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, Tracy Steele, the Assistant Director, the Program Manager, the Management Project Analyst, and the Administrative Specialist.

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.

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 2018 was $69,718.90.

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 2018 was $133,809.00 and 2018 were comprised of 84% SGR and 16% of the POA fund balance.

Table 1. ***Health Services Permit Agency Fiscal Year 2018 Budget and Revenue***

844 – HSPA	FY 2018
APPROVED BUDGET	$499,971.75
GENERAL REVENUE	$392,493.00
POA & COPY FEES	$69,718.90
TOTAL REVENUE	$462,211.90
TOTAL EXPENSES	$446,259.72

PERMIT OF APPROVAL REVIEW PROCESS

Fiscal Year 2018 reviewable projects included Nursing Facilities, 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 Intellectually Disabled (ICF/ID), Residential Care Facilities (RCF), and Psychiatric Residential Treatment 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: https://ahspa.arkansas.gov.

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 2018. 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 2018, there was one appeal 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 Intellectually Disabled (Act 593 of 1987) (Moratorium since 1987)
- Nursing Facilities (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 2018, thirteen (13) applications were approved, zero (0) were denied and zero (0) were withdrawn or returned. Agency decisions resulted in the approval of $ 60,758,194.00 in capital projects.

Table 3. ***Fiscal Year 2018 Applications***

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Facilities	3	$ 13,760,000	3	0	0
PRTF's (moratorium)	0	NA	0	0	0
Home Health	2	$ 190,600	2	0	0
Assisted Living	8	$ 46,807,594	8	0	0
Hospice Agencies	0	$ 0	0	0	0
Hospice Facilities	0	$ 0	0	0	0
Totals	**13**	**$ 60,758,194**	**13**	**0**	**0**

Table 4 illustrates the total applications received from FY 2010 - FY 2018 that the POA applications are averaging 31 applications per year. The largest impact appears to have been new construction or adding beds for Assisted Living Facilities. There is still a large need in many counties for new Assisted Living beds.

Table 4. ***Total Applications FY 2010 – FY 2018***

Type of Projects	2010	2011	2012	2013	2014	2015	2016	2017	2018
Nursing Facilities	10	7	8	13	13	7	5	8	3
RCF (Moratorium 07/05)	0	0	0	0	0	0	0	0	0
Assisted Living	13	16	29	17	17	27	9	20	8
Home Health	1	0	1	1	5	1	2	10	2
Hospice	6	0	1	6	1	0	0	0	0
Hospice Facility	1	3	1	0	0	0	7	0	0
PRTF (Moratorium 02/08)	0	0	0	0	1	0	0	0	0
ICF (Moratorium 03/94)	0	0	0	0	0	1	0	0	0
Total	**31**	**26**	**40**	**37**	**37**	**36**	**23**	**38**	**13**

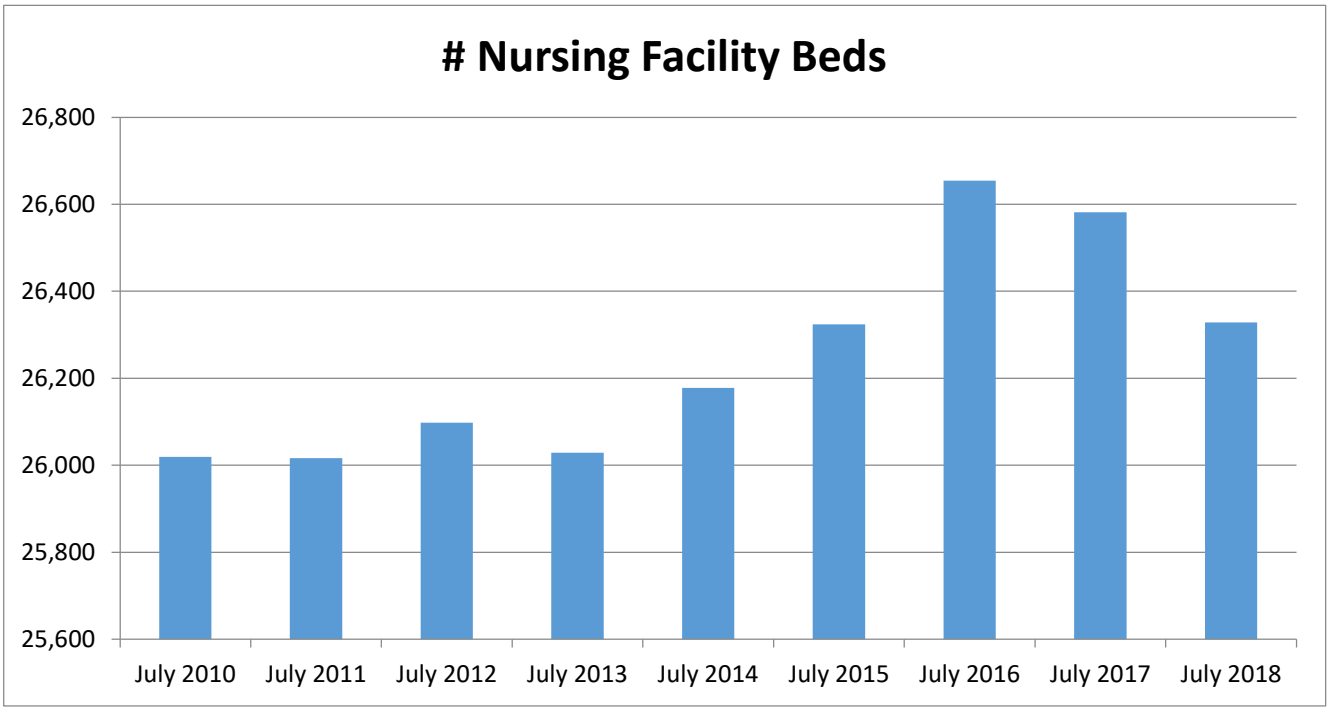
NURSING FACILITIES

Nursing Facilities 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 facility 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. The applicant must acquire the additional beds from a facility that averaged less than 70% occupancy for the previous 12-month period according to the most recent 12-month occupancy data available from Department of Human Services as reflected in the current quarterly published Bed Need Book. POAs for nursing facility 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 2018, the Nursing Facility net need was (-1,895) and the current bed need as of January 2019 is (-1,838).

Figure 1. ***Number of Nursing Facility Beds 2010-2018***



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 facilities are flat.
Replacement facilities were mentioned in a previous section. The Utilization Methodology allows facilities to acquire up to 25 additional beds if the county has no population based need and the applicant nursing facility 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 facilities 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 facilities, 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 facility 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 facility 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 2017 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.

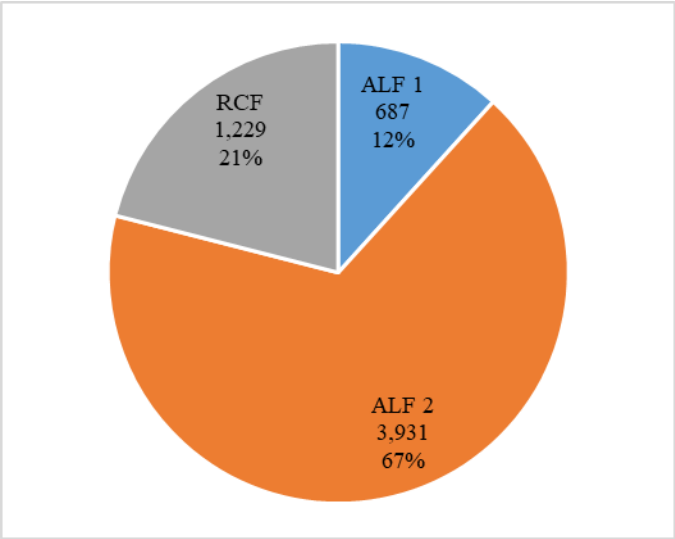
The report below represents 2017 data collected via an Internet based survey of all Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) in each of Arkansas' 75 Counties. The purpose of the mandatory survey was to determine the basic characteristics of ALFs and RCFs in Arkansas.

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 30 RCFs, 12 ALF Level 1, and 60 ALF Level 2 Facilities.

