

HEALTH SERVICES PERMIT AGENCY

SFY 2021 ANNUAL REPORT

SURVEY RESULTS FROM CY 2020

Presented by: Tracy Steele, Director

SCOPE

Arkansas Code Ann. 20-8-101 et seq. creates and establishes the Health Services Permit Agency, which shall be under the supervision and control of the Department of Health. 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:

- retired or practicing physician;
- representative of the Department of Human Services or his or her designee;
- member from the Arkansas Hospital Association, Inc.;
- member from the Arkansas Health Care Association;
- member from the Arkansas Chapter, AARP, Inc.;
- member from the Arkansas HomeCare Association. of Arkansas;
- consumer knowledgeable in business health insurance;
- member from the Arkansas Residential Assisted Living Association;
- member from the Hospice and Palliative Care Association of Arkansas, Inc.

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 four (4), including the Agency Director, Tracy Steele, the Assistant Director, the Program Manager, and the Management Project Analyst.

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 2021 was \$48,546.69

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 2021 was \$31,224.37 and the budget for 2021 was comprised of 90% SGR and 10% POA fund balance.

Table 1. Health Services Permit Agency Fiscal Year 2021 Budget and Revenue

844 – HSPA	FY 2021
APPROVED BUDGET	\$507,540.00
GENERAL REVENUE	\$408,843.00
POA & COPY FEES	\$48,546.69
TOTAL REVENUE	\$473,838.00
TOTAL EXPENSES	\$466,988.00

PERMIT OF APPROVAL REVIEW PROCESS

Fiscal Year 2021 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
November 1	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://www.healthy.arkansas.gov/programs-services/topics/arkansas-health-services-permit-agency>.

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 2021. 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 2021, there were three (3) appeals of Agency decisions and they each 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

POA APPLICATION VOLUME

In FY 2021, eleven (11) applications were approved, six (6) were denied and one (1) was withdrawn or returned. Agency decisions resulted in the approval of \$ 75,537,069.00 in capital projects.

Table 3. Fiscal Year 2020 Applications

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Facilities	6	\$ 25,605,000.00	5	0	1
PRTF's (moratorium)	0	NA	0	0	0
Home Health	3	\$ 321,210.00	1	2	0
Assisted Living	6	\$ 49,610,859.00	5	1	0
Hospice Agencies	3	\$ 0	0	3	0
Hospice Facilities	0	\$ 0	0	0	0
Totals	18	\$ 75,537,069.00	11	6	1

Table 4 illustrates the total applications received from FY 2011 - FY 2021 that the POA applications are averaging twenty-eight (28) 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 2011 – FY 2021

Type of Projects	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Nursing Facilities	7	8	13	13	7	5	8	3	4	16	6
RCF (Moratorium 07/05)	0	0	0	0	0	0	0	0	0	0	0
Assisted Living	16	29	17	17	27	9	20	8	11	5	6
Home Health	0	1	1	5	1	2	10	2	0	1	3
Hospice	0	1	6	1	0	0	0	0	0	0	3
Hospice Facility	3	1	0	0	0	7	0	0	0	0	0
PRTF (Moratorium 02/08)	0	0	0	1	0	0	0	0	0	0	0
ICF (Moratorium 03/94)	0	0	0	0	1	0	0	0	0	0	0
Total	26	40	37	37	36	23	38	13	15	22	18

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 2020, the Nursing Facility net need was (-2,406) and the bed need as of July 2021 is (- 1,532).

Figure 1. Number of Nursing Facility Beds 2011-2021



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.

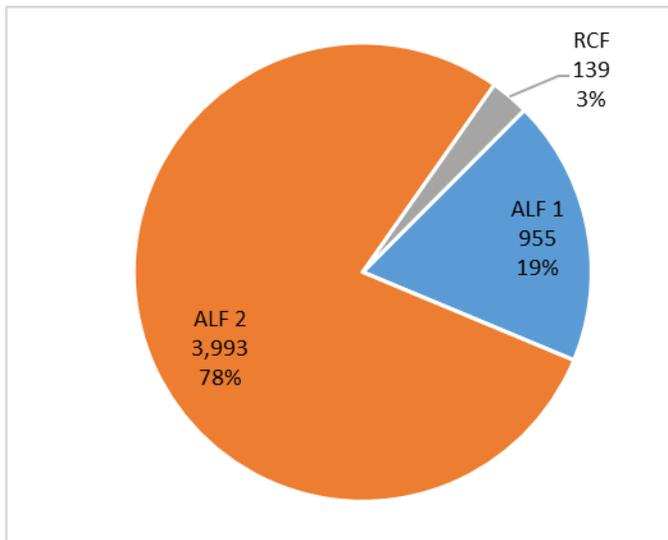
The report below represents 2020 data collected via an Internet based survey of all Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) in Arkansas. The purpose of the mandatory survey was to determine the basic characteristics of ALFs and RCFs in the state.

