EXHIBIT E-5

Arkansas Long Term Care Savings & Reform

February 2, 2016

Arkansas Health Care Association
Arkansas Assisted Living Association

Overview

In a meeting with Governor Asa Hutchinson, a goal of saving $250 million dollars from the long term services and supports continuum over the next five years was identified. Future projections for savings were based on aggregate cost and a 5% growth rate (with growth expectations recently given by DHS).

Three elements were also discussed related to the long term care continuum:

1. Smart Rebalancing
2. Independent Assessment
3. Tier Levels of Care

Other reforms and ideas to modernize the long term care continuum in Arkansas were also discussed. We believe that in addition to savings, adding a health home model that focuses on chronic conditions with a functional limitation component would allow for program sustainability.

This proposal includes recommendations to achieve these elements in the most cost effective way, with an emphasis on state general revenue, while maintaining a high level of quality care in long term care.

Smart Rebalancing

The most critical time to transition someone out of the nursing facility is when they are ending their short term rehabilitative stay (usually paid by Medicare) before they transition to long term care (usually paid by Medicaid) in the nursing facility.

Rebalancing can only happen when adequate networks and programs are in place to transition someone effectively. If services are not coordinated when someone transitions home, the beneficiary is much more likely to have a readmission to the hospital or nursing facility. While there are home & community services available across the vast majority of the state, they vary, especially in rural markets. Some areas of the state that have these programs available can provide services to a large quantity of people, but are not equipped to provide care to a higher acuity patient who just recently transitioned. The nursing facility serves as a bridge between the hospital and home.

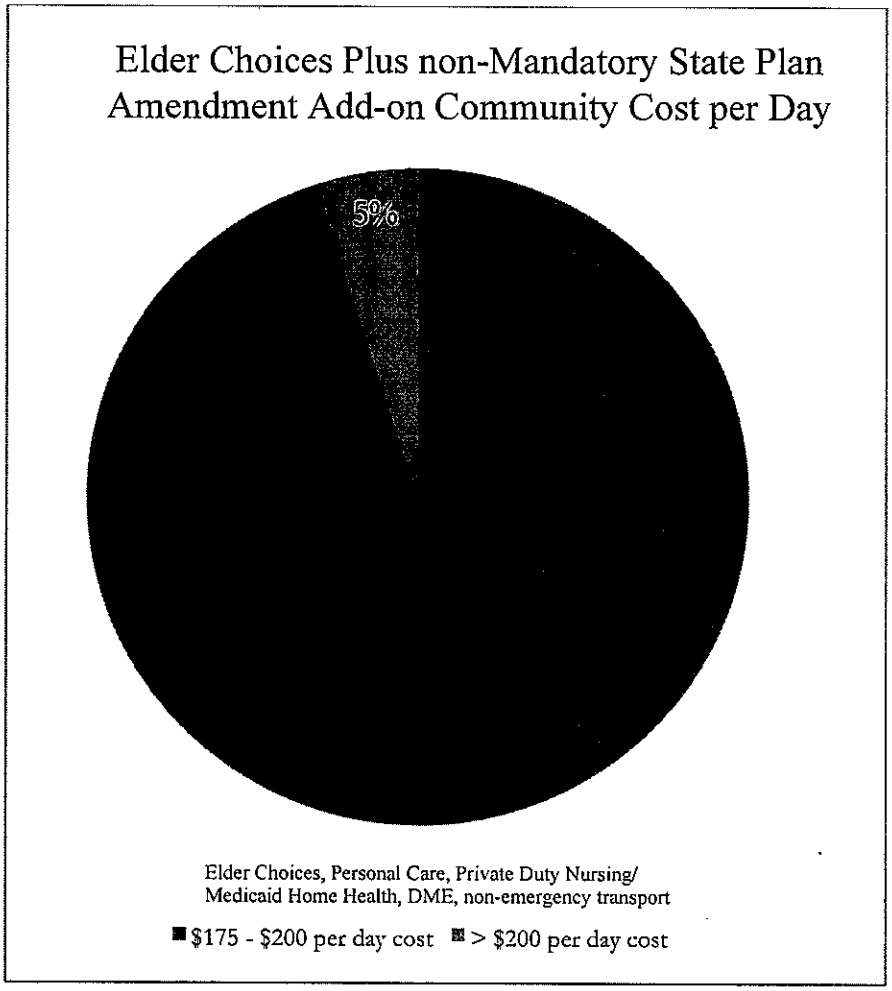
Smart Rebalancing can be achieved with a combined focus of enhanced transitions and a more sophisticated assessment process. We would propose the following to achieve Smart Rebalancing:

1. Create a Transition Bundle
    a. Nursing facility is at risk
    b. Multiple service benefit package based on diagnosis
    c. Provides 45 days or appropriate length of time for DAAS nurse to schedule visit and complete required screening and assessment to authorize appropriate services in the community.
    d. Coordinated with interdisciplinary care team (Medical Director, Nurse, Therapists, Social Services Director, Family, etc.)
    e. Provides attendant care based on expected level of care
    f. Provides home modifications (bathroom fixtures, grab bars, wheelchair ramps, etc.)

    Example: Dual-eligible 85 year old woman living alone at home. Using her cane, she goes to get the newspaper and falls and breaks her hip. She is admitted to the hospital and is later discharged to a nursing facility for rehabilitation (paid by Medicare). After physical and occupational therapy and nursing services, she has improved enough to transition back home. However, she is unable to safely transition in and out of the shower alone, has difficulty preparing meals, and needs a ramp to enter and exit the home. The transition bundle is used to allow her the opportunity to go back to her home with the supports needed, while providing for her health and safety without the risk of her staying in the institution as a long term care resident (paid by Medicaid).

2. Enhanced Transitions
    a. Develop public-private partnership with A+ Team within DAAS. Repurposing their role to assist in connecting social worker at nursing facility to community based services following approval from DAAS RN.
    b. Change regulations to require all nursing facilities to have a certified Social Services Director, with training on patient centered discharge planning. Currently, each facility has someone serving in this position, but it does not have a licensure requirement. Adding a required certification and training curriculum that will be applied statewide will allow for understanding and better coordination of discharge planning and transitions at the facility level.
    c. Potentially utilize Community Health Workers in this capacity to assist with transitions, follow up on doctor's appointments and barriers that may promote hospital or nursing facility readmission.

To effectively achieve smart rebalancing, the state plans and waivers must be reformed. Data needs to be examined further on current recipients within the HCBS programs.



Assessments

The most cost effective way to place emphasis on the assessment process to cover the entire long term care continuum would be to utilize the MDS and build upon its existing infrastructure, while enhancing the audit functions. A level of independence can be added to the infrastructure already in place without creating a very costly and duplicative system.

	DAAS Nurse	Nursing Facility Nurse	Independent Audit Contractor
Tier I – Nursing Facility Level I-II		■	■
Tier I – Nursing Facility Level III	■	■	■
Tier II – Community Based Services	■		
Tier III – Preventative Level of Care	■		

Nursing Home Assessments: Minimum Data Set (MDS)

The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status that forms the foundation of the comprehensive assessment for all residents in Medicare and/or Medicaid-certified long-term care facilities across the country. The MDS contains items that measure physical, psychological and psychosocial functioning. The items in the MDS give a multidimensional view of the patient's functional capacities and helps staff to identify health problems.

The MDS is already mandated for all payer sources by CMS. CMS has created extensive audit functions at various levels, starting with the IT audits, then the recently implemented MDS audits performed by the Office of Long Term Care. MDS data is sent electronically from nursing facilities to the DHS Office of Long Term Care. Data is then routinely sent to the CMS Regional Office. This IT system works very efficiently and has redundancies in place.

The MDS is currently completed for every resident in a nursing facility upon admission, quarterly, and upon a change in condition. This data is submitted electronically to DHS to the Office of Long Term Care. MDS focused surveys are conducted on behalf of the CMS Regional Office to ensure accountability.

Home & Community Based Program Assessments: interRAI Home Care Tool

Arkansas currently uses an electronic assessment tool, the interRAI Home Care instrument for all of its Home & Community Based waiver programs. Nurses employed by the DHS Division of Aging & Adult Services complete these assessments. Electronic data is then sent to the DHS Office of Long Term Care for Utilization Review. This process is the same as the medical eligibility determination process for nursing facilities because the waiver programs require that beneficiaries have a medical need of nursing facility level of care.

Like many HCBS assessments, the interRAI is built upon the foundation of the MDS. The developers of the interRAI were also the developers of the MDS.