Survey Results

There were 5,847 licensed ALF and RCF beds and 4,754 rooms reported for the 2017 Annual Survey. The average number of beds per facility was 57, with 1.23 beds per room. There were ten facilities that had 20 or fewer beds, while 21 facilities had 80 or more beds. There was at least one RCF or ALF in 51 of Arkansas' 75 Counties.

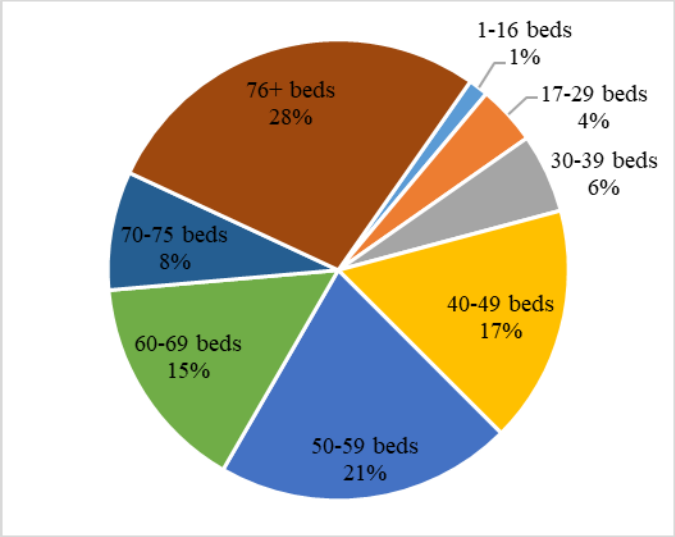
Figure 2. ***ALF and RCF Licensed Beds***



ALF

In 2017, there were 4,618 total ALF beds (687 ALF Level 1; 3,931 ALF Level 2). The average bed count for an ALF was 64.1 beds, with 1.17 beds per room. Overall the facilities were newly built with 45% of them being less than seven years old. RCFs are older than ALFs with approximately half of them being over 27 years old, while over half of the ALFs (59%) were under seven years old.

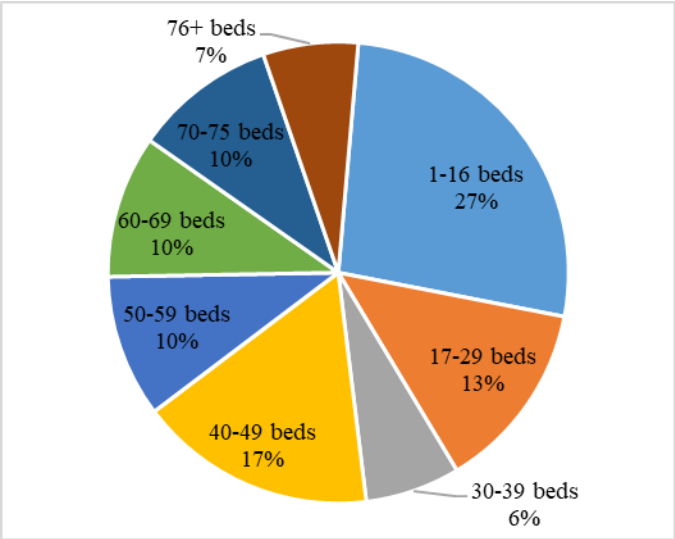
Figure 3. ***ALFs by Number of Beds***



RCF

There were 1,229 RCF beds reported in 2017. RCFs as a whole are also smaller than ALFs. The average number of beds per RCF facility was 41. RCFs also house more residents per room than an ALF. The average number of beds per room for a RCF was 1.5.

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



Occupancy Rates

The average estimated occupancy rate reported by the facilities was 65.6%. When the facilities with a reported occupancy rate of zero were excluded, the average occupancy rate was 66.3%. 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=93) was 45.4%. The average calculated occupancy rate of those facilities with at least one day of residents using beds or where beds are being held was 50.4% (N=83).

County Bed Population Sizes

According to bed population, the five highest (Pulaski, Benton, Garland, Saline, Washington), middle (Columbia, Ashley, Desha, Grant, Van Buren), and lowest populated counties (Stone, Pike, Yell, Little River, Miller) in the state were examined. The top five Counties accounted for 34% of all beds. The average facility size was larger for the higher counties compared to the middle and lower counties (62 beds vs. 60 beds vs. 23 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 outnumbering men by at least two to one in all age categories except <65. The majority of RCF admissions fall into the less than 65-year-old category and are much higher amongst men than women in this age group (106 vs. 71). The 75-84 year age group and 85+ age groups of RCFs swing back to women outnumbering men by at least two to one.

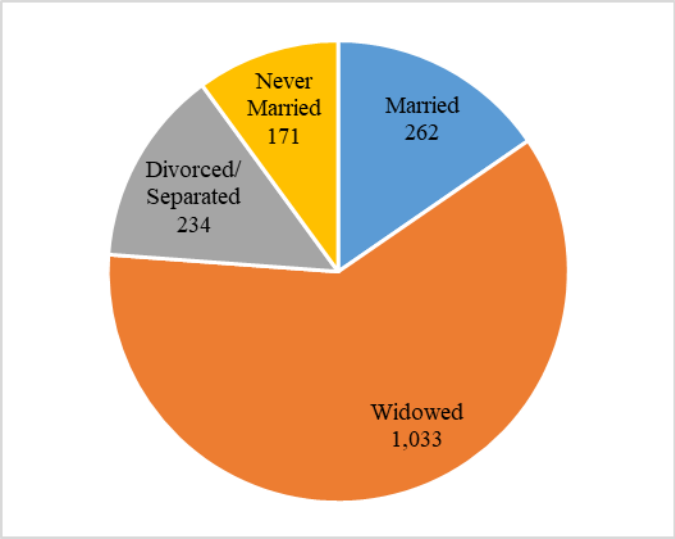
Table 5. ***Admissions by Age and Gender***

AGE	M ALF1	F ALF 1	M ALF 2	F ALF 2	M RCF	F RCF	Total
<65	30	27	17	41	106	71	**292**
65-74	2	12	73	136	16	22	**261**
75-84	8	33	166	382	12	25	**626**
85+	16	52	144	444	18	72	**746**
Total	**56**	**124**	**400**	**1003**	**152**	**190**	**1925**

Admissions by Marital Status and Race

Approximately 61% of all admissions were widowed, 15% were married, 14% were divorced or separated, and 10% were never married. Residents were overwhelmingly white (91%) vs. African American (7%). Of the 51 counties with either an ALF and/or RCF, 29 counties did not admit any African Americans. The three counties with the highest number of African-American admissions accounted for two-thirds of all African-Americans admitted.

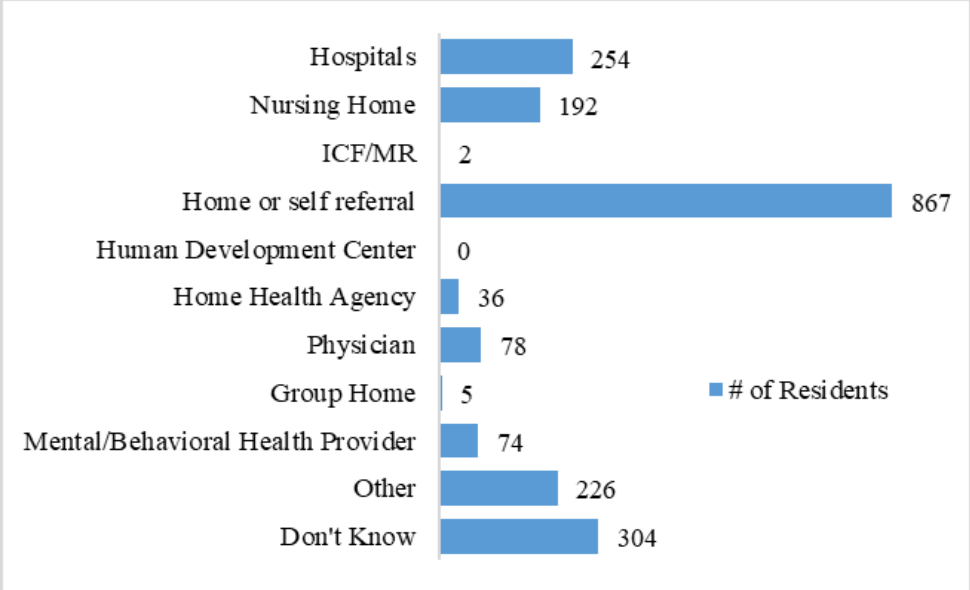
Figure 5. ***Number of Admissions by Marital Status***



Referral Sources and Residence Prior to Admission

Approximately 43% of referrals came from home or self-referrals, followed by hospitals at 12% (see Figure 6, below). Half of all residents were admitted from their own home. Patients are most often discharged to nursing facilities, death, or hospitals.