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 survey results include 4 RCFs, 14 ALF Level 1, 56 ALF Level 2, and 1 ALF with both Level 1 and 2. In order to protect the confidentiality of the single ALF 1 and 2 facility's patients this data will be excluded any time the data is broken out into facility type. Overall there were a total of 75 facilities who completed this year's survey, which continues the trend of a lower participation rate than in the past. Based on anecdotal evidence in the comment field of the survey, there was a lot of turnover in the ownership and/or staff of these facilities. This may be a factor as to why there were less respondents and can limit the amount of information reported on the survey. The COVID-19 pandemic began in 2020 and had an affect on ALFs and RCFs that may show up in the survey results.

Survey Results

There were 5,087 licensed ALF and RCF beds and 4,306 rooms reported in the 2020 Annual Survey. The average number of beds per facility was 67.8, with 1.18 beds per room. There were 3 facilities that had 20 or fewer beds, while 23 facilities had 80 or more beds. There was at least one reported RCF or ALF in 33 of the 75 counties in Arkansas.

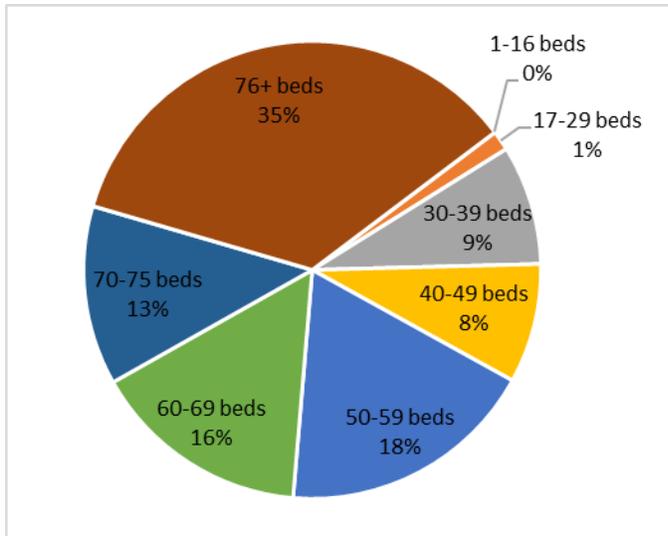
Figure 1. ALF and RCF Licensed Beds



ALF

In 2020, there were 4,948 total ALF beds (955 ALF Level 1; 3,993 ALF Level 2). The average bed count for an ALF was 69.7 beds, with 1.18 beds per room. The resident rooms types reported in ALFs were studio rooms (47%), one bedroom (41%), two bedroom (10%), and rooms for more than two residents (3%).

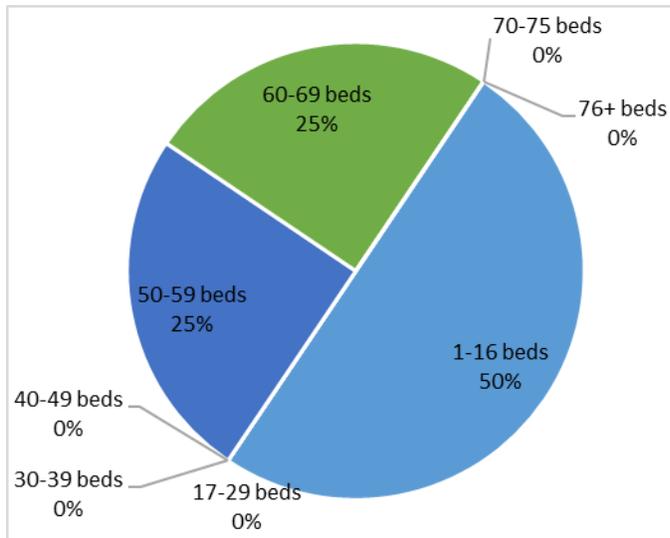
Figure 2. ALFs by Number of Beds



RCF

There were 139 RCF beds reported in 2020. RCFs as a whole are smaller than ALFs. The average number of beds per RCF was 34.8. RCFs also house more residents per room than ALFs. The average number of beds per room for RCFs was 1.20. A majority of the rooms reported in RCFs were studio rooms (87%) with the other 13% being one bedroom.

