SCOPE

Arkansas Code Ann. 20-8-101 et seq. authorizes the Health Services Permit Agency as an independent agency under the supervision and control of the Governor. With direction from a nine (9) member Health Services Permit Commission, the Agency is responsible for implementing the State's Health Services Program that includes a Permit of Approval (POA) process.

The current POA process evolved from federal initiatives in the sixties resulting in passage of an Arkansas Certificate of Need (CON) law in 1975. Legislation in 1987 abolished the CON program and established the existing program. Arkansas Act 593 of 1987, as amended, created the Health Services Permit Commission and the Health Services Permit Agency to implement the State's long-term care planning and review program.

MISSION

The Commission/Agency mission is to ensure appropriate distribution of health care providers through the regulation of new services, protection of quality care and negotiation of competing interests so that community needs are appropriately met without unnecessary duplication and expense.

PUBLIC PURPOSE

The POA process is vital to the state to direct and implement state policy by promoting cost containment, ensuring appropriate distribution of health care providers, and preventing the unwise expenditures of the State's Medicaid dollar. Additionally, implementation of state policy can take the form of encouraging, or discouraging, the growth of certain services for which there may be less costly, or more appropriate alternatives.

COMMISSION

Commission membership is defined by the Legislature, appointed by the Governor and confirmed by the Senate. Commission members serve without pay for a maximum of two (2) four-year terms. By statute, Commissioners must be represented by a:

- member from the Arkansas Hospital Association
- member from the Arkansas Health Care Association
- member from the Arkansas Chapter, AARP
- member from the Arkansas HomeCare Assoc. of Arkansas
- member from the Arkansas Residential/Assisted Living Association
- member from the Arkansas Hospice Association
- representative of the Department of Human Services
- consumer knowledgeable in business health insurance, and a
- practicing physician.

Directives for the Commission as assigned by Act 1800 of 2001:

- evaluate the availability and adequacy of health services
- designate those locales which, due to the requirements of the population or the geography of the area, the health service needs of the population are underserved
- (may) specify within locales or areas, categories of health services which are underserved and over served due to the composition or requirements of the population or the geography of the area
- develop policy and adopt criteria including time limitations for every review of an application to be followed by the Agency in issuing a POA

- (may) define certain underserved locales or areas or categories of services within underserved locales or areas to be exempt for specified periods of time from the POA requirement

- (may) set application fees for POA applications to be charged and collected by the Agency

- upon appeal conduct hearings on decisions by the Agency within 90 days of receipt of the Agency decision. The Commission shall render its final decision within 15 days of the close of the hearing. Failure of the Commission to take final action within these time periods shall be considered a ratification of the Agency decision and shall constitute the final decision of the Commission from which an appeal to Circuit Court may be filed.

AGENCY ADMINISTRATION

The agency has a full time staff of five (5), including the Agency Director, James Luker, the Agency Fiscal Director, the Management Project Analyst, the Planning Specialist and the Administrative Specialist. The agency is charged with providing certain administrative services to the Developmental Disabilities Program which is housed with the Health Services Permit Agency.

Directives for the Agency as mandated by Act 1800 of 2001:

- possess and exercise such duties and powers as necessary to implement the policy and procedures adopted by the Commission

- review all applications for POAs and approve or deny the application within 90 days from the date the application is deemed complete and submitted for review, and

- assist the Commission in the performance of its duties.

In addition to its planning function, the Agency is the designated state agency for The Governor's Developmental Disabilities Council (DDC). Federal Law requires that each state that receives DDC funding have a governor's designated state agency to provide administrative support and to ensure federal compliance with the DDC Act. The DDC's goal is to increase independence, productivity and integration and inclusion of persons with developmental disabilities into all facets of community life. The 26 member Council and full-time staff of four advocate for improvements and changes in the current delivery system, provide training and education on disability issues, provide information and referral services, fund local pilot projects and work with other state and federal agencies to accomplish the DDC goals. The DDC budget is approximately $753,000 annually in federal funds and an additional $38,000 in state general revenue (SGR). The DDC Act requires a state match. The aforementioned SGR provides a portion of that match. Additional match is the result of volunteer hours and local grantee contributions that satisfy the state match requirement. All federal and match funds are budgeted to and used explicitly for DDC activities as outlined in the federal DDC Act.

Fiscal/Budget

Revenue from the Health Services Permit fees and copy fees are deposited into the State Treasury. The review fee is $3,000 per application. The Agency charges $0.25 a page for copying. The total deposit for FY 2012 was $80,364.52, FY 2013 was $93,614.50; and for FY 2014 was $62,065.00.

Arkansas Code 20-8-103 et. Seq. allows all proceeds from fees to be deposited into the State General Services Fund Account. Act 58 of 1997 allows the balance remaining at the close of each state fiscal year to be carried forward to the next state fiscal year to be used exclusively for the maintenance and operation of the Agency. The Agency's carry forward for 2014 was $276,135.00; the carry forward for 2015 is $287,737.12. As a trend, the Agency's expenditures in 2014 were comprised of 91% SGR and 9% of the POA fund balance. Over time, there has been a

gradual change in the proportion of SGR to fund balance account to support Agency expenditures. By 2010, the percentage of SGR had declined substantially to 71% and reliance on the POA fund balance had increased to cover 29% of the Agency expenditures. A fee increase which is covered in another section was approved by the Commission which has resulted in the restoration of the fund balance to previous levels.

Table 1. ***Health Services Permit Agency Fiscal Year 2012 - 2015 Budget and Revenue***

844 – HSPA	FY 2012	FY 2013	FY 2014	FY 2015
APPROVED BUDGET	$377,100	$377,100	$385,927	$385,934
GENERAL REVENUE	$274,424	$276,557	$320,555	$320,614
POA & COPY FEES	$80,365	$93,615	$62,065	
TOTAL REVENUE	$354,789	$370,172	$382,620	
TOTAL EXPENSES	$332,040	$347,552	$352,168	

PERMIT OF APPROVAL REVIEW PROCESS

Fiscal Year 2012, 2013, and 2014 reviewable projects included Nursing Homes, Assisted Living Facilities (ALF), Hospice Agencies and Facilities, and Home Health Services. The POA process includes the addition of beds, cost overruns, movement of existing beds, transfer of a POA and movement of site locations for POAs. Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Residential Care Facilities (RCF), and Psychiatric Residential Care Facilities (PRTF) remain under moratorium since 1987, 2005, and 2008, respectively.

Potential applicants are urged to schedule a pre-application conference with staff for assistance in understanding the POA process, including advising of the need for the proposed service, guidance in developing an application, and the timetable for review. After an application is accepted for review, the 90-day review cycle begins. There are four 90-day review cycles per year. The quarterly application due dates are defined in the Rule Book and the review cycles are scheduled to allow the completed review and if needed, the appeal to be heard within the same review cycle to avoid delays and duplication of paperwork. Applications, which satisfy the requirements for expedited reviews, may be submitted at any time without regard to the established Review Schedule.

Table 2. ***POA Application Review Schedule***

Application Due Date	Application Under Review	Agency Decision
February 1	March 1	May 30
May 1	June 1	August 30
August 1	September 1	November 30
November1	December 1	February 28

In 2012 the application fee was increased from $1,500.00 to $3,000.00 in order to maintain the previously declining POA and copying fee fund balance that helps support the agency.

Applications are reviewed in accordance with the Commission's adopted criteria and standards, along with population projections and up-to-date utilization reports. Detailed objective findings are developed by Agency staff addressing four statutory criteria: need, staffing, economic feasibility, and cost containment. Agency findings

include the criteria for the Agency decision. Agency decisions are final after 30 days, unless the Agency receives a request for an appeal from an applicant or interested party who has filed an objection in the first 30 days of the review cycle. These interested parties or unsuccessful applicants may then appeal to the commission. When the Commission upholds the Agency decision, unsuccessful applicants may seek judicial review in an appropriate court. If no appeal request is received, the Agency issues the POA and the applicant may proceed with implementation and licensing of their project. A POA may be transferred to another party with approval of the Commission. Once implemented (licensed), a POA ceases to exist.

Agency rules, methodologies, applications under review and other information may be found on the Agency's web site: www.arhspa.org.

MEETINGS

The Commission meets at least quarterly; however, meetings may occur more frequently to respond to appeals and requests from the public. The Commission met four (4) times during FY 2012, FY 2013, and FY 2014. Notice is given to the public at the time POA applications are received and at the time a decision is made by the Agency or Commission. Public hearings are held as recourse for affected parties. FY 2012 and 2013, there were two appeals of an Agency decision and it resulted in the support of the Agency's original decision. FY 2014, there were four appeals of an Agency decision and it resulted in the support of the Agency's original decision.

PROJECTS SUBJECT TO POA REVIEW

- Assisted Living Facilities (Act 1230 of 2001)
- Home Health Agencies (Act 956 of 1987)
- Hospice Agencies and Hospice Facilities (Act 396 of 1997)
- Intermediate Care Facilities for the Mentally Retarded (Act 593 of 1987) (Moratorium since 1987)
- Nursing Homes (Act 593 of 1987)
- Psychiatric Residential Treatment Facilities (Act 593 of 1987) (Moratorium since 2008)
- Residential Care Facilities (Act 593 of 1987) (Moratorium since 2005)

The above referenced services require a permit for new or expanded services. Any increase in cost in an approved project or cost of renovation, construction or alteration of a facility is deemed a cost overrun and must be documented and filed with the agency.

PROJECTS REQUIRING APPROVAL BY THE COMMISSION

- Movement of beds or site location change
- Transfers of Permits of Approval, legal title or right of ownership
- Expedited Review (No additional beds may be approved by the Commission under expedited review). The expedited review process may be utilized if a capital expenditure is required to:
    - eliminate or prevent imminent safety hazards
    - comply with State licensure standards
    - comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that Act
    - eliminate emergency circumstances that pose an imminent threat to public health, or
    - increase the cost of an approved project in order to replace remodeling with new construction.

POA APPLICATION VOLUME

In FY 2012, thirty-four (34) applications were approved, four (4) were denied and two (2) were withdrawn or returned. Agency decisions resulted in the approval of $ 138,130,268.00 in capital projects.

Table 3. ***Fiscal Year 2012 Applications***

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Homes	8	$ 22,251,602	7	1	0
PRTF's (moratorium)	0	NA	0	0	0
Home Health	1	$ 15,000	1	0	0
Assisted Living	29	$ 115,329,546	25	2	2
Hospice Agencies	1	$ 0	0	1	0
Hospice Facilities	1	$ 534,120	1	0	0
Totals	**40**	**$ 138,130,268**	**34**	**4**	**2**

Table 4. ***Fiscal Year 2013 Applications***

In FY 2013, twenty-seven (27) applications were approved, three (3) were denied and seven (7) were withdrawn or returned. Agency decisions resulted in the approval of $ 119,370,448.95 in capital projects.

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Homes	13	$ 53,183,047.95	11	1	1
PRTF's (moratorium)	0	NA	0	0	0
Home Health	1	$ 0.00	1	0	0
Assisted Living	17	$ 66,187,401.00	15	1	1
Hospice Agencies	6	$ 0.00	0	1	5
Hospice Facilities	0	$ 0.00	0	0	0
Totals	**37**	**$ 119,370,448.95**	**27**	**3**	**7**

Table 5. ***Fiscal Year 2014 Applications***

In FY 2014, twenty-nine (29) applications were approved, five (5) were denied and three (3) were withdrawn or returned. Agency decisions resulted in the approval of $ 140,806,425.00 in capital projects.