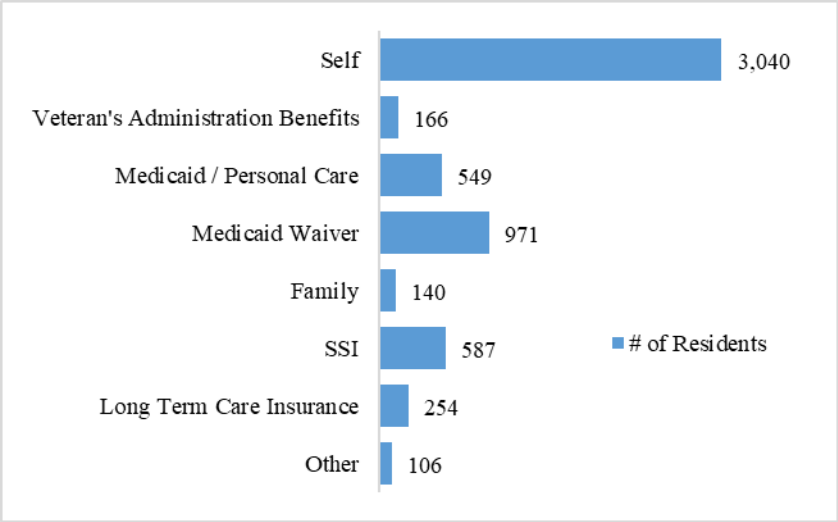
Figure 6. ***Referral Source of Residents***



Residential Reimbursement

The top three methods of payment for residents of ALFs and RCFs are: Self pay (52%), Medicare Waiver (17%), and Supplemental Security Income (10%).

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



According to the survey results, only Assisted Living Level 2 Facilities reported Medicaid Waivers. Of the 60 ALF 2 facilities, 40 accepted Medicaid waivers. The average number of waivers per facility was 27, with a range between 1 and 207.

Table 6. ***Number of Medicaid Waivers by Facility***

Facility Name	County	# Lic. Beds	# Medicaid Waivers
Better Home Living	Benton	26	18
The Pillars...of the Community	Ashley	75	20
RiverLodge Assisted Living	Baxter	75	29
Gardens at Osage Terrace	Benton	51	33
Maple Esplanade Assisted Living	Boone	78	34
Holly House	Carroll	22	9
The Plaza at Twin Rivers	Clark	55	18
Magnolia Manor Assisted Living	Clay	36	18
Southridge Village Retirement Center	Cleburne	89	26
Dudneywood Retirement and Assisted Living	Columbia	80	7
St. Bernards Villa	Craighead	116	3
Memory Lane at Legacy Heights	Crawford	74	14
Hope's Creek Retirement & Assisted Living	Crawford	118	60
Daltons Place @ Fordyce	Dallas	50	3
The Oasis Of Dumas Assisted Living Facility	Desha	30	1
Grand Manor	Drew	55	9
StoneBridge of Conway	Faulkner	80	11
Village Park of Conway	Faulkner	47	19

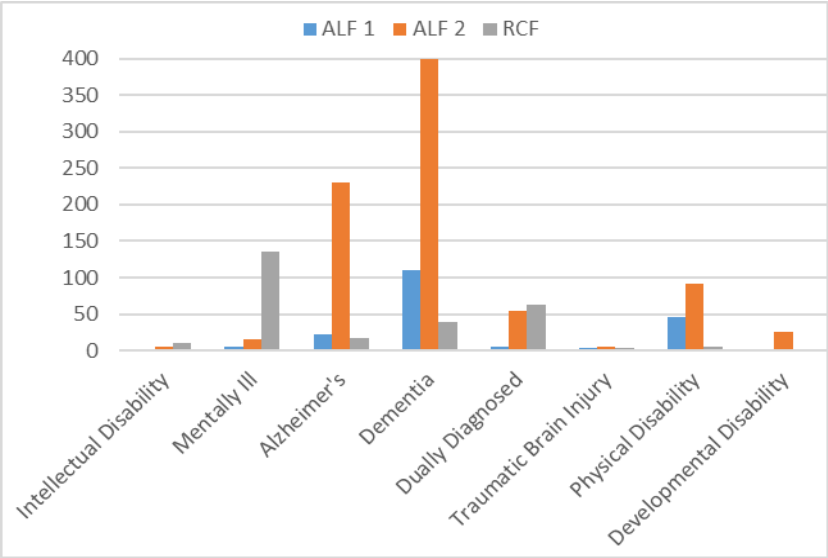
Crown Point Retirement	Grant	69	32
Hope Haven Assisted Living	Hempstead	52	7
The Crossing at Malvern	Hot Spring	84	33
Eagle Mountain Assisted Living	Independence	58	6
Trinity Village Inc.	Jefferson	54	6
Garden Pointe Living Center	Jefferson	60	18
Daltons Place Assisted Living	Lincoln	53	20
StoneBridge of Cabot	Lonoke	80	3
Countryside Assisted Living	Madison	92	53
StoneBridge of Blytheville	Mississippi	60	15
Montgomery County Assisted Living	Montgomery	42	25
Oak Park Village	Pike	32	15
The Oaks at Mena	Polk	40	23
The Manor	Pulaski	90	61
StoneBridge of Pocahontas	Randolph	60	11
St. Francis Assisted Living	St. Francis	55	9
Four Seasons assisted living	Saline	50	23
Fox Ridge Bryant	Saline	130	25
Dalton's Place in Waldron	Scott	58	30
Mercy Crest Assisted Living	Sebastian	102	207
Ella Manor LLC	Union	60	12
Providence Assisted Living	White	58	5
Total		**1,234**	**567**

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: Intellectual Disability, Mentally Ill, Alzheimer's, Dementia, Dually Diagnosed, Traumatic Brain Injury, Physical Disability, Developmental Disability. The ALF facilities had fewer residents that were either intellectually disabled or had a mental illness (5 and 21), vs. RCF (11 and 135, respectively). However, the ALFs did have more residents that had either Alzheimer's or Dementia (253 and 509) than the RCFs (17 and 39).

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



	Intellectual Disability	Mentally Ill	Alzheimer's	Dementia	Dually Diagnosed	Traumatic Brain Injury	Physical Disability	Developmental Disability
ALF 1	0	6	23	110	6	4	46	0
ALF 2	5	15	230	399	55	6	91	26
RCF	11	135	17	39	62	4	6	1

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.

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 largest differences occur amongst 19-64 year olds where personal care admissions are higher than intermittent (35% vs. 27%), while the opposite is true for 75-84 year olds (28% intermittent vs. 22% personal care).

In comparison to personal care, the percentage of 0-1 year olds amongst intermittent admissions is larger at 0.71%. In personal care admissions, this age group only accounted for 0.05%, or 2 total admissions.

Table 7. ***Intermittent Admissions by Age***

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	483	514	18,251	15,775	18,886	14,164	68,073
	0.71%	0.76%	26.81%	23.17%	27.74%	20.81%	**100.00%**

Table 8. ***Personal Care Admissions by Age***

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	2	44	1,401	957	875	685	3,964
	0.05%	1.11%	35.34%	24.14%	22.07%	17.28%	**100.00%**

Professional Discipline and Payor Source

There were 906,082 skilled nursing visits in Arkansas in 2017 and 3,687 Registered Nurses and Licensed Practical Nurses (2,711 and 976, respectively) that worked for the Home Health Agencies in the state. That averages to 246 nursing visits per nurse per year or 0.67 visits per nurse per day.