Figure 3. RCFs by Number of Beds



Occupancy Rates

The average estimated occupancy rate reported by the facilities was 59.2% (N=62). After removing the facilities that reported a zero occupancy rate, the average occupancy percentage reported was 61.2% (N=60). 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. Due to the large number of nonresponses along with responses that are impossible, this number will not be reported from this year’s survey.

County Bed Population Sizes

According to bed population, the five highest (Pulaski, Benton, Faulkner, Craighead, Washington), five middle (Madison, Independence, Greene, Cleburne, Hot Spring), and five lowest populated counties (Johnson, Montgomery, Pike, Van Buren, Little River) in the state were examined. The top five Counties accounted for 40% of all beds. The average facility size was larger for the middle counties compared to the higher and lower counties (79 beds vs. 71 beds vs. 30 beds).

Admissions by Age and Gender

Females accounted for 65% of the total admissions to ALFs and RCFs in 2020. For ALF admissions, women outnumbered men in all age categories. RCF admissions were higher amongst men than women in the less than 65 years old age group as well as the 65-74 years age group. In the 85+ age group of RCFs, women substantially outnumbered men. The majority of RCF residents fall into the 85+ age group, while the 75-84 years and 85+ years age groups accounted for 42% and 41% of ALF admissions, respectively.

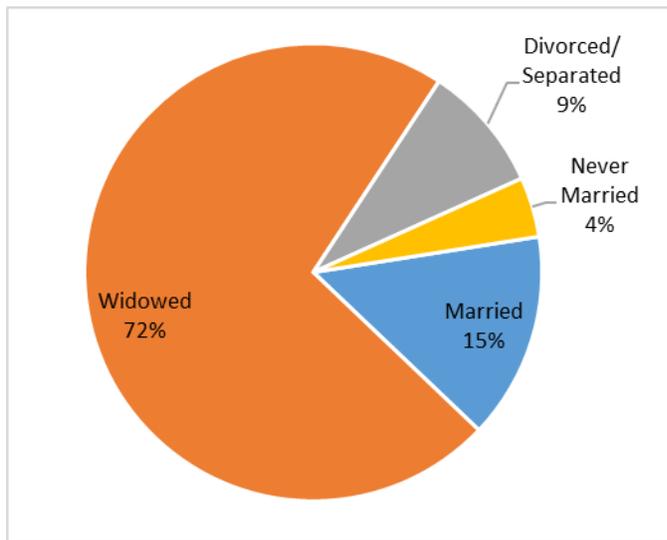
Table 1. Admissions by Age and Gender

AGE	M ALF1	F ALF 1	M ALF 2	F ALF 2	M RCF	F RCF	Total
<65	2	3	25	25	2	1	58
65-74	6	8	89	151	4	0	258
75-84	42	93	225	402	2	3	767
85+	47	105	204	382	3	14	755
Total	97	209	543	960	11	18	1,838

Admissions by Marital Status and Race

Approximately 72% of all admissions were widowed, 15% were married, 9% were divorced or separated, and 4% were never married. Residents were overwhelmingly White (96%) vs. African American (1%). Of the 33 counties with either an ALF and/or RCF, only 5 counties reported African American admissions.

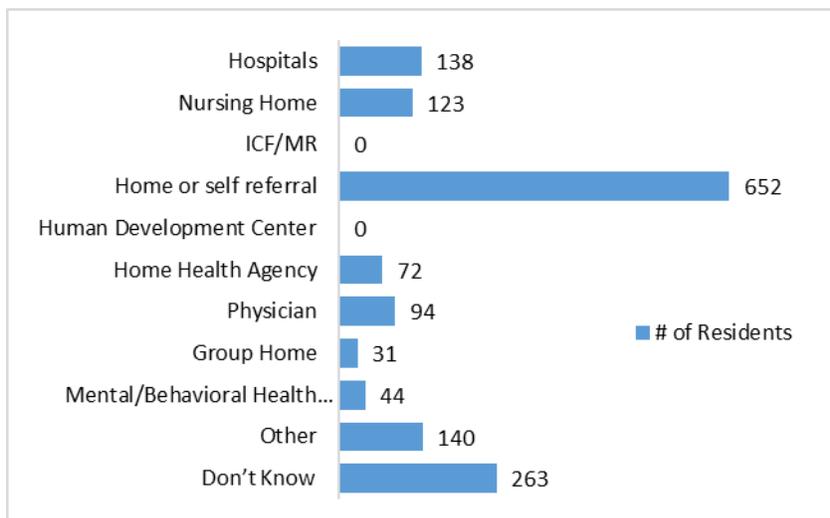
Figure 4. Number of Admissions by Marital Status



Referral Sources and Residence Prior to Admission

Approximately 42% of referrals came from home or self-referrals, followed by “Don’t Know” at 17% (see Figure 6, below). “Other” and hospitals at 9% were the next highest categories, with “Other” being specified most often as other assisted living facilities, referral agencies, and family/friends. Over half of all residents (61%) were admitted from their own home. Patients are most often discharged to nursing homes (32%) or hospitals/rehab centers (10%). Deaths, at 28%, also account for a significant portion of patient loss.