DHS-703

In Arkansas, medical eligibility for waivers or institutional services requiring nursing facility level of need is determined using the DHS-703 form, which is currently completed by two means:

- Nursing Facility: Nurse in nursing facility completes form along with MDS, submits to the Office of Long Term Care at DHS for Utilization Review
- HCBS Waivers: DAAS nurse completes 703 form and submits to the DHS Office of Long Term Care for Utilization Review

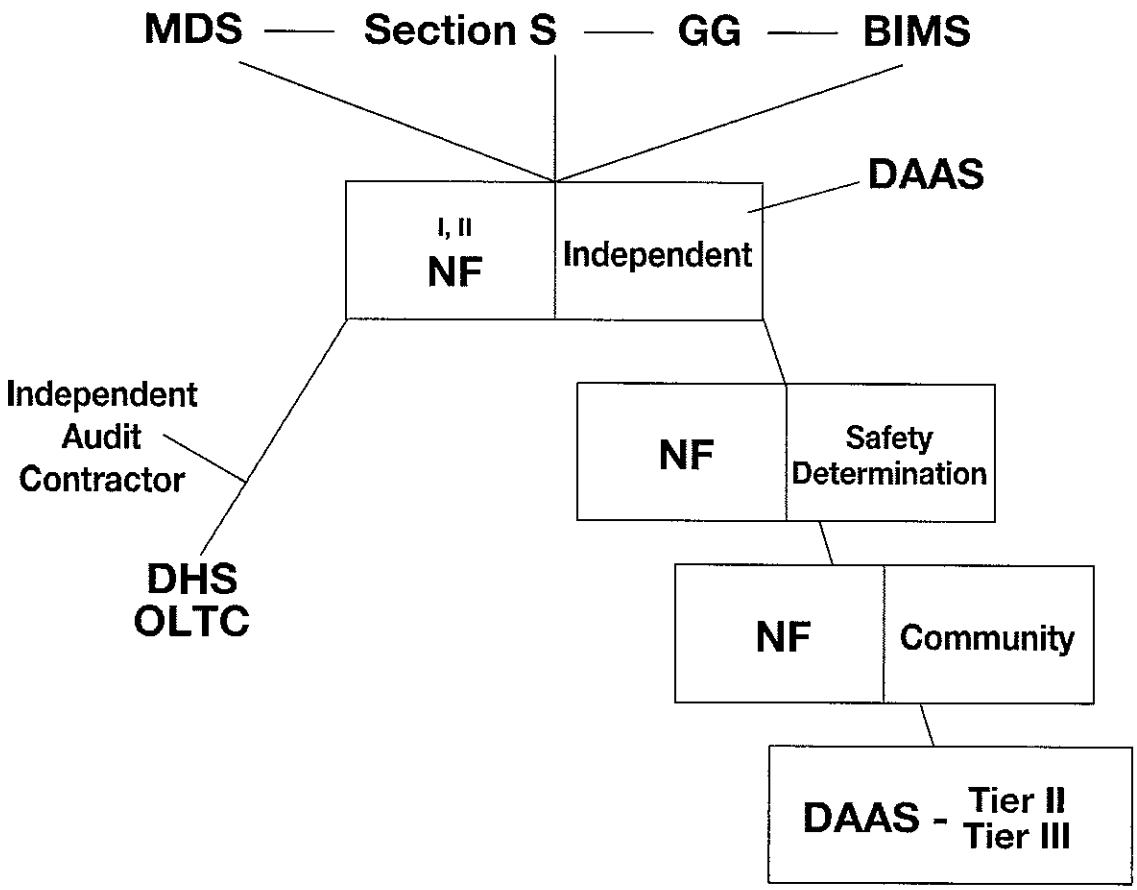
This process is currently done by paper. The Office of Long Term Care has been working on making the process electronic. There would need to be a transition pilot process for implementation.

We suggest that additional emphasis should be placed on the following sections of the MDS:

- Section C: BIMS (Brief Interview of Mental Status)
- Section GG: Functional Abilities & Goals
- Section S: State-Defined Section (would include enhanced MDS features that serve as the gathering and repository for eligibility determination – replacing the paper DHS-703 form)

We propose the following for cost effective assessments:

1. Transition the DHS-703 form to an electronic format. Add the format to Section S of the MDS. This would allow for electronic data submission without creating an entire new instrument, in a format that would provide the State with a more accessible audit format. It would also add medical eligibility determination components to the federally required clinical assessment.
2. State of Arkansas to contract with entity to perform enhanced audit functions focused on Tier I, Level III with penalties, focusing on those conducted in the nursing facility.
3. Add a Safety Determination process, similar to the process in Tennessee. This will allow for an appeals process and third party screening when someone is denied eligibility but their health and safety needs do not allow for them to live in the community. There would be an appeal process, limited to physicians, family members, and advocates.
4. Further evaluation is needed to determine what percentage of the Level III patients would need to be evaluated by both the nursing facility RN and the DAAS RN. A strong workgroup is required for this process to be effective. This would require case studies and further discussion of details.
5. Continue modification process of interRAI assessment instrument to save time and only capture data needed to determine eligibility and meet health and safety needs.
6. Develop system of tracking transitions in and out of nursing facilities and community programs. Add to interRAI assessment the setting in which the individual received prior services.



Additional Considerations:

The IMPACT (Improving Medicare Post-Acute Care Transformation) act was signed into law by President Obama last year. This will require all providers to report standardized patient assessment data, data on quality measures, and data on resource use and other measures. It also requires PAC assessment instruments applicable to PAC providers for the submission of standardized patient assessment data on such providers and enable assessment data comparison across all such providers.

Development on national implementation of the IMPACT act is still under way. We strongly recommend that Arkansas pause development of further assessment instruments at this time as there will be new federally required assessment processes for all Medicaid recipients – in nursing facilities and community based programs in the coming months that will likely be of use to states.

Presumptive Eligibility

We propose to further explore options related to eligibility determination as related to transitions of care. We understand that presumptive eligibility requires that the state bear cost at 100% GR, so this must be done in a way that is sensitive to the state budget.

Clients are presumed to be financially eligible when going to a lower level of services provided. It takes up to 45 days for DAAS nurses to conduct medical eligibility assessments. We would like to further evaluate barriers in place for clients transitioning to different settings of care.

Tier Levels of Care

Modeling after some of the work done in states like Tennessee and Rhode Island, we propose to simplify the tier levels of care while eliminating duplicative services and non-mandatory state plans for community programs. Less case management will be needed as service benefits can be bundled together to allow efficiency on the part of the nursing facility and the DAAS nurses.

Tier I – Nursing Facility Services	**Tier II – Home & Community Based Services** *(NH Eligible Level of Care)*	**Tier III – Preventative Level of Care Services**
Nursing Facility Services	ARChoices Waiver Attendant Care Meals Non-Emergency Medical Transportation PERS (Personal Emergency Response System) Minor Environmental Modifications -or- Living Choices Assisted Living Waiver	15 hours per month of Attendant Care Meals Non-Emergency Medical Transportation visits to physician and dialysis PERS (Personal Emergency Response System) Minor Environmental Modifications

Tier I – Nursing Facility Services

Provides traditional nursing facility services for elders with the highest acuity. Within the current nursing facility regulations, there are three levels of intermediate level of care. Level I has the highest

acuity ranking, and Level III has the lowest acuity ranking; with waiver service medical eligibility being based on Level III.

It is important to note that Level III residents would have enhanced screenings under this proposed model.

Tier II – Community Based Services

Services in Tier II will have a wide range depending on beneficiary need. More services may be needed following an immediate transition from an institution, or a hospital stay. Services would include those in the current ARChoices menu of services, along with attendant care.

Tier III – Preventative Level of Care Services

This would include beneficiaries who are at home and at future risk of entering into a nursing facility and beneficiaries currently receiving Personal Care only who may not qualify for ARChoices benefits because they do not meet Nursing Home Intermediate Level of Care, but would still require some services.

Savings

We propose the following changes to the existing reimbursement methodology for nursing facilities:

- Elimination of Provisional Rates (with the exception of new construction facilities)
- Limit Population Based Methodology for Nursing Facility Beds
- Limit the population based methodology component, to slow the growth of new nursing facilities and further the development of home & community based services.
- Place ceiling on reimbursement of professional liability insurance (This is unrelated to non-economic or punitive caps on damage awards.)
- Downward adjust the fair rental value of facilities below 50% census
- We propose the following changes in other Medicaid programs:
- Freeze the cost of living adjustment for Living Choices Assisted Living Waiver
- Reduce the duplicative nature of services and the ability of consumers to maximize services beyond their needs

- Determine efficiencies at Arkansas Health Center. We understand the need for such a facility, but they remain to be held harmless from reforms and could significantly impact overall plan effectiveness if their growth is included in projections and calculations for savings.