Home Health Aide visits account for the second largest number of visits to patients' homes. There were 635,609 Home Health Aide visits in 2017. There were 1,191 Home Health Aides and 3,257 Personal Care Aides for a total of 4,448 employees. That represents 37% of the Home Health employees in the state. Of the 4,448 Aides, 3,362 (76%) were part time or contract employees, only 24% were full time employees. By contrast, 71% of the RNs were full time employees.

Table 9. ***Professional Discipline by Payor Source***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	633,832	80,303	189,167	2,175	605	**906,082**
Physical Therapy Visits	407,462	23,912	108,873	348	323	**540,918**
Speech Pathology Visits	38,866	290	7,661	25	41	**46,883**

Occupational Therapy Visits	108,720	640	27,966	70	74	**137,470**
Medical Social Services Visits	5,619	2,954	2,330	618	68	**11,589**
Home Health Aide Visits	143,955	423,538	55,114	12,389	613	**635,609**
Other	3,502	91,936	2,735	639	19	**98,831**
Total	**1,341,956**	**623,573**	**393,846**	**16,264**	**1,743**	**2,377,382**

Table 10. ***Professional Discipline by Payor Source Percentage***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	69.95%	8.86%	20.88%	0.24%	0.07%	**100.00%**
Physical Therapy Visits	75.33%	4.42%	20.13%	0.06%	0.06%	**100.00%**
Speech Pathology Visits	82.90%	0.62%	16.34%	0.05%	0.09%	**100.00%**
Occupational Therapy Visits	79.09%	0.47%	20.34%	0.05%	0.05%	**100.00%**
Medical Social Services Visits	48.49%	25.49%	20.11%	5.33%	0.59%	**100.00%**
Home Health Aide Visits	22.65%	66.63%	8.67%	1.95%	0.10%	**100.00%**
Other	3.54%	93.02%	2.77%	0.65%	0.02%	**100.00%**
Total	56.45%	26.23%	16.57%	0.68%	0.07%	**100.00%**

Referral Source

Most of the Home Health referrals (70%) were from hospitals (42%) and physicians (28%). The remaining 30% are spread out among five other categories.

Among Intermittent admissions, hospital referrals account for 46% of the admissions and physician referrals account for 31%. This closely mirrors the overall figures above, with the intermittent admissions accounting for 89% of the admissions.

Personal Care admissions are distributed with the Family/Friend/Self category accounting for half of the admissions, "Other" 30%, Physician 8%, and Hospital 6%.

Table 11. ***Referral Source by Type of Admission***

State Totals	Hospital	Rehab Facility	Physician	Payor (HMO, PPO, etc.)	Family/ Friend/ Self	Nursing Home	Other	Total
Intermittent	31,990	7,734	21,302	114	526	4,201	3,770	**69,637**
Personal Care	471	25	666	455	4,151	29	2,438	**8,235**
Extended Care	12	0	2	1	3	0	3	**21**
Total	**32,473**	**7,759**	**21,970**	**570**	**4,680**	**4,230**	**6,211**	**77,893**

Table 12. ***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	45.94%	11.11%	30.59%	0.16%	0.76%	6.03%	5.41%	**100.00%**
Personal Care	5.72%	0.30%	8.09%	5.53%	50.41%	0.35%	29.61%	**100.00%**

Extended Care	57.14%	0.00%	9.52%	4.76%	14.29%	0.00%	14.29%	**100.00%**
Total	41.69%	9.96%	28.21%	0.73%	6.01%	5.43%	7.97%	**100.00%**

Staffing

Home Health staffing is distributed among full time, part time, and contract labor (54%, 40%, and 6%, respectively). The percentage of staff in a particular field can vary widely from each of the categories. Examples of this can be seen among the RNs, Aides, and Clerical Staff.

Overall, RNs account for 22% of the total population of Home Heath employees, but compose 30% of all full time employees. Seventy-one percent (71%) of the RNs are employed full time.

The personal care aides are comprised of 21% full time employees. The remainder of the personal care aides are employed part time (78%) and less 1% are contract workers.

The vast majority of the clerical staff (87%) is made up of full time employees, with only 12% being part time, and 1% being contract. Overall 13% of the home health staff are clerical.

Therapists (physical, speech, and occupational) are employed mainly on a full time basis. Of the therapists, physical therapists account for over three times the number of speech and occupational therapists (12% vs. 2% and 4%). Contract labor accounts for 22% of the physical therapists, 26% of the speech therapists, and 14% of the occupational therapists.

Table 13. ***Staffing Information***

State Totals	RN	LPN	Physical Therapist	Speech Therapist	Occupational Therapist	Medical Social Worker	Home Health Aide	Personal Care Aide	Clerical Staff	Total
Full Time	1,926	730	957	101	289	49	389	697	1,367	**6,505**
Part Time	620	241	227	107	131	64	708	2,553	192	**4,843**
Contract	165	5	327	74	70	22	94	7	18	**782**
Total	**2,711**	**976**	**1,511**	**282**	**490**	**135**	**1,191**	**3,257**	**1,577**	**12,130**

Table 14. ***Staffing Information Percentage***

State Totals	RN	LPN	Physical Therapist	Speech Therapist	Occupational Therapist	Medical Social Worker	Home Health Aide	Personal Care Aide	Clerical Staff	Total
Full Time	29.61%	11.22%	14.71%	1.55%	4.44%	0.75%	5.98%	10.71%	21.01%	**100.00%**
Part Time	12.80%	4.98%	4.69%	2.21%	2.70%	1.32%	14.62%	52.72%	3.96%	**100.00%**
Contract	21.10%	0.64%	41.82%	9.46%	8.95%	2.81%	12.02%	0.90%	2.30%	**100.00%**
Total	22.35%	8.05%	12.46%	2.32%	4.04%	1.11%	9.82%	26.85%	13.00%	**100.00%**

Unduplicated Admissions

Table 15. ***Unduplicated Admissions***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	42,622	4,593	14,900	187	78	**62,380**

Personal Care	0	3,161	636	369	39	**4,205**
Extended Care	0	21	13	0	0	**34**
Total	**42,622**	**7,775**	**15,549**	**556**	**117**	**66,619**

Table 16. ***Unduplicated Admissions Percentage***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	68.33%	7.36%	23.89%	0.30%	0.13%	**100.00%**
Personal Care	0.00%	75.17%	15.12%	8.78%	0.93%	**100.00%**
Extended Care	0.00%	61.76%	38.24%	0.00%	0.00%	**100.00%**
Total	63.98%	11.67%	23.34%	0.83%	0.18%	**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 2017 46.6% 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

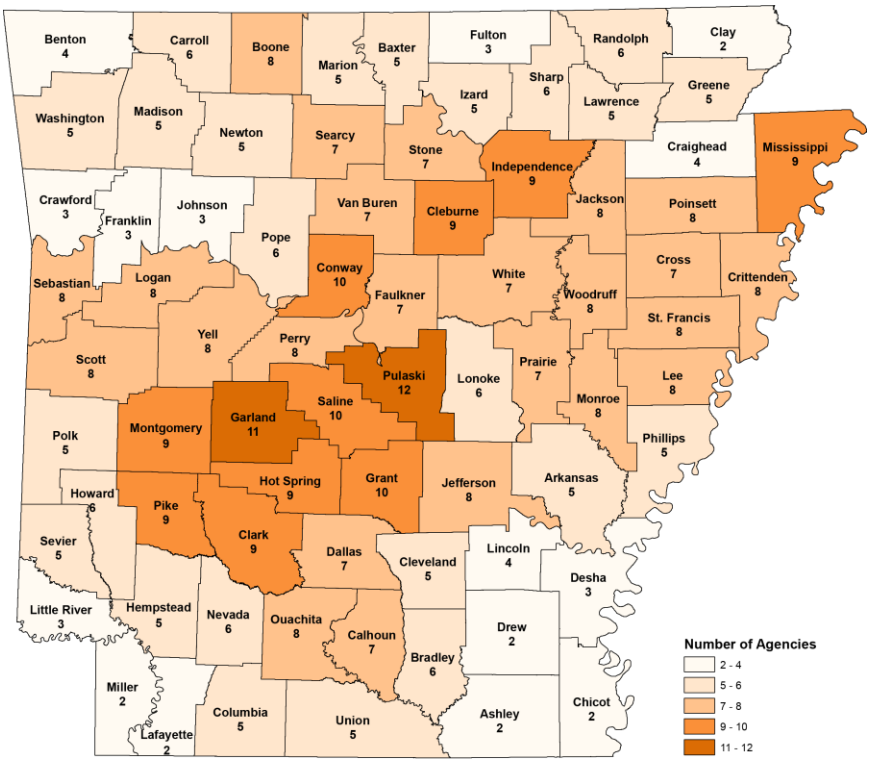
Hospice and Palliative Care Organization, 48% of U.S. deaths were served by hospice in 2016. This shows that Arkansas has a very similar utilization rate to the nation.