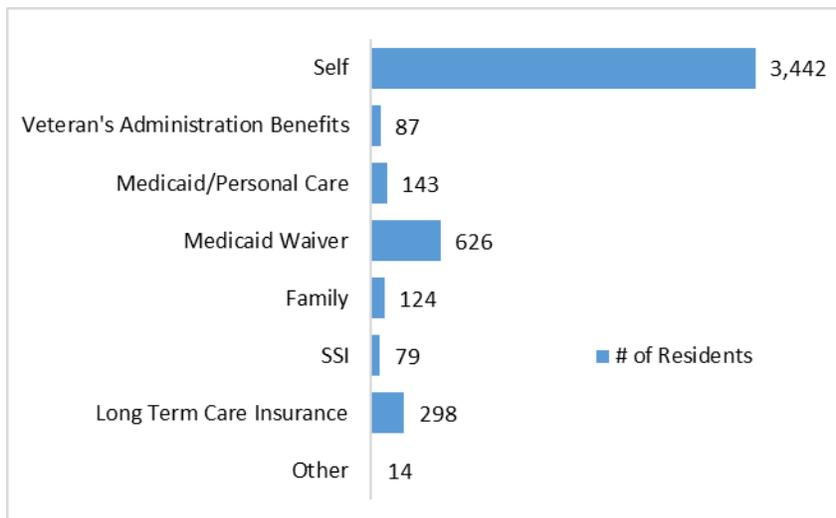
Figure 5. Referral Source of Residents



Residential Reimbursement

The top methods of payment for residents of ALFs and RCFs are: Self pay (72%), Medicare Waivers (13%), and Long Term Care Insurance (6%).

Figure 6. Source of Payment by Residents



According to the survey results, only Assisted Living Level 2 Facilities reported Medicaid Waivers. Of the 56 ALF 2 facilities, 28 accepted Medicaid waivers. The average number of waivers per facility that reported Medicaid Waivers was 22, with a range between 3 and 61.

Table 2. Number of Medicaid Waivers by Facility

Facility Name	County	# Lic. Beds	# Medicaid Waivers
Countryside Assisted Living	Madison	106	61
Mercy Crest Assisted Living	Sebastian	102	51
Hope's Creek Retirement & Assisted Living	Crawford	118	49
Maple Esplanade Assisted Living	Boone	78	45
The Manor	Pulaski	90	35
Gardens at Osage Terrace	Benton	51	34
The Crossing at Malvern	Hot Spring	84	33
Fox Ridge Assisted Living	Saline	130	31
RiverLodge Assisted Living	Baxter	75	27
Stonebridge of Heber Springs	Cleburne	89	27
Daltons Place of Waldron	Scott	58	27
Prestige Assisted Living	Carroll	60	26
Village Gardens	Van Buren	20	20
Montgomery County Assisted Living	Montgomery	42	19
Village Park of Conway	Faulkner	47	17
StoneBridge of Conway	Faulkner	80	16
Van Buren Legacy, LLC	Crawford	40	14
StoneBridge Senior Living Pocahontas	Randolph	60	13
The Plaza at Twin Rivers	Clark	55	11