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Homes	13	$ 65,069,125	11	1	1
PRTF's (moratorium)	1	$ 50,000	1	0	0
Home Health	5	$ 0	0	4	1
Assisted Living	17	$ 75,681,300	16	0	1
Hospice Agencies	1	$ $6,000	1	0	0
Hospice Facilities	0	$ 0	0	0	0
Totals	**37**	**$ 140,806,425**	**29**	**5**	**3**

Table 6 illustrates the increase in applications from FY 2008-FY 2014 that the POA applications are again increasing from their low of 26 in 2011. The largest impact appears to have been new construction for Assisted Living Facilities. There is still a large need in many counties for new Assisted Living beds.

Table 6. ***Total Applications FY 2008 – FY 2014***

Type of Projects	2008	2009	2010	2011	2012	2013	2014
Nursing Home	12	14	10	7	8	13	13
Population	1	2	1	0	4	2	2
Utilization	2	1	6	1	4	6	6
Replacement	6	10	3	6	0	5	5
Other	3	1	0	0	0	0	0
RCF (Moratorium 07/05)	0	0	0	0	0	0	0
Assisted Living	26	11	13	16	29	17	17
Home Health	3	2	1	0	1	1	5
Hospice	3	7	6	0	1	6	1
Hospice Facility	2	4	1	3	1	0	0
PRTF (Moratorium 02/08)	0	0	0	0	0	0	1
Total	**46**	**38**	**31**	**26**	**40**	**37**	**37**

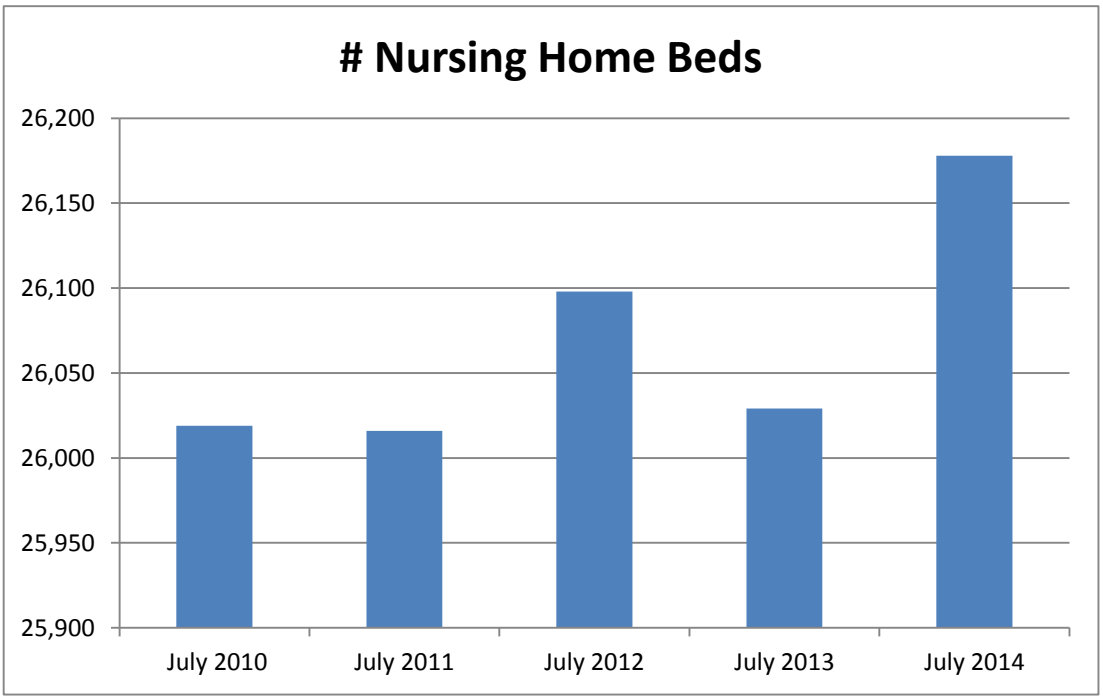
NURSING HOMES

Nursing homes are defined as an "institution, or other place for the reception, accommodation, board, care or treatment of more than three (3) unrelated individuals who because of mental or physical infirmity are unable to sufficiently or properly care for themselves, and for which reception, accommodation, board, care and treatment, a charge is made."

POA rules require a Permit of Approval for new, expanded, or renovated long term care facilities, movement of long term care beds and replacement of facilities. Replacement nursing home applications require replacement of the entire facility with new construction. The Agency Rules allow replacement facilities to request and be approved for up to a 20% increase in current licensed capacity up to 140 beds. POAs for nursing home renovations are needed based on the cost of renovation. Any project requiring expenditure of $1,000,000 or more requires an application for a POA.

In July 2013, the Nursing Home net need was (-5,928) and the current bed need as of October 2014 is (-5,962). Over the years, most of the additional beds have been added because of the Replacement Facility Methodology.

Figure 1. ***Number of Nursing Home Beds 2010-2014***



The formula for the Population based methodology is based on demand and the decreased demand has diminished the need for new beds under this methodology. Therefore, population based applications for nursing homes are flat. Replacement facilities were mentioned in a previous section. The Utilization Methodology allows facilities to increase capacity by 10% (or ten beds) if the county has no population based need and the applicant nursing home had an occupancy that averaged at least 90% over the previous 12 months and the additional beds are acquired from a facility that has an occupancy of 70% or less for the previous 12 months.

The utilization of nursing homes has changed over time on a national level as well as in Arkansas. National demographics show an increase in the growth of the aging population. However, as the population ages, they are healthier and are remaining independent longer. Those that enter nursing homes, enter at an older age and with a greater need for assistance with daily living and a greater need for skilled nursing care. Information which is available on the internet from The Center for Disease Control's National Nursing Home Survey and from AARP

studies provides useful statistical information on the aging population. The age and gender at which long term care is needed the typical diagnosis for uses of long term care and the level of care required.

These changes in nursing home utilization may be due to healthier lifestyles and a shift in morbidity and wellness by the aging population. Some of the changes are also due to the introduction and growth of other services such as home health and other home based services as well as the growth of assisted living facilities (ALFs). Assisted Living Facilities were legislated in Arkansas in 2001 and will be covered in an upcoming section of this report.

Those reports and studies reflect the different characteristic or demographic of nursing home residents that are composed of the older, very frail, long term residents who require skilled nursing care and a younger population of residents who are short term, post hospitalization, rehab, therapy, post-acute care residents.

Section Summaries

The following sections include information collected from the provider surveys for Assisted Living / Residential Care, Home Health, Hospice and Psychiatric Residential Treatment Facilities.

Residential Care / Assisted Living Summary

In 1987, Act 537 placed Residential Care Facilities (RCF) under the Permit of Approval process. Act 1230 of the 2001 Legislative session was enacted to create the Assisted Living Program with encouragement to develop innovative and affordable assisted living housing for low to moderate-income persons. The statute also allowed Residential Care Facilities (RCFs) to convert to Assisted Living Facilities (ALFs) without meeting physical plant requirements for assisted living. DHS drafted language for ALF licensure and in an effort to reach consensus, the Department of Human Services developed a split-level acuity with ALF Level I and ALF Level II. The ALF Level I was virtually identical to an RCF, therefore, in 2005, there was a moratorium placed on new construction of RCFs. The exception to this rule would be replacement applications for RCFs of sixteen (16) beds or less.

The current methodology, adopted in 2007 allows beds based on 30/1000 per persons 65 years and older in the county population.

According to Act 1271 of 2005 the Health Services Permit Agency is authorized to collect utilization statistics annually from health facilities requiring a permit of approval. The report below represents data from the 2013 Assisted Living Annual Report, collected via an Internet based survey of all Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) in each of Arkansas' 75 Counties. The purpose of the mandatory survey was to determine the basic characteristics of ALFs and RCFs in Arkansas.

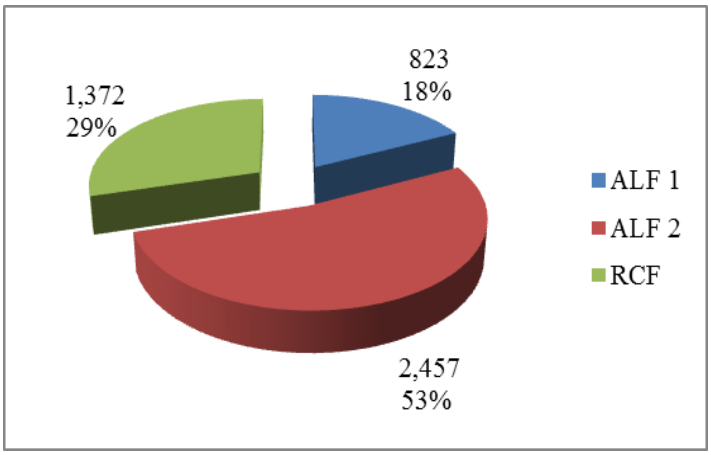
The report below represents 2013 data collected via an Internet based survey of all Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) in each of Arkansas' 75 Counties. The purpose of the mandatory survey was to determine the basic characteristics of ALFs and RCFs in Arkansas.

According to Act 1271 of 2005 the Health Services Permit Agency is authorized to collect utilization statistics annually from health facilities requiring a permit of approval. This survey included 38 RCFs, 13 ALF Level 1, and 37 ALF Level 2 Facilities.

Survey Results

There were 4,652 licensed ALF and RCF beds and 3,197 rooms reported for the 2013 Annual Survey. The average number of beds per facility was 53, with 1.46 beds per room. There were thirteen facilities that had 20 or fewer beds, while eighteen facilities had 80 or more beds. There was at least one RCF or ALF in 43 of Arkansas' 75 Counties.

Figure 2. ***ALF and RCF Licensed Beds***



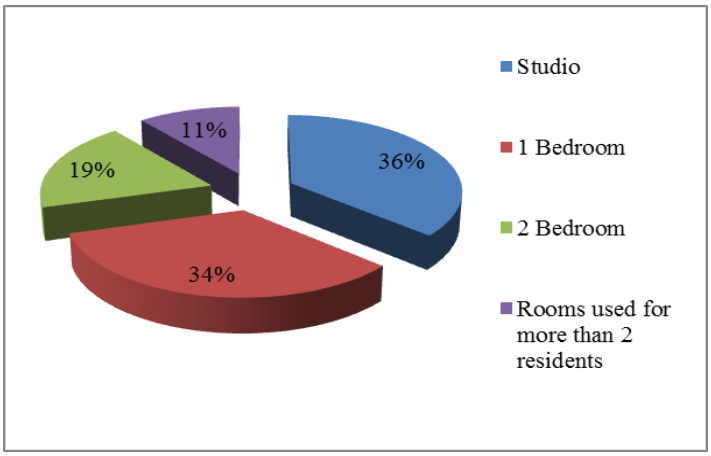
ALF

Act 1230 of 2001 created the category of ALFs in Arkansas and allowed RCFs to convert to either an ALF 1 or ALF 2. However, the first ALF applications were not received until May 2002. In 2013, there were 3,280 total ALF beds (823 ALF Level 1; 2,457 ALF Level 2). The average bed count for an ALF was 66.2 beds, with 1.31 beds per room. Overall the facilities were newly built with the majority being less than seven years old. RCFs are older than ALFs with half of them being over 27 years old, while over half of the ALFs (59%) were under seven years old.