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 9 is a map of Arkansas with the number of hospice agencies serving each county.

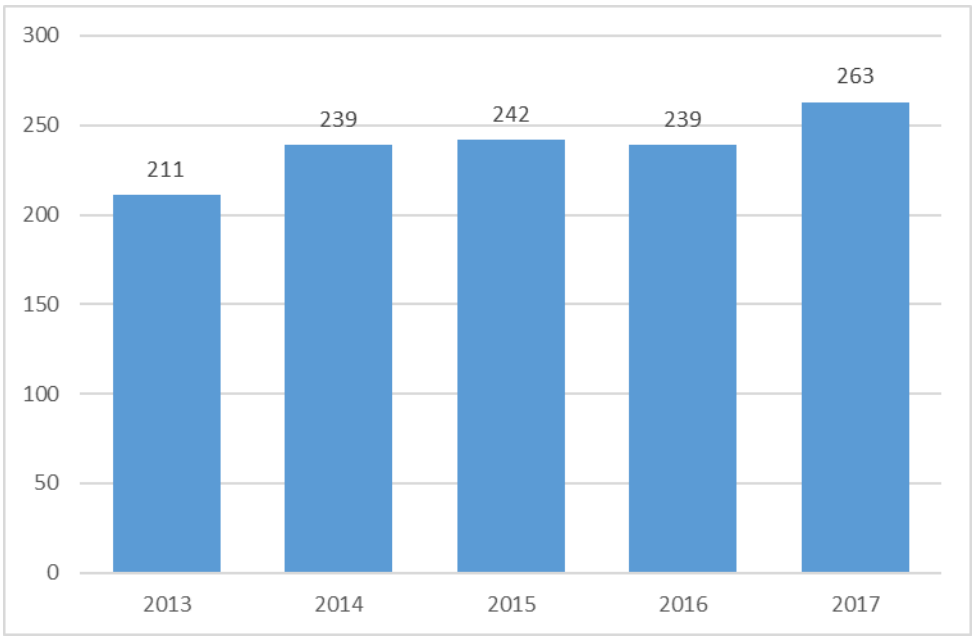
Arkansas Hospice Survey Results

Figure 9. ***Number of Hospice Agencies per County in Arkansas***



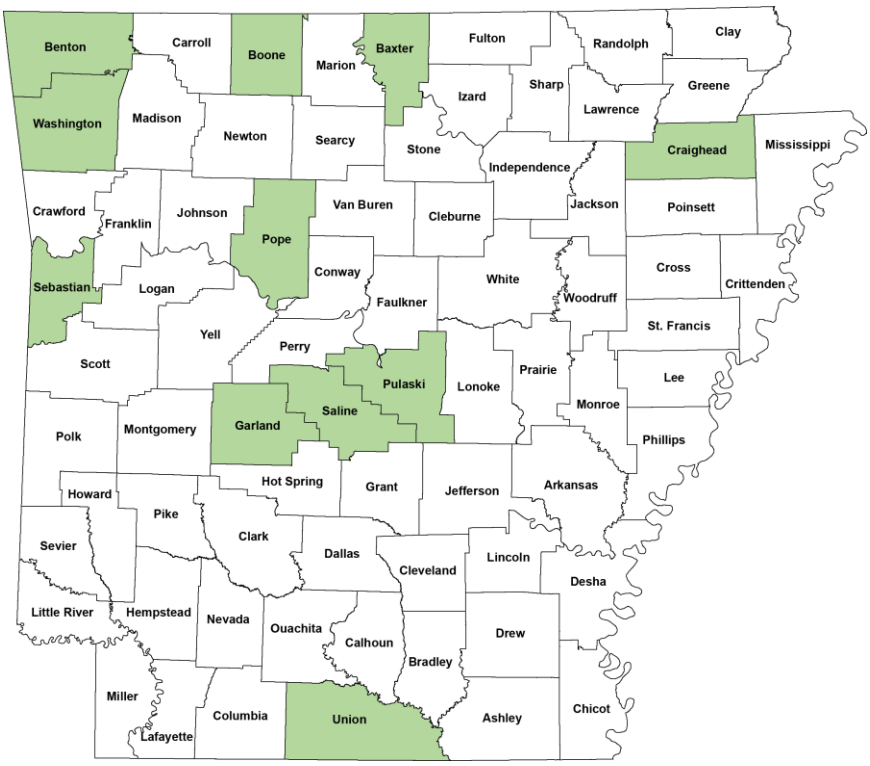
As illustrated on the graph below, the annual surveys show an increase in the number of inpatient hospice beds over the last 5 years. Since 2013 there has been a 24.6% increase in beds reported.

Figure 10. ***Number of Survey Reported Licensed Hospice Inpatient Beds 2013-2017***



According to the 2017 survey, there are now hospice facilities with inpatient beds in 11 of Arkansas's 75 counties (see the map below). There were 263 licensed beds reported across the 14 facilities.

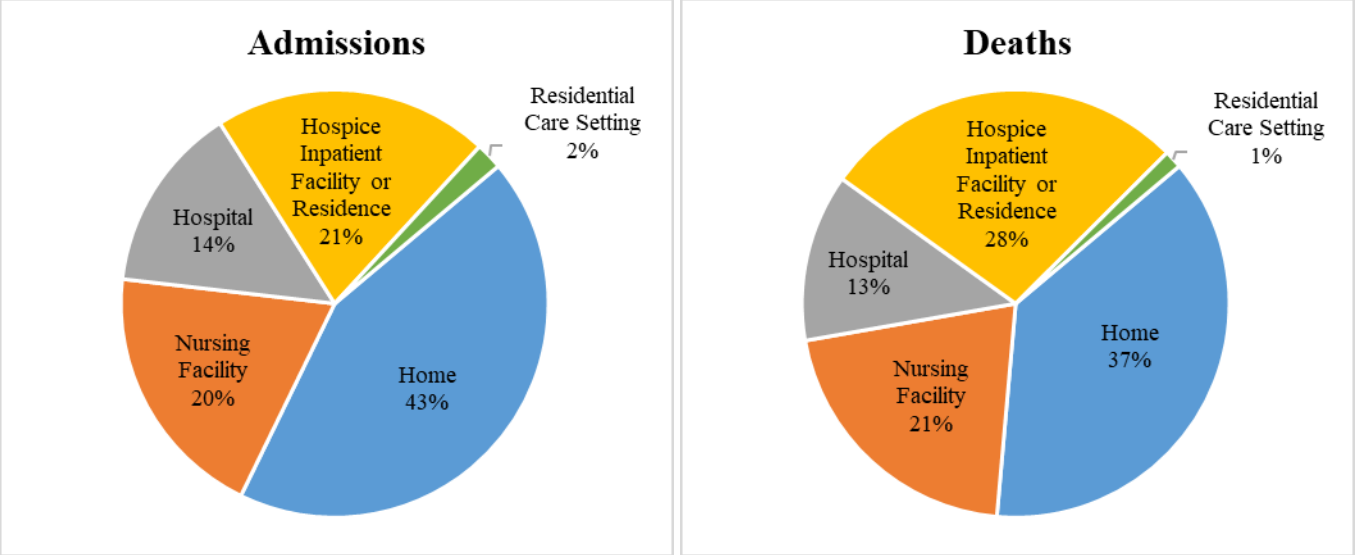
Figure 11. ***Counties with Hospice Inpatient Beds in Arkansas***