Value Based Purchasing Program – 3 - 5% Withhold

Goal: Improve the quality outcomes for Arkansas Medicaid beneficiaries who are residing in a nursing facility, and reduce the number of admissions to a SNF from becoming a long term care Medicaid resident and thereby decrease Medicaid expenses.

While quality of long term residents has been improving in a number of areas, opportunities remain to improve further. Current Medicaid payment policies do not reward or incentivize higher quality. Prior VBP programs often do not create financial incentives linked to meaningful outcomes. Implementing a program with a withhold payment from Medicaid rates to create an incentive pool that can be earned back based on quality performance and overall savings to Medicaid is an expense shouldered by the facilities and will ultimately improve quality of care. (See attachment)

Health Home

The most cost effective way to place emphasis on the assessment process to cover the entire long term care continuum would be to utilize the MDS and build upon its existing infrastructure, while enhancing the audit functions.

Other Considerations

We would propose the following high level changes to the current HCBS programs:

1. **Eliminate non-mandatory Personal Care state plan, Modify ARChoices waiver.** This program has16,603 people being served. The program does not have a standardized form of assessment or data collection. Our data indicates that almost 80% of Personal Care beneficiaries are also receiving ARChoices services, creating duplicative services and additional cost. If the Attendant Care portion, which is currently offered in Personal Care, were added to the ARChoices waiver, clients could receive all services without duplication.
2. **Phase out Independent Choices program for the Aging population.** Independent Choices is a non-mandatory waiver program, serving 2,976 recipients in SFY14. It is our strong

recommendation that this program be restricted to those with physical disabilities. Self directed programs can work well for those with physical disabilities, but not for the elderly, especially those with dementia. Elderly beneficiaries, especially those with dementia, can be served through the same array of services provided under ARChoices, without the $7M contractor required. Beneficiaries can receive same services, but state can pay providers that are measured for quality outcomes instead of paying family members. Also, this program does not require an institutional level of care to receive services.

3. **Phase out Adult Family Home program.** Only 7 beneficiaries in previous calendar year participated with very limited oversight. Program has been in development for many years without success.
4. **Evaluate and Develop Program Integrity for Home & Community Based Services.**
5. **Further assess capacity & potential function of community health workers to assist with community transitions.**
6. **Assess current Targeted Case Management Program.**

CMS Final Rule: Home & Community Based Settings

CMS issued its final rule on Home & Community Based Services in 2014 and gave states five years to bring all programs and services funded by Medicaid into compliance. The final Home & Community Based Services regulations set forth new requirements for several Medicaid authorities under which states may provide home and community based long term services and supports. The regulations enhance the quality of HCBS and provide additional protections to individuals that receive services under these Medicaid authorities.

Arkansas is currently working with CMS to bring providers into compliance while assessing current settings and regulations. We have completed phase 2 of 5 and have received Clarifications and/or Modifications needed for Initial Approval (CMIA). There are unknown factors in play and the following LTSS settings and their ability to receive Medicaid funds may be affected:

- Assisted Living Facilities
    - dementia care, secured units
    - proximity to institution, characteristics of institution
- Adult Day Care / Adult Day Health Care – dementia care, secured entry/exit
    - dementia care, secured units
    - proximity to institution, characteristics of institution
- Residential Care Facilities

Workforce Development

There is an immediate and critical need for certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs) and advanced practice nurses (APNs) in Arkansas. Specifically registered nurses with high level assessment skills are necessary for proper assessment in skilled nursing and home health arenas to reduce avoidable hospitalizations.
In addition, across all of the aforementioned job listings, the scarcity of resources and the competition for the nursing applicants or pool is significantly driving up nurse wages much higher, exponentially higher than the rate of inflation. This puts additional pressure on Medicaid cost and essentially drives cost.

We would like to propose a small group specifically to look at the return on investment to see if there is a cost effective or if spending some money on CNAs, LPNs and RNs would be cost effective for the state. In addition, we believe that especially with a certified nursing assistant and licensed practical nurses, this would work hand in hand with the work requirements or work referrals from the governor's Arkansas works program.

We are willing to develop a workgroup that would include key health care providers, workforce training, members of the legislature and governor's office and higher education. This is an issue that broad consensus could be reached among urban and rural areas across ethnic groups and would provide benefit to hospitals, nursing facilities, physicians and home care.