RCF

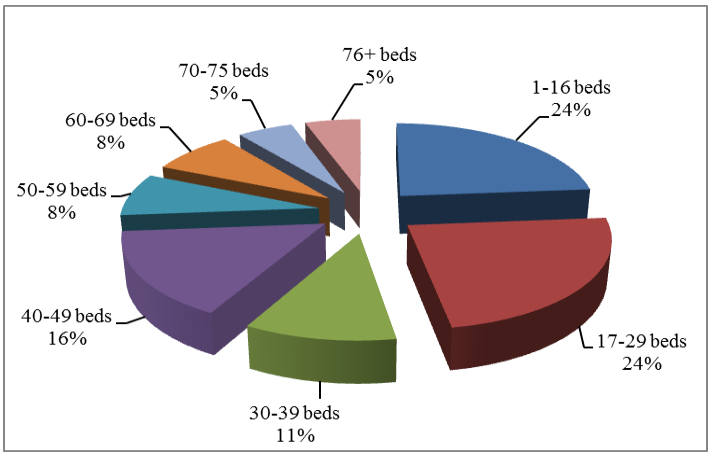
There were 1,372 RCF beds reported in 2013. RCFs as a whole are also smaller than ALFs. The average number of beds per RCF facility was 37.1. RCFs also house more residents per room than an ALF. The average number of beds per room for a RCF was 1.96 beds.

Figure 3. ***RCF Rooms by Type***



The mean score for licensed ALF beds (M=64.86, SD=23.88, N=50) was significantly larger than the RCF licensed beds (M=37.08, SD=24.27, N=38).

Figure 4. ***RCFs by Number of Beds***



Occupancy Rates

The average estimated occupancy rate reported by the facilities was 64%. When the facilities with a reported occupancy rate of zero were excluded, the average occupancy rate was 77%. An occupancy rate was also calculated by dividing the number of resident occupancy days (RODs) by the number of days that residents are using beds or that beds are being held for residents. After removing the facilities that reported zero RODs, the average occupancy percentage for ALFs and RCFs (N=81) was 53%. The average calculated occupancy rate of those facilities with at least one day of residents using beds or where beds are being held was 62% (N=69).

County Bed Population Sizes

According to bed population, the five highest (Arkansas, Benton, Faulkner, Pulaski, Washington), middle (Columbia, Grant, Johnson, Madison, Van Buren), and lowest populated counties (Jackson, Lee, Little River, Miller, Woodruff) in the state were examined. The top five Counties accounted for 33% of all ALF and RCFs and 38% of all beds. While the average facility size was larger for the middle counties compared to the higher or lower counties (72 beds vs. 61 beds vs. 10 beds).

Admissions by Age and Gender

There are significant differences between ALFs and RCFs in the admissions by age and by gender. The majority of ALF residents fall into the 75+ age group, with women typically outnumbering men by two to one in all age categories except <65. The RCF admissions are much higher amongst men, than women, in the less than 65 year old category (181 vs. 90). The 75-84 year age group and 85+ age groups of RCFs swing back to women outnumbering men by two to one.

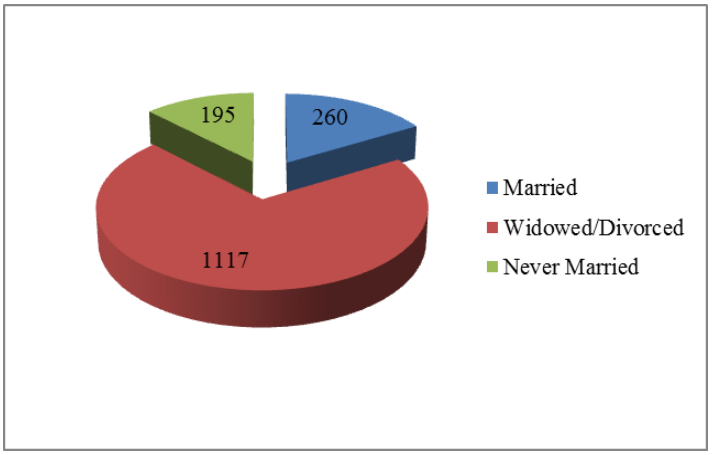
Table 7. ***Admissions by Age and Gender***

AGE	M ALF1	F ALF 1	M ALF 2	F ALF 2	M RCF	F RCF	Total
<65	1	5	19	17	181	90	**313**
65-74	5	22	28	53	40	50	**198**
75-84	42	86	70	222	24	56	**500**
85+	61	115	91	267	39	107	**680**
Total	**109**	**228**	**208**	**559**	**284**	**303**	**1,691**

Admissions by Marital Status and Race

Approximately 71% of all admissions were widowed, divorced, or separated; 12% were never married and 17% of residents were married. Residents were overwhelmingly white (92%) vs. African American (7%). Of the 54 counties with either an ALF and/or RCF, 27 counties did not admit any African Americans. The six counties with the highest number of African-American admissions accounted for 75% of all African-Americans admitted.

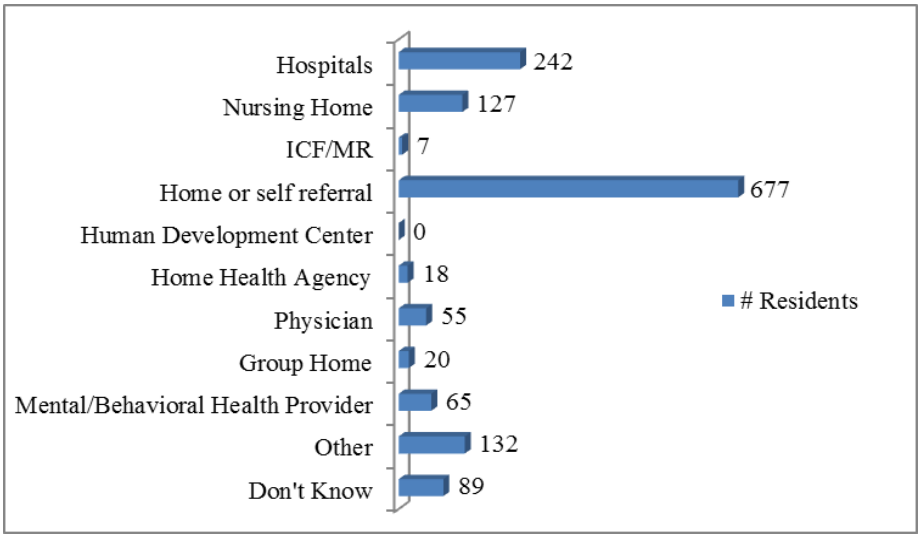
Figure 5. ***Number of Admissions by Marital Status***



Referral Sources and Residence Prior to Admission

Approximately 47% of referrals came from home or self-referrals, followed by hospitals at 17% (see Figure 6, below). Half of all residents were admitted from their own home. Patients are most often discharged to nursing homes, their own home, or death.

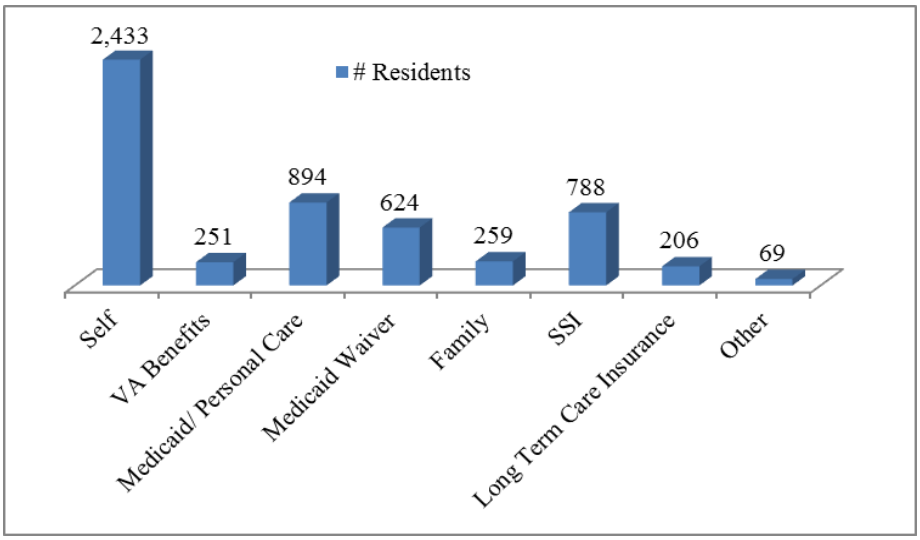
Figure 6. ***Referral Source of Residents***



Residential Reimbursement

The top three methods of payment for residents of ALFs and RCFs are: Self pay (44%), Medicaid/Personal Care (16%), and Social Security Income (14%). Other methods of payment include: Medicaid Waiver, VA Benefits, Family, etc.

Figure 7. ***Source of Payment by Residents***



According to the survey results, only Assisted Living Level 2 Facilities reported Medicaid Waivers. Of the 37 ALF 2 facilities, 22 accepted Medicaid waivers. The average number of waivers per facility was 27 beds, with a range between 4 and 74 beds.

Table 8. ***Number of Medicaid Waivers by Facility***

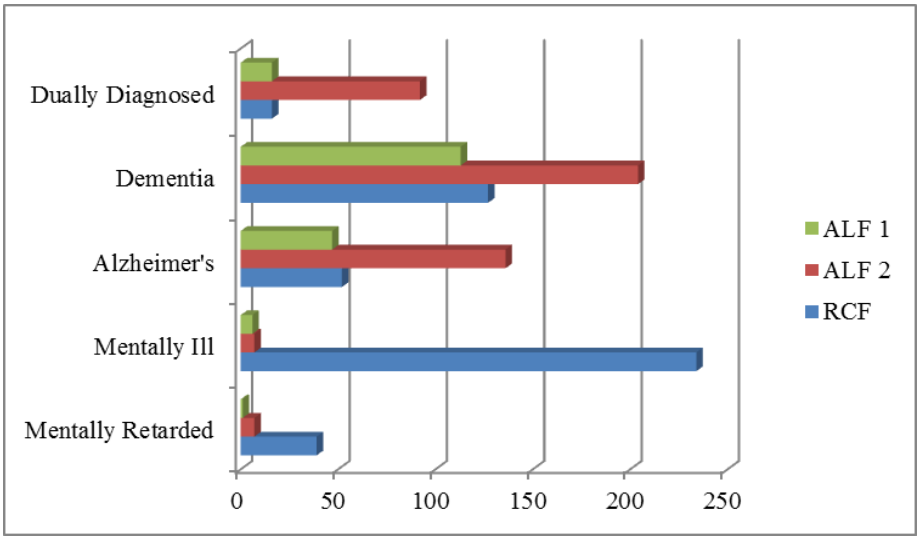
Facility Name	County	# Lic. Beds	Med. Waiver%	# Medicaid Waiver Beds
The Crossing at Malvern	Arkansas	84	45.2	38
The Pillars...of the Community	Ashley	75	36.0	27
RiverLodge Assisted Living	Baxter	75	14.7	11
Gardens at Osage Terrace	Benton	55	67.3	37
Green Acre Lodge	Carroll	41	46.3	19
The Plaza at Twin River	Clark	55	32.7	18
Magnolia Manor	Clay	36	61.1	22
Southridge Village Retirement Center	Cleburne	89	33.7	30
Dudneywood Retirement and Assisted Living	Columbia	80	5.0	4
Hope's Creek Retirement & Assisted Living	Crawford	118	62.7	74
Southridge Village of Conway	Faulkner	80	18.8	15
Crown Point Retirement	Grant	69	62.3	43
Eagle Mountain Assisted Living	Independence	58	12.1	7
Garden Pointe Living Center	Jefferson	60	26.7	16
The Gardens at Whispering Knoll	Jefferson	40	107.5	43
Whispering Knoll	Jefferson	40	70.0	28
Southridge Village Assisted Living of Cabot	Lonoke	80	20.0	16
Countryside Assisted Living, LLC	Madison	75	49.3	37
The Oaks at Mena	Polk	40	55.0	22
Madison Residential Care	Pulaski	32	46.9	15
Mercy Crest Retirement Living	Sebastian	102	63.7	65
Providence Assisted Living	White	46	8.7	4
Total	**22 counties**	**1,430**	**41.3**	**591**

Note: Counties are listed as reported in the survey results.