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 21% of all admissions, it makes up 28% of the

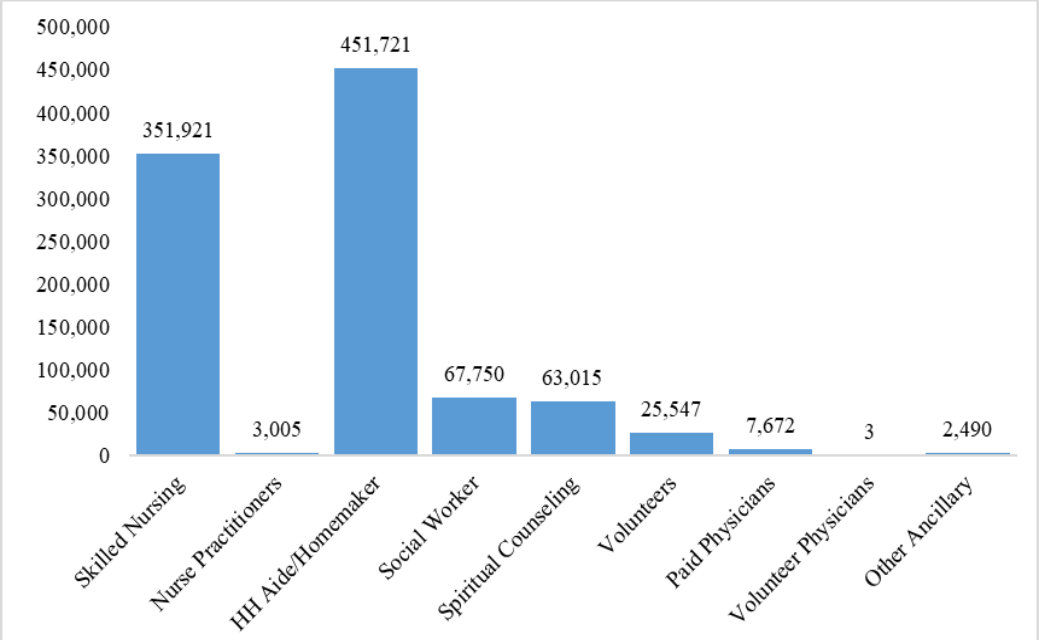
hospice deaths. This can be accounted for by drops from admission to death percentages of Home, Hospital, and Residential Care Setting admissions (see chart below).

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 83% of patient visits. The remainder of the visits is led by social workers (7%) and spiritual counselors (6%).

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.

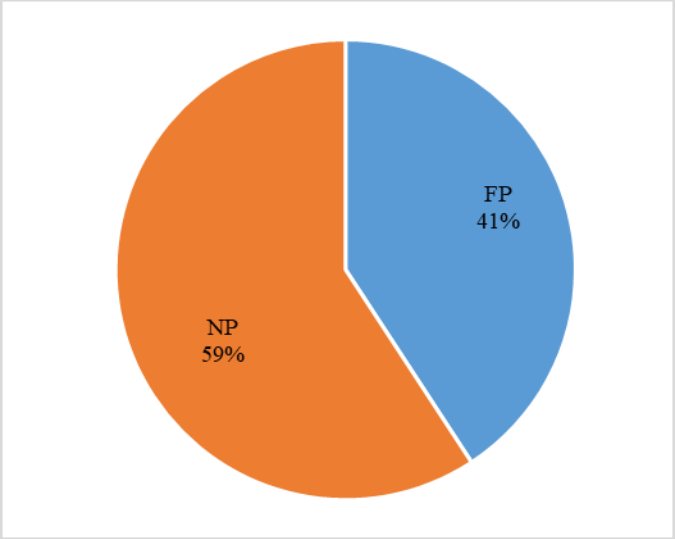
Survey Results

The survey respondents included six PRTFs, which were made up of two for profits (FP) and four nonprofits (NP). There were 797 licensed beds and 568 resident rooms reported for 2017. The average number of beds per facility was 133, with 1.4 beds per room.

Licensed Beds

There were 797 licensed beds reported in 2017. The FPs accounted for 325 beds from two facilities, and the NPs had 472 beds from four facilities.

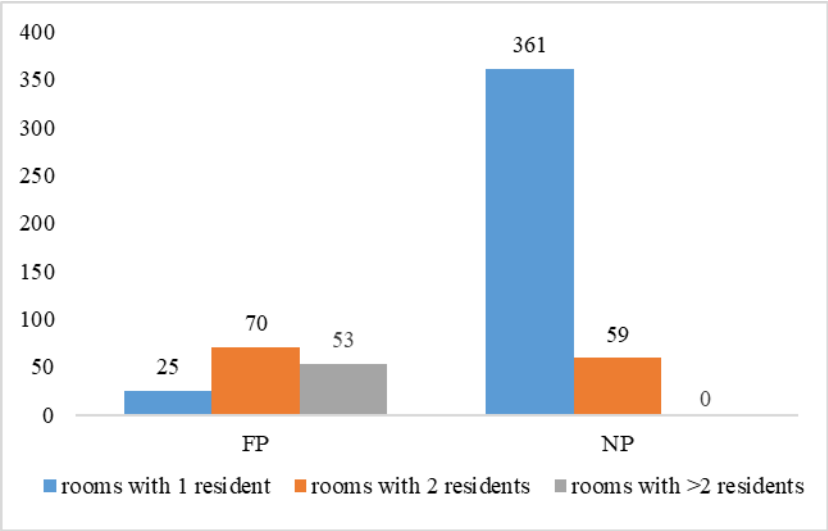
Figure 14. ***Licensed Beds by Type of Facility***



Average Number of Residents per Rooms

For all PRTFs, most of the rooms were utilized for one or two residents (68% and 23%, respectively.) The FPs had a larger percentage of rooms with three or more residents (36%) compared to NPs with none. The majority of rooms in the NPs had one resident (86%.)

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



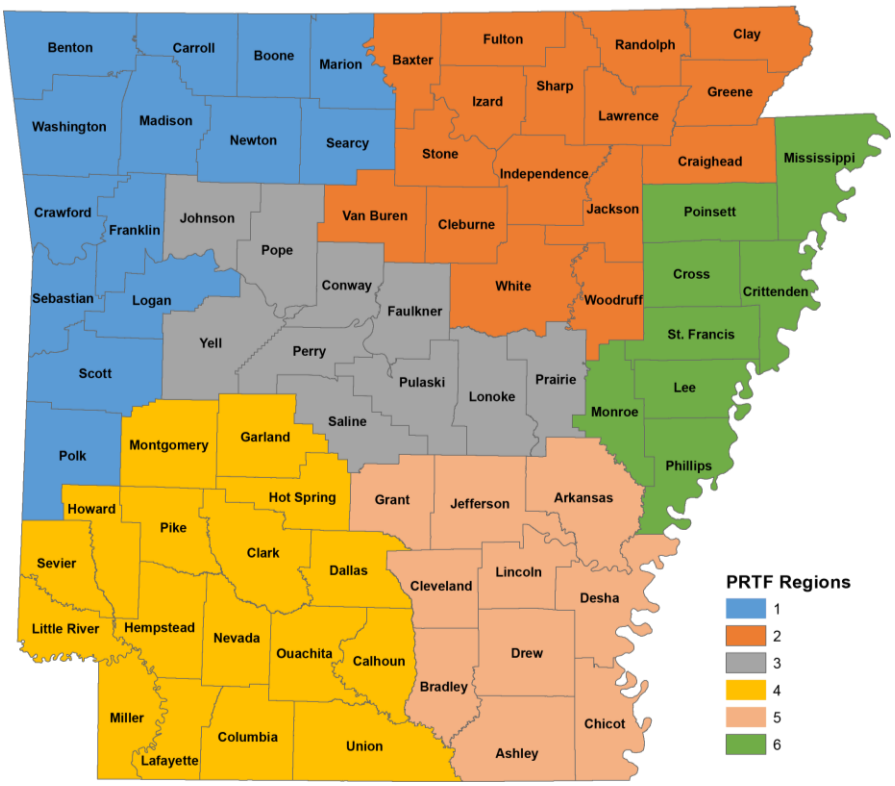
Payment Methods

In 2017, there were 162,276 total resident days and 908 admissions in the six PRTFs. Arkansas Medicaid paid for 116,095, or 71.5%, of those days. The Medicaid cap for PRTFs is $350 per child per day; based on this rate, total spent by Medicaid for calendar 2017 was $168,806,380**.** The remaining 28.5% was covered by Medicaid (from a state other than Arkansas), private insurance, and "other" (as listed on the survey) forms of payment.

