the Waiver to supplant parental responsibility. In short, they think the Waiver is just a glorified day care program. The fact is that individuals under the age of nineteen make up around 12% of the individuals in the Waiver, with close to 7% being over the age of fifteen. Many of these are foster children in the DCFS program that are using reserved slots in the Waiver so that the State can receive federal matching funds for their care. The ACS Waiver is a lot of things to a lot of people, but a glorified day care program it's not.

Prior discussions about addressing the waiting list issue have focused almost exclusively on the budget implications of expanding the ACS Waiver. The Stephen Group Report discussed how a future “Global Waiver” might include features in the Community First Choice Option that would increase the availability of HCBS, but at the same time continue to set an upper limit on enrollment. What seems to have merited little consideration is that the existence of the waiting list is a violation of the integration mandate of the Americans with Disabilities Act, which requires that all services provided by any state program be furnished in the most integrated setting appropriate to the

individual. It is argued by some that because the State does offer *some* long term care services in a HCBS setting, that the State has complied with the integration mandate.

This argument is belied by the Supreme Court's Olmstead ruling. The Court said that a state could demonstrate its compliance with the ADA if, "it were to demonstrate that it had...a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated". While 'a reasonable pace' was not defined, a wait of over eight years can never be considered reasonable. The very fact that removing the HDCs from any discussion regarding the future of the DD program has been proposed is strong evidence that the resolution of the waiting list issue is being controlled by the State's endeavors to keep the HDCs fully populated.

When the State first decided to make the provision of long term care a goal, had the objectives described above guided the development of the program, it may well have been that a reliance on nursing homes and HDCs was the most effective and efficient manner in which to accomplish the objectives. Times have changed. Institutionalization has become disfavored as a result in consumer preferences and fiscal constraints. There now exists a system of home and community based services that did not exist years ago. However, the State has been slow to change its approach. Change affects both the service providers and the recipients of the service. It is understandable that service providers have a vested self-interest in maintaining the status quo. Maintaining the status quo is not an objective.

The objectives that form the basis for achieving the State's goal of providing long term care do not change over time. Conditions, circumstances and capabilities do change. Effectively addressing complex problems requires comprehensive solutions. When solutions that were effective in the past become stale and outdated, a slavish adherence to standard operating procedures becomes the bane of every organization. An effective organization constantly reviews its operations to confirm that policies, procedures and programs are aligned with the objectives they seek to accomplish.

Providers of LTSS to the DD population in a home and community based setting would welcome an opportunity to propose reforms to the State's DD program. However, given the constraints under which such a proposal would be subject to, any proposal made would be far from credible, in that it would not be worthy of belief or confidence, or considered capable of achieving a goal. The DD program is a part of a goal. As such, it must be viewed within the context of the overall goal. Long term care is concerned with care for the aged and the developmentally disabled. Institutionally based care and home and community based care are both integral components of the DD program, just as home and community based care is inseparable from nursing home care when analyzing long term care for the aged.

Controlling future expenditures by the Arkansas Medicaid program is a legitimate concern. As a significant percentage of the total budget is represented by expenditures for long term care, it is clearly a program that should be looked at closely to determine that it is being run as effectively and efficiently as possible. We welcome such an analysis, and are confident that structural and programmatic changes will lead to better outcomes that can be achieved for less money. We are also convinced that the long term care program must be analyzed as a single entity. To do otherwise is to employ the same level of thinking that created the problems we now face. The current DD program is a part of the larger long term care problem, but the HCBS component of the DD program also has the potential to be the critical part of the solution.

By only focusing on reducing costs in one segment of the total DD program, the decision makers are sacrificing the ability to achieve the other objectives that should be applicable to all of the segments.

Requesting that DD providers develop a proposal to reduce by a certain dollar amount what is spent on HCBS care will require the providers to explicitly consider actions that do not provide the services and supports that an assessment indicates are necessary, to only some of the people that need help, in an amount that may insufficient to achieve a desired outcome, in a setting that is not of the individual's choosing, and at a cost that is not reflective of what can be obtained from the low cost provider. If we continue to approach problems using the same level of thinking that created the problem, we will simply perpetuate the problem. Asking the DD providers for a credible proposal to reduce DD program costs, or suggesting that managed care is a viable option, are examples of thinking that does not produce positive results but, rather, perpetuates a system that is broken. There is no reason why we can't reform the long term care program in a manner that it, like other reforms to the Arkansas Medicaid program, will be something that other states seek to emulate.