Diagnosis

The respondents were asked to identify residents based on certain diagnoses. The diagnoses were: mentally retarded, mentally Ill, Alzheimer's, Dementia, or dually diagnosed. The ALF facilities had fewer residents that were either mentally retarded or had a mental illness (8 and 13), vs. RCF (39 and 234, respectively). However, the ALFs did have more residents that had either Alzheimer's or Dementia (183 and 317) than the RCFs (52 and 127).

Figure 8. ***Type of Diagnosis by Facility Type.***



	Mentally Retarded	Mentally Ill	Alzheimer's	Dementia	Dually Diagnosed
RCF	39	234	52	127	16
ALF 2	7	7	136	204	92
ALF 1	1	6	47	113	16

Home Health

Act 956 of 1987 placed Home Health services under the Permit of Approval process and defined home health as the provision and coordination of acute, restorative, rehabilitative, maintenance, preventive or health promotion services through professional nursing or by other therapeutic services such as physical therapy, occupational therapy, speech therapy, home health aide or personal services in a client's residence. Home Health (HH) agencies were defined as agencies licensed to provide the above referenced services. A HH agency can be defined as a person, partnership, association, corporation or other organization that is public or private, proprietary or nonprofit.

Many of the existing HH agencies were "grandfathered" into the system at the time of the above referenced Act 956. These agencies were either licensed by the Arkansas Department of Health or they had a license application or intent to apply in progress. This group of "grandfathered" HH agencies had geographic service areas that were not defined by county lines as is required by the Permit of Approval. Because the Department of Health's license requirement allowed a maximum service area of 50 miles, these HH agencies had service areas of either the county or a geographic radius of up to 50 miles. By Agency calculation, a 50 mile radius can cover 7,850 square miles. Therefore, many of these agencies overlap several counties and will serve complete county areas and small to large portions of multiple counties. In fact, one HH agency can cover as many as twenty (20) partial counties.

Of the four surveys conducted by the Health Services Permit Agency, the Home Health Survey is the most difficult to conduct and analyze. There are several reasons for this, but a large portion of the difficulty is related to the number of HH agencies and the joint effort of the Agency and providers to collect county specific data and information for agencies that are licensed to cover geographic areas that overlap multiple counties. Another difficulty is the wide range of service types and professions that are involved in the delivery of home health services. Collection of this data by payor source, staffing and types of services as well as data on patients makes this survey the largest volume of data to be collected and analyzed.

There are 219 licensed HH agencies according to the Provider List and License Verification published by the Dept. of Health, Office of Health Facilities Services. While at first glance, this number appears rather high, in reality the number can be reduced to 77 parent HH agencies. For example, the Arkansas Department of Health Home Health Agencies account for 74 of the 219 (34%) Home Health Agencies. Because of the POA process, and its county by county application process, there are other HH agencies around the state that are individually licensed for different counties, but are the same company (e.g., Area Agency on Aging of Southeast Arkansas, Inc. - Arkansas County, Area Agency on Aging of Southeast Arkansas, Inc. – Ashley, Area Agency on Aging of Southeast Arkansas, Inc. - Bradley, etc.). If the Arkansas Department of Health Home Health is counted, as well as other multiple county licensed Home Health Agencies, as one Agency, there is a more realistic view of the number of operating HH in Arkansas. However, for our survey purposes, all home health agencies must respond on a county by county basis.

Although the HH Survey is quite large and there are a variety of ways in which to look at it, the Agency has chosen to analyze the survey from the following perspectives, as shown below.

AGE

Proportionally speaking, the age of admission for HH patients appear to be fairly similar regardless of whether the patient is a personal care or intermittent admission. The number of admissions amongst 19-64 year olds, 65-74 year olds, and 75-84 year olds are high and within a few percentage points of each other (28%, 24%, and 28% for Intermittent Admissions; 32%, 21%, and 23% for personal admissions, respectively).

In comparison to personal care, the percentage of 0-1 year olds amongst intermittent admissions is significantly larger at 1.22%. In personal care admissions, this age group only accounted for 0.03%, or 2 total admissions.

Table 9. ***Intermittent Admissions by Age***

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	713	406	16,350	14,160	16,039	10,572	**58,240**
	1.22%	0.70%	28.07%	24.31%	27.54%	18.15%	**100.00%**

Table 10. ***Personal Care Admissions by Age***

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	2	130	2,351	1,552	1,632	1,535	**7,202**
	0.03%	1.81%	32.64%	21.55%	22.66%	21.31%	**100.00%**

Profession Discipline and Payor Source

There were 899,657 skilled nursing visits in Arkansas in 2013 and 3,027 Registered Nurses and Licensed Practical Nurses (2,192 and 835, respectively) that worked for the Home Health Agencies in the state. That averages to 297 nursing visits per year or 0.81 visits per day.

Home Health Aides account for the second largest number of visits to patients' homes. There were 489,762 Home Health Aides visits in 2013. There were 1,510 Home Health Aides and 5,125 Part Time Aides for a total of 6,635

employees. That represents 55% of the Home Health employees in the state. Of the 6,635 Aides, 5,484 (83%) were part-time or contract employees, only 17% were full-time employees. By contrast, 73% of the RNs were full time employees.

Table 11. ***Professional Discipline by Payor Source***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	648,235	113,469	126,518	5,792	5,643	**899,657**
Physical Therapy Visits	318,984	17,105	59,518	1,596	1,425	**398,628**
Speech Pathology Visits	19,612	2,020	3,249	78	57	**25,016**
Occupational Therapy Visits	54,856	633	7,872	112	41	**63,514**
Medical Social Services Visits	4,866	2,674	944	388	56	**8,928**
Home Health Aide Visits	258,261	197,351	19,675	12,459	2,016	**489,762**
Other	1,426	113,686	1,658	3,641	27	**120,438**
Total	**1,306,240**	**446,938**	**219,434**	**24,066**	**9,265**	**2,005,943**

Table 12. ***Professional Discipline by Payor Source Percentage***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	72.05%	12.61%	14.06%	0.64%	0.63%	**100.00%**
Physical Therapy Visits	80.02%	4.29%	14.93%	0.40%	0.36%	**100.00%**
Speech Pathology Visits	78.40%	8.07%	12.99%	0.31%	0.23%	**100.00%**
Occupational Therapy Visits	86.37%	1.00%	12.39%	0.18%	0.06%	**100.00%**
Medical Social Services Visits	54.50%	29.95%	10.57%	4.35%	0.63%	**100.00%**
Home Health Aide Visits	52.73%	40.30%	4.02%	2.54%	0.41%	**100.00%**
Other	1.18%	94.39%	1.38%	3.02%	0.02%	**100.00%**
Total	**65.12%**	**22.28%**	**10.94%**	**1.20%**	**0.46%**	**100.00%**

Referral Source

Most of the Home Health referrals (79%) were from hospitals (46%) and physicians (33%). The remaining 21% are spread out among five other categories.

Among Intermittent admissions, hospital referrals account for 48% of the admissions and physician referrals account for 35%. This closely mirrors the overall figures above, with the intermittent admissions accounting for 94% of the admissions.

Personal Care admissions are distributed with the Family/Friend/Self category accounting for 38% of the admissions, Physician 18%, "Other" 13%, and Hospital 13%.

Table 13. ***Referral Source by Type of Admission***

State Totals	Hospital	Rehab Facility	Physician	Payor (HMO, PPO, etc.)	Family/ Friend/ Self	Nursing Home	Other	Total
Intermittent	28,252	4,610	20,434	185	657	2,474	2,572	**59,184**
Personal Care	496	114	676	456	1,459	111	501	**3,813**
Extended Care	38	2	9	1	3	0	5	**58**
Total	**28,786**	**4,726**	**21,119**	**642**	**2,119**	**2,585**	**3,078**	**63,055**

Table 14. ***Referral Source by Type of Admission Percentage***

State Totals	Hospital	Rehab Facility	Physician	Payor (HMO, PPO, etc.)	Family/ Friend/ Self	Nursing Home	Other	Total
Intermittent	47.74%	7.79%	34.53%	0.31%	1.11%	4.18%	4.35%	**100.00%**
Personal Care	13.01%	2.99%	17.73%	11.96%	38.26%	2.91%	13.14%	**100.00%**
Extended Care	65.52%	3.45%	15.52%	1.72%	5.17%	0.00%	8.62%	**100.00%**
Total	**45.65%**	**7.50%**	**33.49%**	**1.02%**	**3.36%**	**4.10%**	**4.88%**	**100.00%**

Staffing

Home Health is equally distributed among full-time, part-time, and contract labor (36%, 28%, and 35%, respectively). However, the percentage of staff in a particular field can vary widely from each of the categories. Three examples of this can be seen among the RNs, Aides, and Clerical Staff.

Overall, RNs account for 18% of the total population of Home Heath employees, but compose 37% of all fulltime employees. Seventy-three percent (73%) of the RNs are employed fulltime.

The part time aides category, whose nomenclature in and of itself would suggest that the employees would be made up of only part time or contract labor, surprisingly is comprised of 15% full time employees. The remainder of the part time aides are split between part time (28%) and contract labor (57%).

The vast majority of the clerical staff (93%) is made up of full time employees, with only 5% being part time, and 2% being contract. Overall only 7% of the home health staff are clerical.

Therapists (physical, speech, and occupational) are employed mainly on a contract basis. Of the therapists, physical therapists account for over four times the number of speech and occupational therapists (7.7% vs. 1.7% and 1.7%). Contract labor accounts for 66% of the physical therapists, 59% of the speech therapists, and 61% of the occupational therapists.

Table 15. ***Staffing Information***

State Totals	RN	LPN	Physical Therapist	Speech Therapist	Occupational Therapist	Medical Social Worker	Home Health Aides	Part Time Aides	Clerical Staff	Total
Full Time	1,609	371	267	24	54	59	399	752	790	**4,325**
Part Time	460	333	45	60	27	36	959	1,438	46	**3,404**
Contract	123	131	614	120	126	25	152	2,935	16	**4,242**
Total	**2,192**	**835**	**926**	**204**	**207**	**120**	**1,510**	**5,125**	**852**	**11,971**

Table 16. ***Staffing Information Percentage***

State Totals	RN	LPN	Physical Therapist	Speech Therapist	Occupational Therapist	Medical Social Worker	Home Health Aides	Part Time Aides	Clerical Staff	Total
Full Time	37.20%	8.58%	6.17%	0.55%	1.25%	1.36%	9.23%	17.39%	18.27%	**36.13%**
Part Time	13.51%	9.78%	1.32%	1.76%	0.79%	1.06%	28.17%	42.24%	1.35%	**28.44%**
Contract	2.90%	3.09%	14.47%	2.83%	2.97%	0.59%	3.58%	69.19%	0.38%	**35.44%**
Total	**18.31%**	**6.98%**	**7.74%**	**1.70%**	**1.73%**	**1.00%**	**12.61%**	**42.81%**	**7.12%**	**100.00%**

Unduplicated Admissions

Table 17. ***Unduplicated Admissions***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	40,386	5,562	9,886	520	702	**57,056**
Personal Care	11	3,761	485	314	24	**4,595**
Extended Care	0	48	17	3	0	**68**
Total	**40,397**	**9,371**	**10,388**	**837**	**726**	**61,719**

Table 18. ***Unduplicated Admissions Percentage***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	70.78%	9.75%	17.33%	0.91%	1.23%	**100.00%**
Personal Care	0.24%	81.85%	10.55%	6.83%	0.52%	**100.00%**
Extended Care	0.00%	70.59%	25.00%	4.41%	0.00%	**100.00%**
Total	**65.45%**	**15.18%**	**16.83%**	**1.36%**	**1.18%**	**100.00%**

Hospice Services and Facilities

Act 396 of 1997 required separate Permits of Approval for hospice facilities and hospice agencies and required the Health Services Permit Agency to develop criteria for granting POAs for each category of service. The methodology for hospice services was adopted in 2001 and the methodology for hospice facilities was not adopted until 2002.