PRTFs and Host Counties

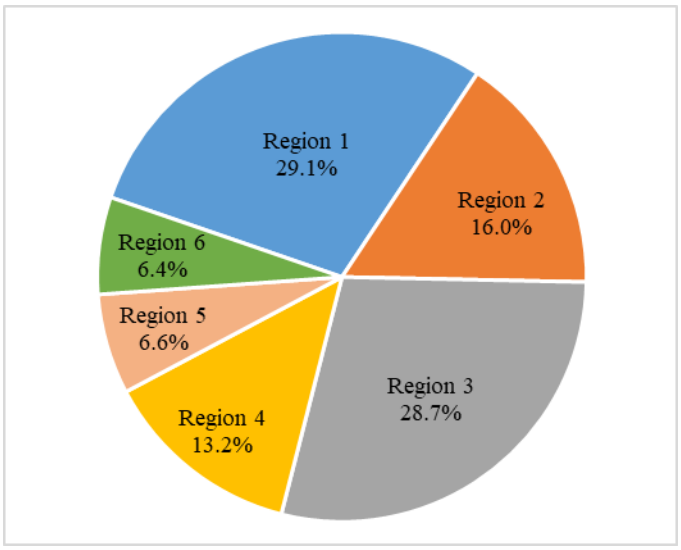
Arkansas is split into six PRTF regions (shown in the map below), which are serviced by the six responding PRTFs around the State. Region 3, which includes Pulaski County, houses two PRTFs as does Region 5. Regions 2 and 6 have no PRTFs which responded to the survey; Regions 1 and 4 have one PRTF each.

Figure 16. ***PRTF Regions***



The six regions are not split evenly according to population. Regions 1 and 3 account for over half of the state's 2017 population estimate, while the smallest regions (5 and 6) each comprise less than 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 – 94%

Region 2 – NA
Region 3 – 84%
Region 4 – 96%
Region 5 – 88%
Region 6 – NA
State Total –90 %

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

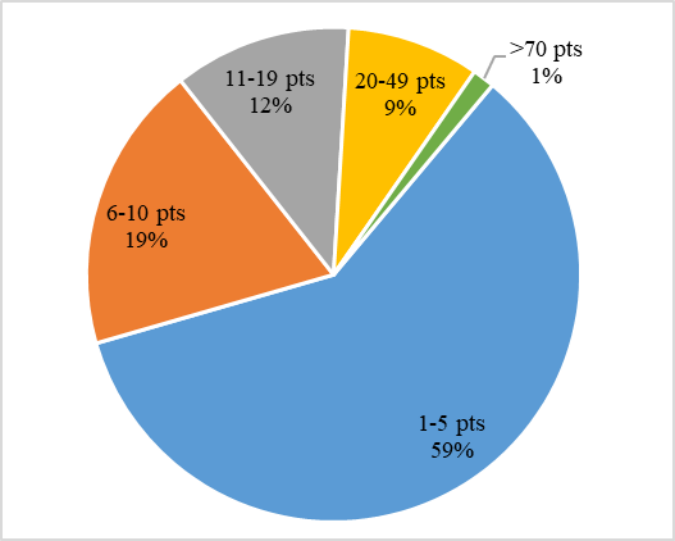


Table 17. Number of Patients Served Per County

Patients Per County		Total Patients Seen	County
>70 pts	(1)	160	Pulaski
50-70 pts	(0)	0	
20-49 pts	(6)	198	Faulkner, Garland, Saline, Sebastian, Washington, White
11-19 pts	(8)	104	Benton, Greene, Hempstead, Hot Spring, Jefferson, Lonoke, Miller, Union,
6-10 pts	(13)	96	Arkansas, Ashley, Bradley, Craighead, Crawford, Drew, Independence, Logan, Ouachita, Pope, Sharp, Stone, Van Buren
1-5 pts	(41)	118	Baxter, Boone, Carroll, Chicot, Clark, Cleburne, Cleveland, Columbia, Conway, Crittenden, Cross, Dallas, Desha, Franklin, Grant, Howard, Izard, Jackson, Johnson, Lafayette, Lawrence, Lee, Lincoln, Little River, Madison, Mississippi, Monroe, Montgomery, Nevada, Perry, Phillips, Pike, Poinsett, Polk, Randolph, Scott, Searcy, Sevier, St. Francis, Woodruff, Yell

Gender

Overall, there were significantly more males than females being served in PRTFs. There were 535 boys between the ages of 6-20 and 373 girls that were 6-20 years old. There were two facilities that had more female residents than males. Boys outnumbered girls across all age ranges in the FP facilities. In the NP facilities, girls outnumbered boys in the 11-15 year old, 16-18 year old, and the 19 to 20 year old groups. The 16-18 year old group saw the biggest difference with 19 more girls than boys.

Age

The 11-15 year old range had the highest percentage of residents (59%), followed by 16-18 year olds (26%), 14% of the residents were 6-10 years old, and only 1% was in the 19-20 year old age group.

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

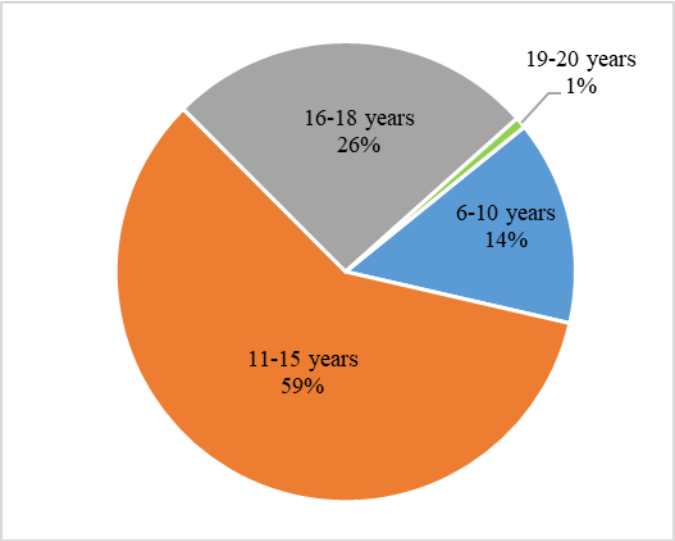
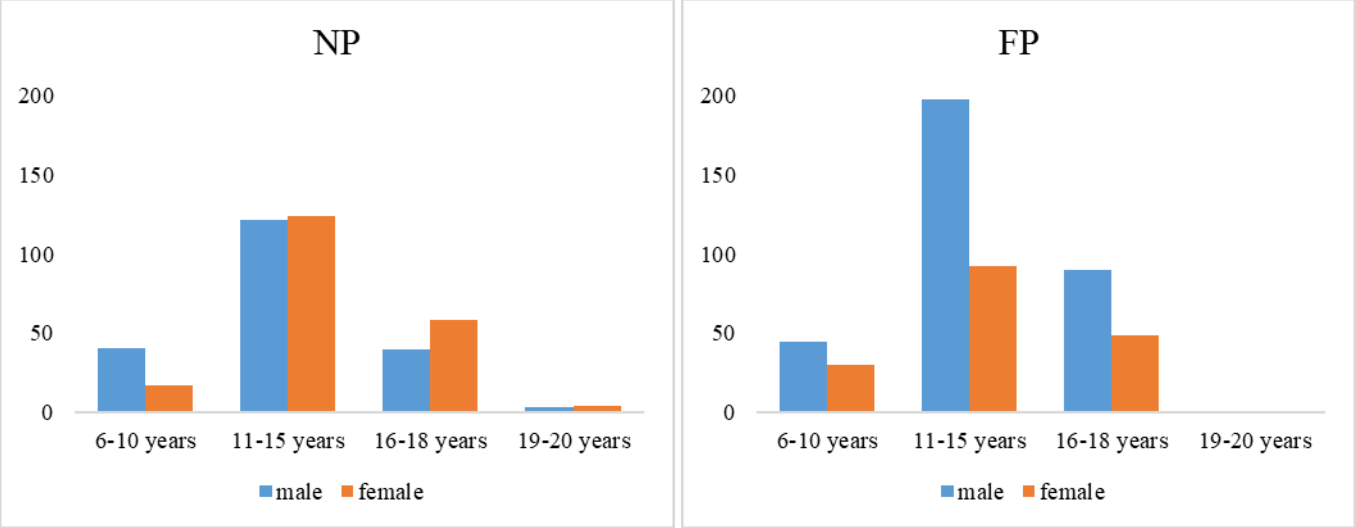