Hospice care as defined by state statute means an autonomous, centrally administered, medically directed, coordinated program providing home and outpatient care for the terminally ill patient and family, and which employs an inter-disciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement. The care shall be available twenty-four (24) hours a day, seven (7) days a week, and provided based on need, regardless of the ability to pay.

A hospice program is defined as an agency or organization that is primarily engaged in providing care to terminally ill individuals. A hospice facility is defined as a facility that houses hospice beds licensed exclusively to the care of terminally ill patients but not beds licensed to a hospital, nursing home or other assisted living or residential facilities. It can provide any of the four levels of hospice care. For purposes of this application, terminally ill patients are defined according to the Social Security Act as those individuals with a terminal diagnosis and a prognosis of six months or less if the diagnosed condition runs its normal course.

The initial hospice methodology used a formula that was based on a percentage of cancer deaths (55%) and a much smaller percentage (13-15%) of non-cancer deaths. The total of these percentages were subtracted from the total number of county deaths to determine a county's hospice need. Over time, national data reflected that hospice services were being utilized by a growing number of non-cancer patients with a prognosis that fit the hospice definition. The Agency survey of Arkansas hospice services reflected this same trend. Therefore, the methodology was changed in 2005 to reflect a percentage of all deaths. The percentage of hospice deaths for the determination of need is changed periodically to reflect national and statewide utilization and trends.

Nationally, hospice has grown significantly. Arkansas has seen a similar growth trend in that 30.5% of deaths were served by hospice in 2007 and by 2013 42.0% of deaths in Arkansas were served by hospice. The percent of deaths

served by hospice was calculated by dividing the sum of the number of deaths in hospice care (not limited to inpatient facilities) from the quarterly hospice reports and by the total number of deaths in Arkansas reported by the Department of Health. According to the *Facts and Figures: Hospice Care in America* report by the National Hospice and Palliative Care Organization, 44.6% of U.S. deaths were served by hospice in 2011. This shows that Arkansas has a very similar utilization rate to the nation.

Although the number of deaths served by hospice was beginning to grow in Arkansas, there is an uneven distribution of the number served. In some areas of the state there appears to be a slower willingness to accept hospice services or to accept a death diagnosis that defines hospice. In some cases there are perhaps cultural or religious reasons that hospice has not been widely accepted. This is reflected in the number of deaths served even when hospice providers are licensed and available in the community.

The current hospice methodology is based on 30% of all deaths in the county as reported by the Arkansas Department of Health, Center for Health Statistics. Licensed hospice agencies report quarterly hospice deaths to the agency and these deaths are subtracted from the total deaths reported; this figure is the projected need. Numeric need for the county is demonstrated if the projected number of hospice patients for the previous four (4) quarters is 35 or greater in the county. Shown below in figure 10 is a map of Arkansas with the number of hospice agencies serving each county.

As illustrated on the graph below, the number of inpatient hospice beds has grown significantly since 2003. When inpatient hospice beds were initially placed under the POA process, forty (40) inpatient beds in the state were already licensed in Pulaski County. As of 2013, there are 230 licensed beds and 42 approved beds pending.

Figure 9. Number of Licensed Hospice Inpatient Beds 2003-2013

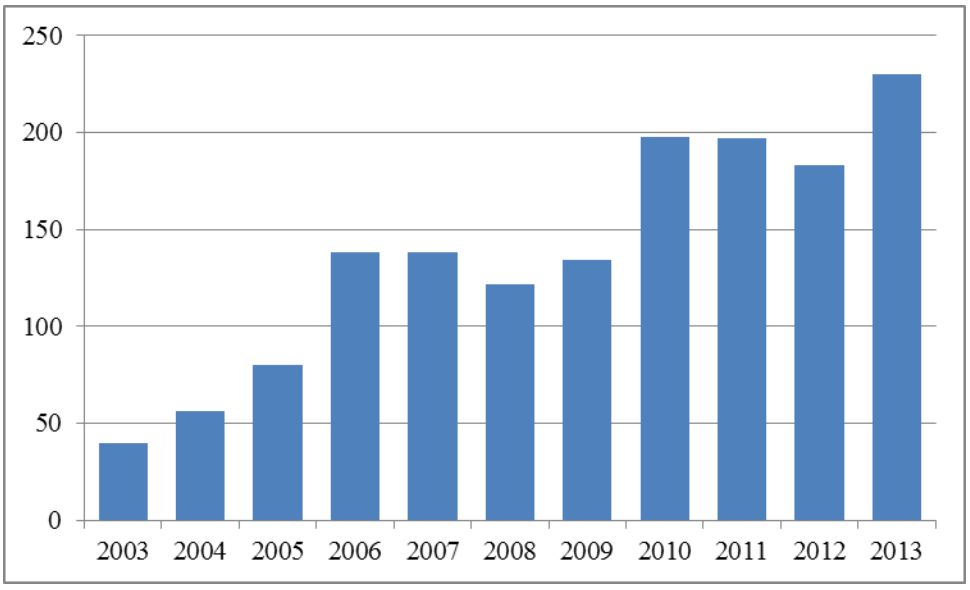
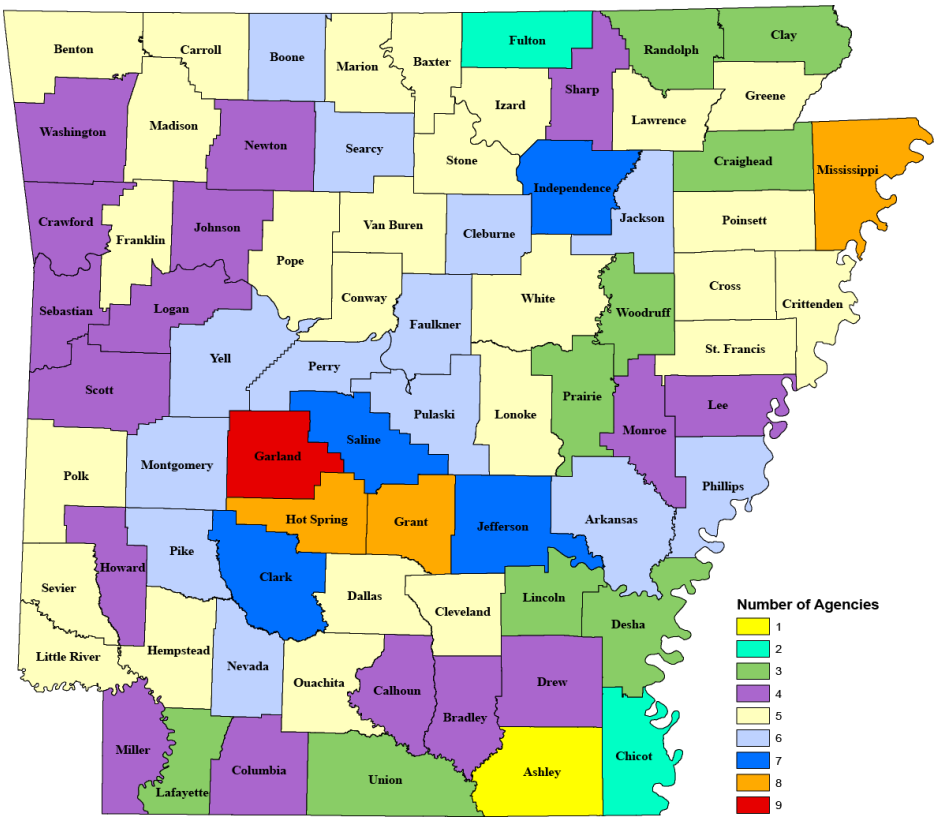
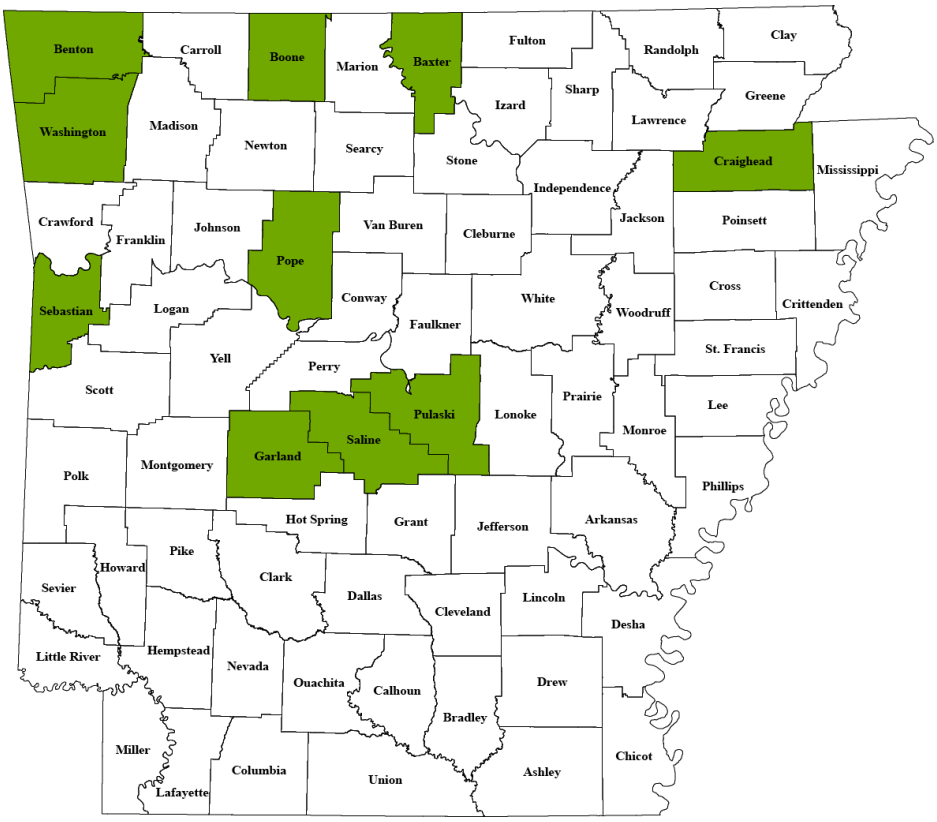


Figure 10. ***Number of Hospice Agencies per Counties in Arkansas***



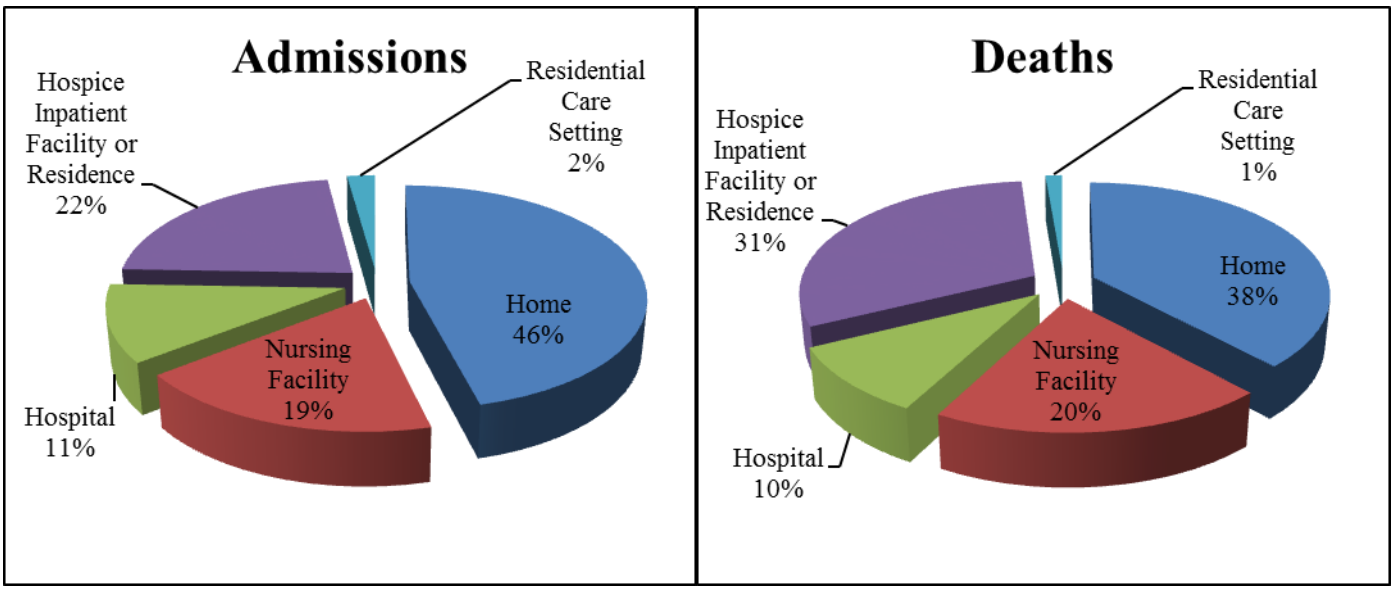
According to the 2013 survey, there are now hospice facilities in 10 of Arkansas's 75 counties (see the map below). There were 211 licensed beds reported across the 13 facilities.

Figure 11. ***Counties with Hospice Inpatient Beds in Arkansas***



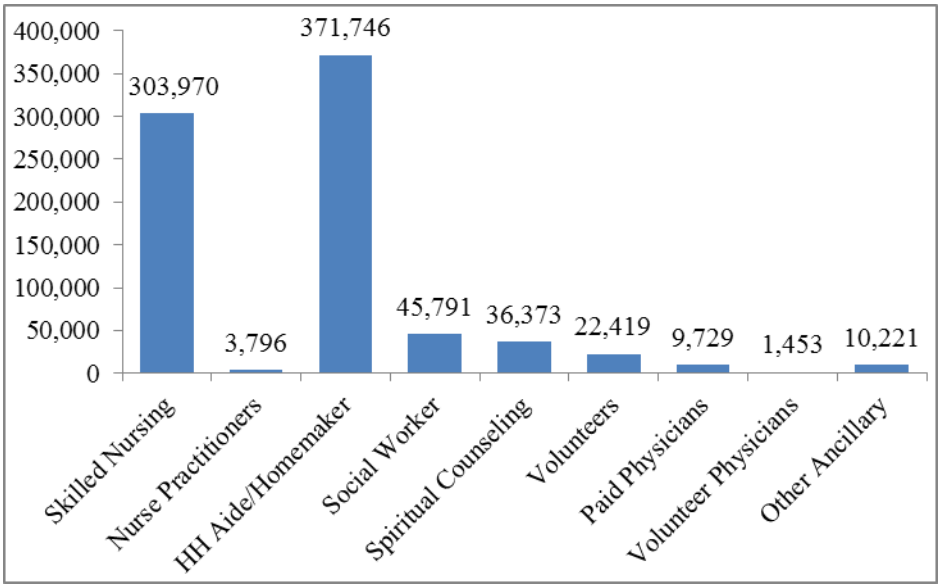
There is a slight difference in the percentage of admissions and deaths by location that is likely explained by post-admission transfers with hospice agencies. The most notable difference is Hospice Inpatient Facility admissions and deaths. While Hospice Inpatient Facility accounts for approximately 22% of all admissions, it makes up 31% of the hospice deaths. This can be accounted for by drops from admission to death percentages of Home, Hospital, and Residential Care Setting admissions (see chart below).

Figure 12. ***Hospice Admissions and Deaths by Location***



A look at patient visits by discipline (see chart below) shows that home health aide and skilled nursing visits account for the majority of visits by hospice personnel. In fact, nurses and aides account for 84% of patient visits. The remainder of the visits is lead by social workers (6%) and spiritual counselors (5%).

Figure 13. ***Patient Visits by Discipline***



PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) SUMMARY

Act 596 of 1987 called for all specialized psychiatric facilities to have a POA and license. At that time there were 226 existing PRTF beds that were "grand-fathered" into the system. The Need Methodology for PRTFs was established in 1995. According to this methodology, Arkansas projects 1.001 beds per 1,000 persons between 6-17 years old and 0.78 beds for 1,000 persons between the ages of 18-21. As of February 1, 2008, there is a moratorium on the construction or addition of PRTF beds.

The Health Services Permit Agency conducts a mandatory annual PRTF Report. According to Act 1271 of 2005 the Health Services Permit Agency is authorized to collect utilization statistics annually from health facilities requiring a permit of approval.

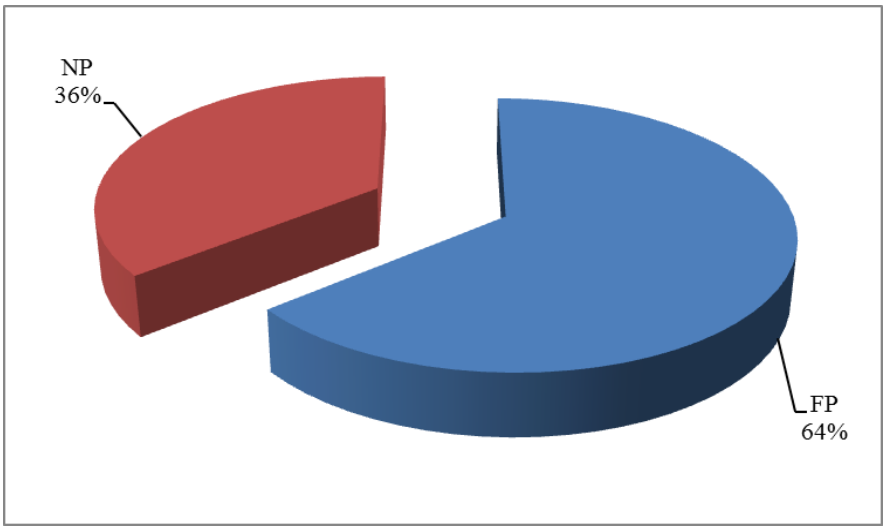
Survey Results

The survey respondents included eight PRTFs, which were made up of four for profits (FP) and four nonprofits (NP). There were 577 licensed beds and 360 resident rooms reported for 2013. The average number of beds per facility was 72, with 1.6 beds per room.

Licensed Beds

There were 577 licensed beds reported in 2013. The FPs accounted for 370 beds from four facilities, and the NPs had 207 beds from four facilities.

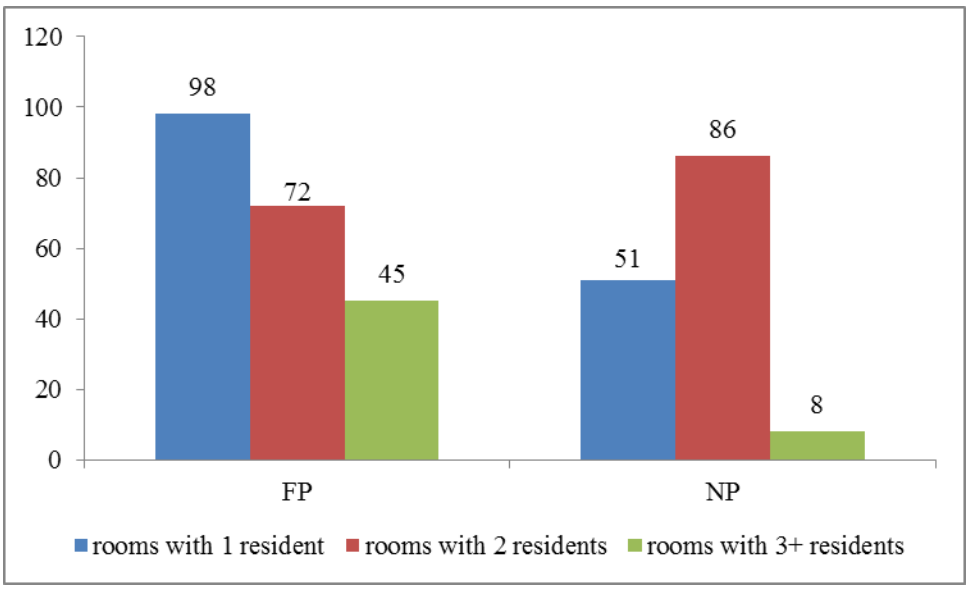
Figure 14. ***Licensed Beds by Type of Facility***



Average Number of Residents per Rooms

For all PRTFs, most of the rooms were utilized for one or two residents (41% and 44%, respectively.) The FPs had a larger percentage of rooms with three or more residents (21%) compared to NPs with only 6%. The majority of rooms in the NPs had two residents (59%.)

Figure 15. ***Type of Resident Room by Facility Type***



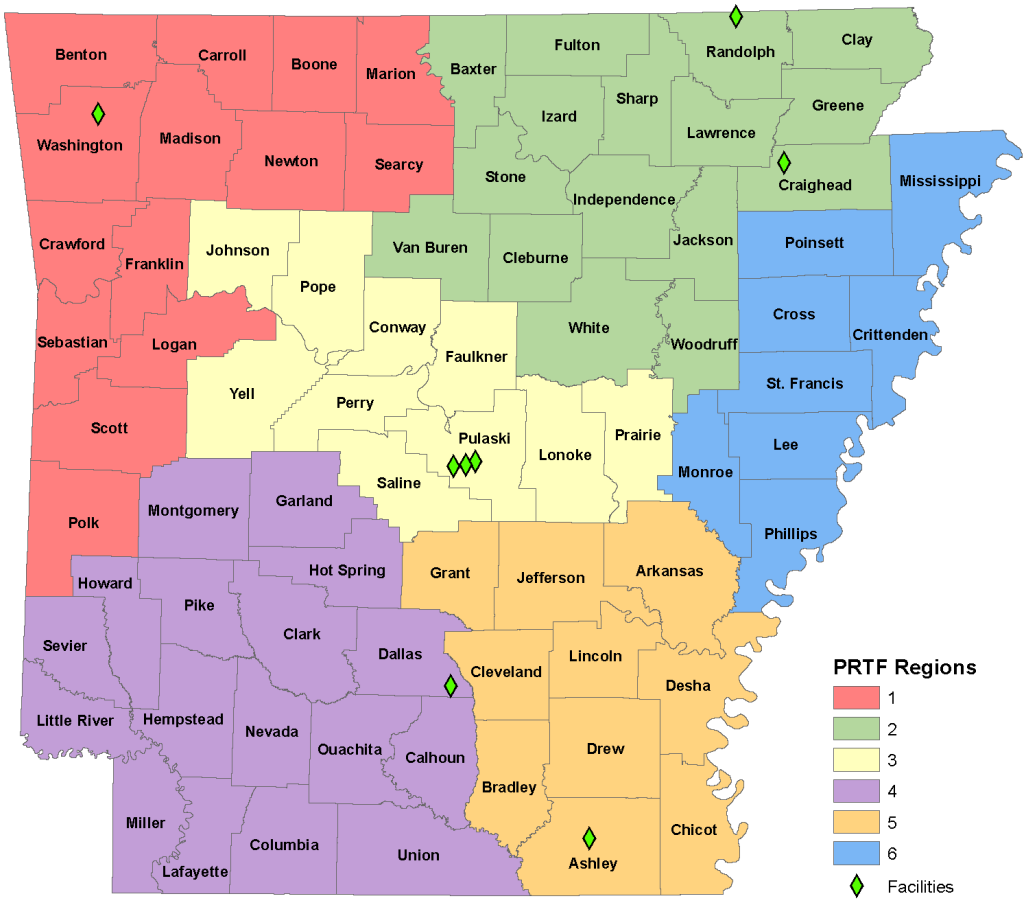
Payment Methods

In 2013, there were 182,355 total residential days and 1,048 admissions in the eight PRTFs. Arkansas Medicaid paid for 170,210, or 93.3%, of those days. The Medicaid cap for PRTFs is $350 per child per day; based on this rate, the potential cost to Arkansas Medicaid is $59,573,500 in 2013. The remaining 6.7% was covered by private insurance and "other" (as listed on the survey) forms of payment.