Figure 20. ***Sex and Age by Facility Type***



Race

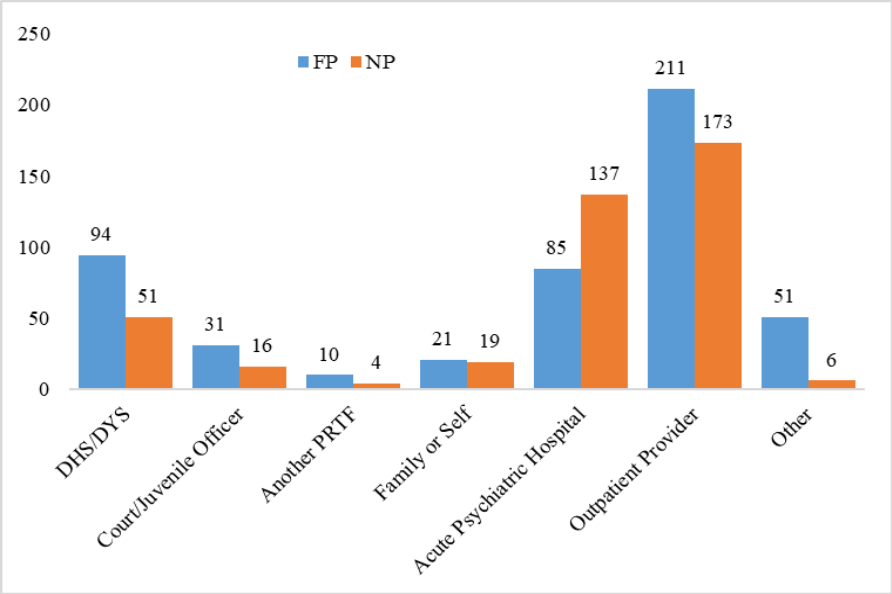
According to the 2017 population estimates 75% of children, in Arkansas, between the ages of five and nineteen are white and 18% are black (see Table 20 below), with the remaining 7% from other races. However, black children constitute a disproportionate 37% of the residents in PRTFs. Region 4 saw the largest difference between the reported percentages of black residency compared to the black population (47.4% vs. 23.9%).

Table 18. Differences in race population percentages vs. PRTF residency percentages by Region

Area	% white pop 5-19	white PRTF residency %	% black pop 5-19	black PRTF residency %
Region 1	85.8%	81.0%	3.4%	11.4%
Region 2	87.2%	NA	8.3%	NA
Region 3	69.1%	62.7%	25.0%	35.8%

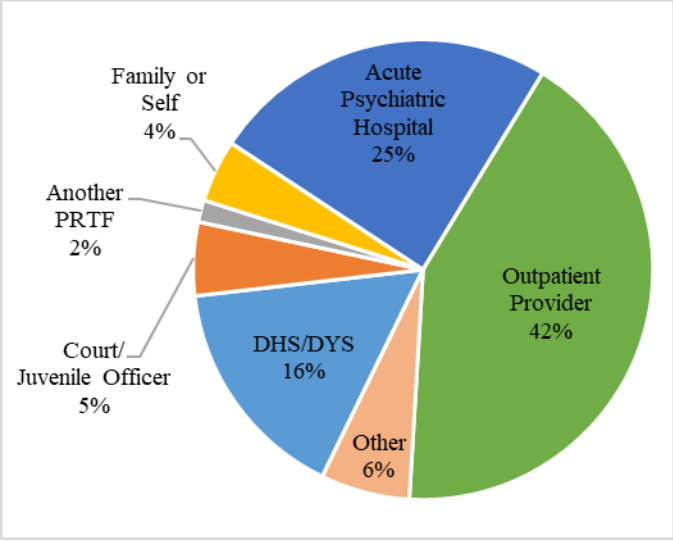
Region 4	70.2%	51.3%	23.9%	47.4%
Region 5	53.9%	63.3%	42.2%	36.7%
Region 6	47.8%	NA	48.5%	NA
Total	**74.7%**	**61.1%**	**18.3%**	**37.0%**

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



Note: Other is made up of Physician (other than PCP admitting physician), Schools, and "Other."

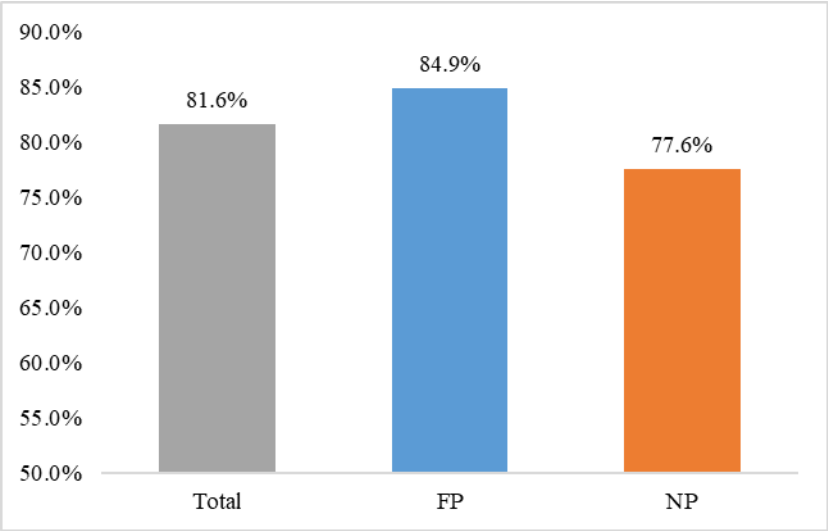
Figure 22. ***Percentage of Residents by Referral Source***



Readmissions

Of the 908 PRTF admissions in 2017, 741 (81.6%) of the children had previously been admitted to a PRTF or psychiatric hospital (see Figure 23 below). FPs had a higher 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 69.0% of their residents to their home, most of the remaining 31% of discharged residents went to foster care (18.9%), "other" (3.6%), another PRTF (3.6%), or group homes (3.3%). The NP facilities returned 65.1% of their residents to the parents' home, 18.9% to foster care, 7.0% to hospitals, and 2.9% to group homes, 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 176 days, or over five and a half months (see Table 21 below). Two of the facilities had an average length of stay greater than six months. The NPs had the shortest average length of stay at 150 days. The FP residents stayed for over one and a half months longer (201 days).

Table 19. ***Average Length of Stay by Facility Type***

Facility Type	Facility Name	Average LoS (days)	Average LoS (months)
FP	Piney Ridge Treatment Center, LLC	307.9	10.1
FP	Habilitation Center, Inc/dba Millcreek of Arkansas	163.6	5.4
FP Total		**200.9**	**6.6**
NP	Youth Home, Inc.	185.9	6.1
NP	Birch Tree Communities Inc.	NA	
NP	Centers for Youth and Families - Little Rock Residential	118.2	3.9
NP	Centers for Youth and Families - Monticello Residential	149.6	4.9
NP Total		**150.0**	**4.9**