PRTFs and Host Counties

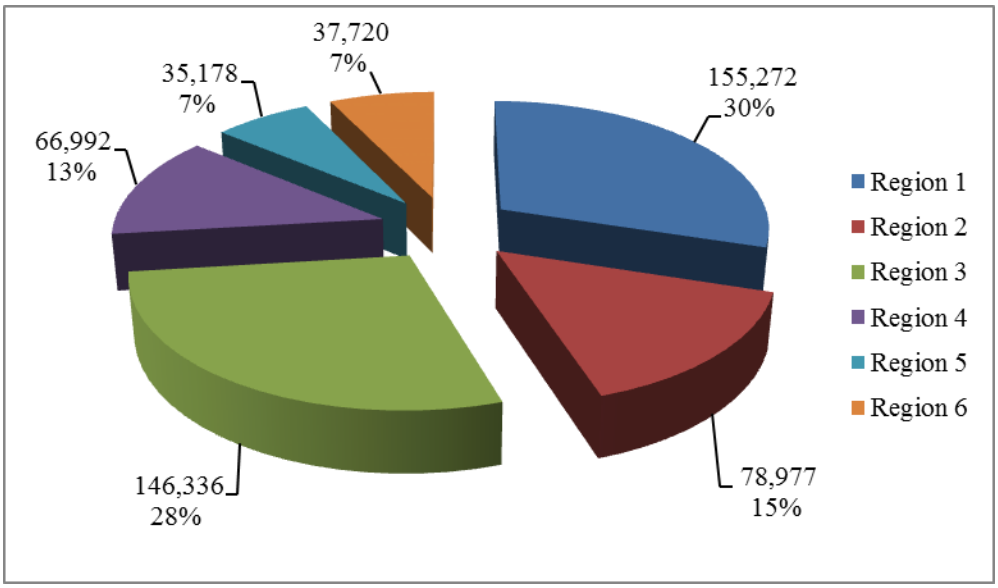
Arkansas is split into six PRTF regions (shown in the map below), which are serviced by the eight responding PRTFs around the State. Region 3, which includes Pulaski County, houses three PRTFs. Region 6 has no PRTFs which responded to the survey; Region 2 has two PRTFs, and the other regions (1, 4, and 5) have one PRTF each.

Figure 16. ***PRTF Regions and Locations of Facilities***



The six regions are not split evenly according to population. Regions 1 and 3 account for over half of the state's 2013 population projection, while the smallest regions (5 and 6) each comprise only 7% of the state's population.

Figure 17. ***Population by Region***



Occupancy Rates

Occupancy rate was calculated by taking the number of occupied beds divided by the number of licensed and available beds. The occupancy rates by region are as follows:

Region 1 – 87%
Region 2 – 78%
Region 3 – 95%
Region 4 – 100%
Region 5 – 94%
Region 6 – NA
State Total – 90%

Figure 18. ***Overall Percentage of Patients Served by Number of Patients***

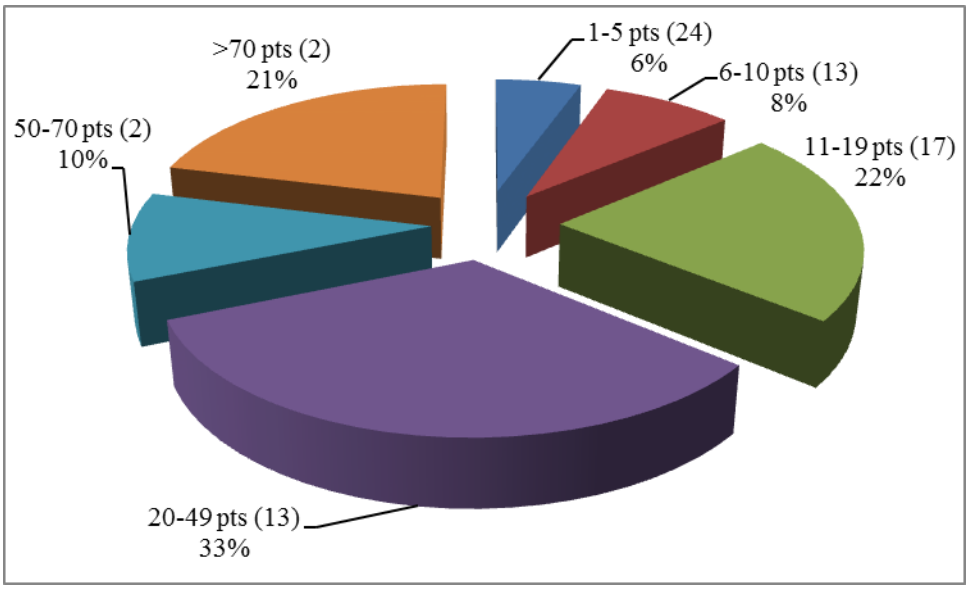


Table 19. Number of Patients Served Per County

Patients Per County	Total Patients Seen	County
>70 pts (2)	244	Garland, Pulaski
50-70 pts (2)	116	Faulkner, Craighead
20-49 pts (13)	380	White, Union, Crawford, Lonoke, Conway, Ashley, Jefferson, Pope, Hot Spring, Washington, Benton, Saline, Sebastian
11-19 pts (17)	255	Jackson, Arkansas, Bradley, Hempstead, St. Francis, Poinsett, Chicot, Cleburne, Yell, Drew, Miller, Grant, Ouachita, Greene, Mississippi, Clark, Independence
6-10 pts (13)	97	Crittenden, Cross, Desha, Franklin, Logan, Searcy, Van Buren, Boone, Pike, Polk, Baxter, Lincoln, Lawrence
1-5 pts (24)	63	Dallas, Sevier, Woodruff, Carroll, Fulton, Howard, Izard, Johnson, Lee, Little River, Marion, Newton, Scott, Clay, Columbia, Madison, Montgomery, Sharp, Stone, Nevada, Perry, Randolph, Cleveland, Phillips

Gender

Overall, there were significantly more males than females being served in PRTFs. There were 647 boys between the ages of 6-18 and 400 girls that were 6-18 years old. There were two facilities that had more female residents than males. Boys outnumbered girls across all age ranges and facility types, except for NP corporations 16-18 year olds, at which the girls outnumbered the boys by 3 children.

Age

The 11-15 year old range had the highest percentage of residents (60.9%), followed by 16-18 year olds (23.9%), and 15.2% of the residents were 6-10 years old.

Figure 19. ***Residents by Age***

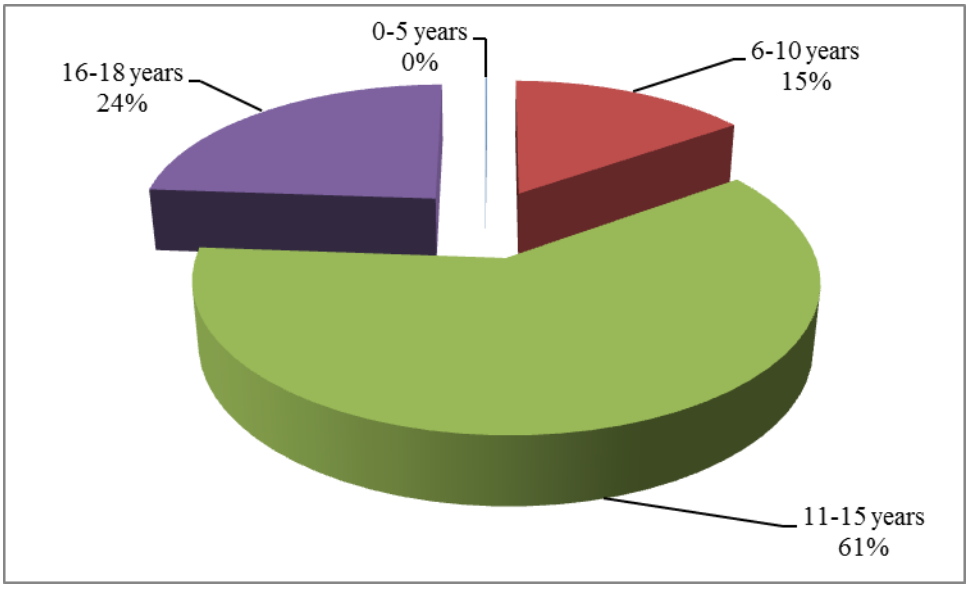
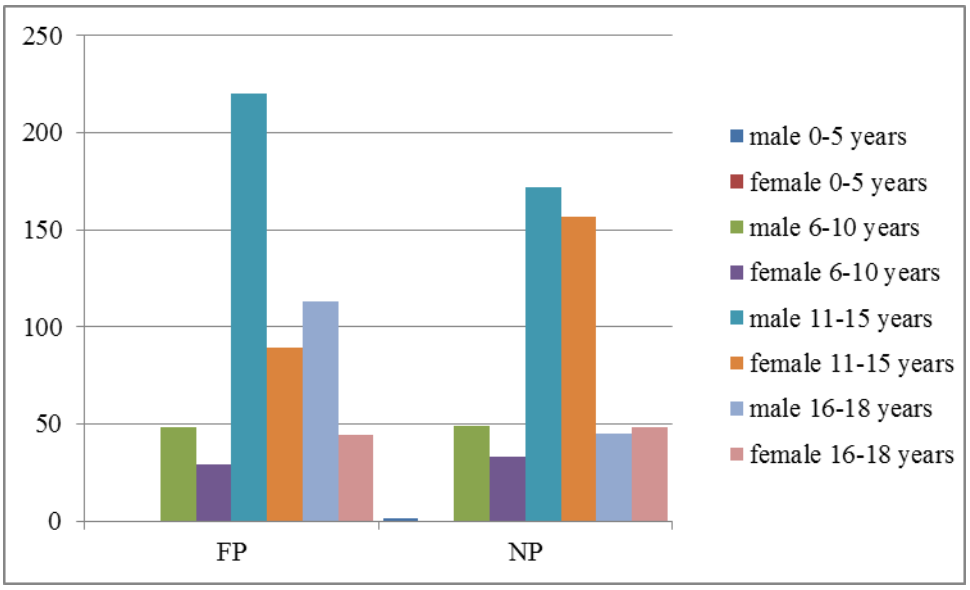


Figure 20. ***Sex and Age by Facility Type***



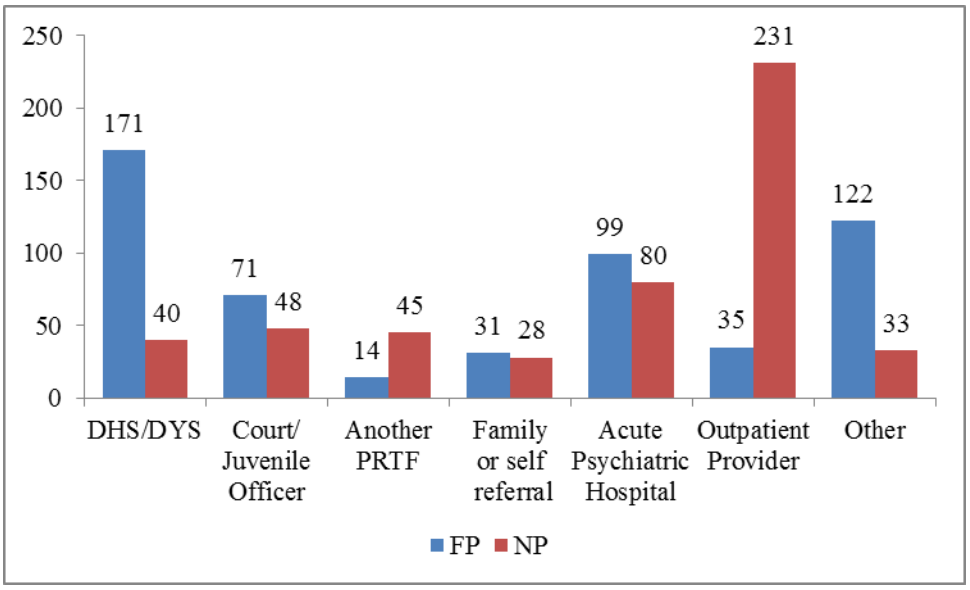
Race

According to the 2013 population projections 69% of children, in Arkansas, between the ages of six and eighteen are white and 18% are black (see Table 19 below), with the remaining 13% from other races. However, black children constitute a disproportionate 35% of the residents in PRTFs. Unlike the state level, the white-to-black ratio of PRTF residents in each region is highly correlated with the percentage of the total number of black and white residents living in each region. This is not true for Region 4, which show a much higher percentage of black residency compared to black population.

Table 20. Differences in race population percentages vs. PRTF residency percentages by Region

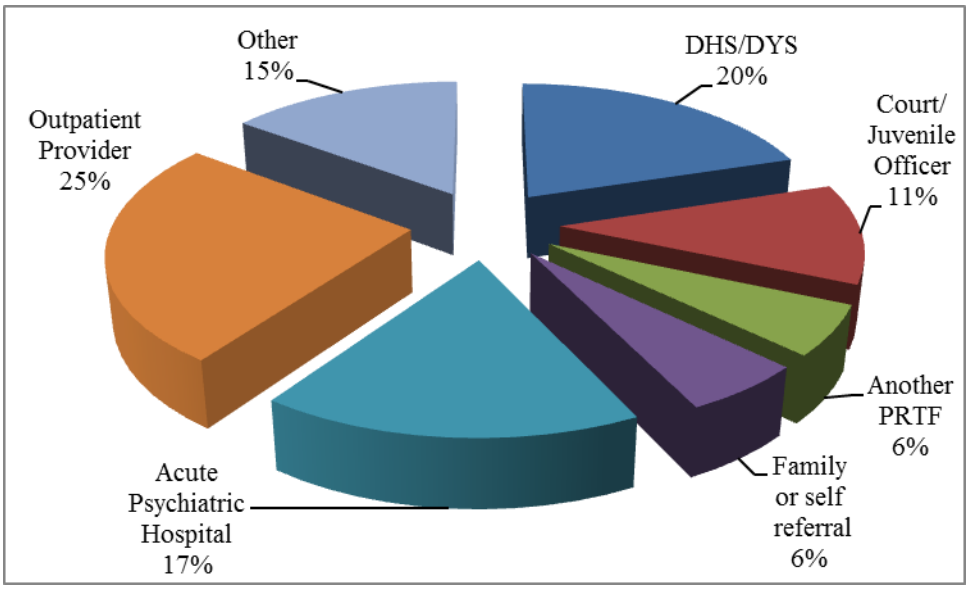
Area	% white pop 6-18	white PRTF residency %	% black pop 6-18	black PRTF residency %
Region 1	75.16	75.65	3.05	15.65
Region 2	85.95	73.39	7.39	14.16
Region 3	65.12	66.83	24.29	30.53
Region 4	65.14	19.21	24.34	75.11
Region 5	51.54	56.36	41.05	40.00
Region 6	45.23	NA	50.23	NA
Total	**68.92**	**58.30**	**18.41**	**35.50**

Figure 21. ***Resident Referral by Facility Type***



Note: Other is made up of Juvenile Detention Center, Emergency Shelter, School, and "Other."

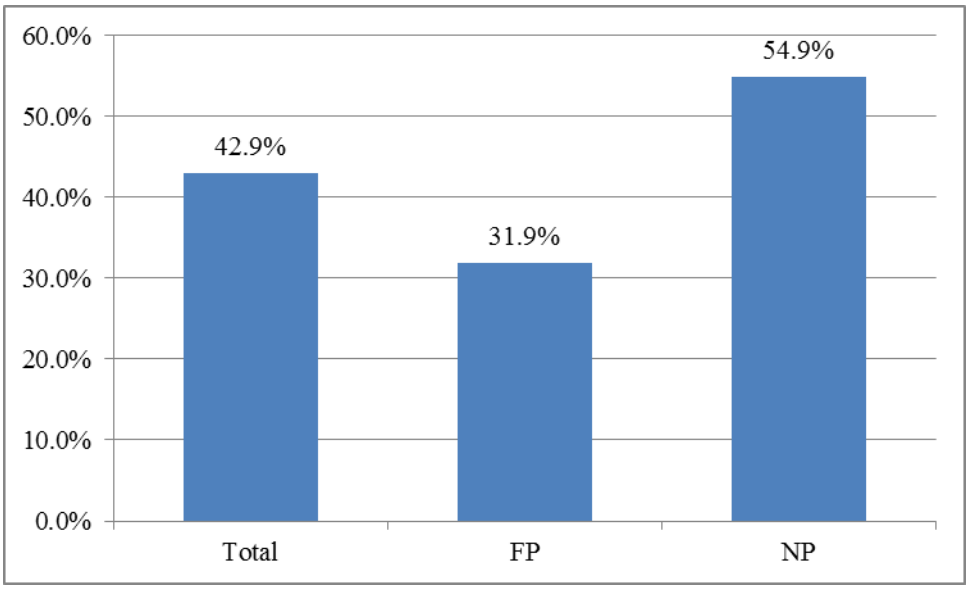
Figure 22. ***Percentage of Residents by Referral Source***



Readmissions

Of the 1,048 PRTF admissions in 2013, 450 (42.9%) of the children had previously been admitted to a PRTF or psychiatric hospital (see Figure 23 below). FPs had a lower level of readmission than NPs.

Figure 23. ***Percent Readmitted by Facility Type***



Discharged To

The survey examined where residents went after they were discharged from the PRTF. Ultimately, the long term goal may be to successfully integrate the child/adolescent into a supportive home like environment. The FP facilities returned 67.8% of their residents to the home or parent, most of the remaining 32.2% of discharged residents went to "other" (14.2%), foster care (10.4%), or group homes (3.7%). The NP corporations returned 63.7% of their residents to the parents' home, with foster care (12.5%), group homes (6.2%), other PRTF (5.6%) and hospitals (5.2%), accounting for a majority of the remaining residents.

Average Length of Stay

The average length of stay for an Arkansas resident in a PRTF was 172 days, or over five months (see Table 21 below). Half of the facilities had an average length of stay greater than six months. The NPs had the shortest average length of stay at 132 days. The FP residents stayed for two and a half months longer (207 days).

Table 21. ***Average Length of Stay by Facility Type***

Facility Type	Facility Name	Average LoS (days)	Average LoS (months)
FP	Delta Family Health and Fitness Center for Children, Inc.	139.2	4.6
FP	Piney Ridge Treatment Center	257.3	8.6
FP	Habilitation Center, Inc/dba Millcreek of Arkansas	182.0	6.1
FP	Trinity Behavioral Health Care System, Inc.	234.8	7.8
FP Total		**207.0**	**6.9**
NP	Youth Home, Inc.	213.6	7.1
NP	Centers for Youth & Families, Inc.	128.1	4.3
NP	United Methodist Children's Home Dacus PRTF	76.4	2.5
NP	United Methodist Children's Home Fillmore PRTF	101.9	3.4
NP Total		**131.9**	**4.4**

Out of State Facilities

The following data was provided by Arkansas Department of Human Services Division of Medicaid Services.

Table 22. ***Medicaid Days & Expenditures For Out-of-State PRTFs For Paid Dates in SFY 2013***

Provider State	Unduplicated Recipient Count	Medicaid Days Paid(SFY2013)	Paid Amount (SFY2013)
91 - STATE OF LOUISIANA	5	39	$19,748.00
92 - STATE OF MISSOURI	199	20,369	$6,371,337.31
93 - STATE OF MISSISSIPPI	32	1,014	$242,261.00
95 - STATE OF TENNESSEE	481	53,851	$18,734,258.05
96 - STATE OF TEXAS	2	680	$212,922.00
97 - ALL OTHER STATES	4	682	$325,214.00
Total:	**701**	**76,635**	**$25,905,740.36**

Medicaid Expenditure for In-State PRTFs for Paid Dates in SFY 2013 is $130,767,192.17

Note: The cap is $350/day/child and it does not differ from in state versus out of state and average length of stay is 106. We used Provider Type 25 and Provider speciality WA, WB, W3 to generate this report.

Table 23. ***Medicaid Days & Expenditures For Out-of-State PRTFs For Paid Dates in SFY 2014***

Provider State	Unduplicated Recipient Count	Medicaid Days Paid(SFY2014)	Paid Amount (SFY2014)
91 - STATE OF LOUISIANA	3	23	$11,477.00
92 - STATE OF MISSOURI	245	18,984	$6,710,232.90
93 - STATE OF MISSISSIPPI	21	1,079	$343,324.00
95 - STATE OF TENNESSEE	358	40,776	$14,165,474.89
96 - STATE OF TEXAS	2	313	$99,495.00
97 - ALL OTHER STATES	7	1,773	$817,530.00
Total:	**636**	**62,948**	**$22,147,533.79**

Medicaid Expenditure for In-State PRTFs for Paid Dates in SFY 2014 is $128,849,442.74

Note: The cap is $350/day/child and it does not differ from in state versus out of state and the average length of stay is 76.67. We used Provider Type 25 and Provider speciality WA, WB, W3 to generate this report.

Psychiatric Hospitals

Psychiatric Hospitals are not subject to the POA process and do not report to the Agency. However, their services can be very similar to the PRTFs that report to the Agency. Listed below are the nine psychiatric hospitals and their bed counts.

Miller County (Region 4)
Riverview Behavioral Health – 62 beds

Pulaski County (Region 3)
Arkansas State Hospital – 321 beds
Pinnacle Pointe Behavioral Healthcare System – 124 beds
The BridgeWay – 103 beds
United Methodist Behavioral Hospital – 60 beds

Saline County (Region 3)
Rivendall Behavioral Health Services of Arkansas – 77 beds

Sebastian County (Region 1)
Valley Behavioral Health System – 75 beds

Washington (Region 1)
Springwoods Behavioral Health Services – 80 beds
Vantage Point of Northwest Arkansas– 114 beds

Psychiatric Hospital Beds Totals
Region 1 – 269 beds
Region 3 – 685 beds
Region 4 – 62 beds
Total – 1,016 beds