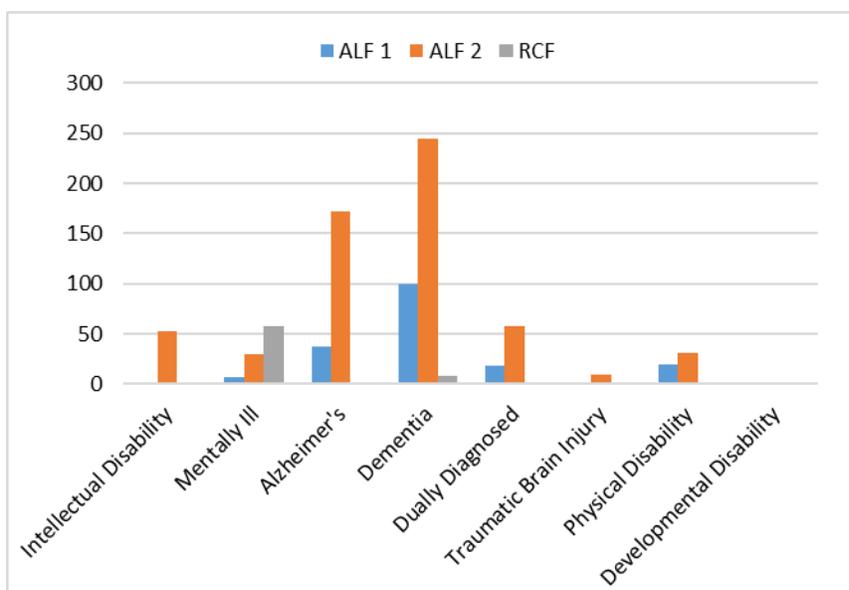
Hope Haven Assisted Living	Hempstead	52	11
Grand Manor	Drew	55	10
Oak Park Village	Pike	32	10
The Blossoms at West Dixon Assisted Living	Pulaski	32	10
Dudneywood, LLC	Columbia	80	9
Hillside Lodge Assisted Living	Baxter	57	8
StoneBridge Cabot	Lonoke	80	5
St. Bernards Villa	Craighead	116	4
Eagle Mountain Assisted Living	Independence	58	3
Total		1,947	626

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 ALFs had fewer residents that had a mental illness (37), vs. RCF (58). However, the ALFs had more residents with Alzheimer's or Dementia (209 and 344) than the RCFs (1 and 8).

Figure 7. Type of Diagnosis by Facility Type



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 appears to be fairly similar regardless of whether the patient is a personal care or intermittent admission. The largest differences occur amongst 75-84 year olds where intermittent admissions are higher than personal care (28% vs. 23%), and for 19-64 year olds where there were more personal care admissions (30% personal care vs. 26% intermittent).

Table 3. Intermittent Admissions by Age

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	358	435	17,552	16,788	18,553	13,536	67,222
	0.53%	0.65%	26.11%	24.97%	27.60%	20.14%	100.00%

Table 4. Personal Care Admissions by Age

	0-1	1-18	19-64	65-74	75-84	85+	Total
State Total	1	46	1079	900	840	720	3,586
	0.03%	1.28%	30.09%	25.10%	23.42%	20.08%	100.00%

Professional Discipline and Payor Source

There were 800,975 skilled nursing visits in Arkansas in 2020 and 1,209 Registered Nurses and Licensed Practical Nurses (869 and 340, respectively) that worked for the Home Health Agencies in the state. That averages to 663 nursing visits per nurse per year or 1.82 visits per nurse per day.

Physical Therapy visits account for the second largest number of visits to patients’ homes. There were 503,979 Physical Therapy visits in 2020. There were 417 Physical Therapists, which represents 8% of the Home Health employees in the state. Of the Physical Therapists, 33% were part time or contract employees and 67% were full time employees.

Table 5. Professional Discipline by Payor Source

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	537,107	65,901	196,042	1,404	521	800,975
Physical Therapy Visits	352,796	24,551	125,833	566	233	503,979
Speech Pathology Visits	28,219	511	8,509	194	29	37,462
Occupational Therapy Visits	76,776	481	28,397	140	55	105,849
Medical Social Services Visits	5,451	555	2,453	65	17	8,541
Home Health Aide Visits	78,464	262,923	17,327	6,878	827	366,419
Other	124	32,682	443	145	23	33,417
Total	1,078,937	387,604	379,004	9,392	1,705	1,856,642

Table 6. Professional Discipline by Payor Source Percentage

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	67.06%	8.23%	24.48%	0.18%	0.07%	100.00%
Physical Therapy Visits	70.00%	4.87%	24.97%	0.11%	0.05%	100.00%
Speech Pathology Visits	75.33%	1.36%	22.71%	0.52%	0.08%	100.00%
Occupational Therapy Visits	72.53%	0.45%	26.83%	0.13%	0.05%	100.00%
Medical Social Services Visits	63.82%	6.50%	28.72%	0.76%	0.20%	100.00%
Home Health Aide Visits	21.41%	71.75%	4.73%	1.88%	0.23%	100.00%
Other	0.37%	97.80%	1.33%	0.43%	0.07%	100.00%
Total	58.11%	20.88%	20.41%	0.51%	0.09%	100.00%

Referral Source

Most of the Home Health referrals were from hospitals (45%) and physicians (30%). The remaining 24% 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 97% of the admissions.

Personal Care admission referrals are distributed among the categories Family/Friend/Self (39%), “Other” (32%), and Payor (HMO, PPO, etc.) (11%).

Table 7. Referral Source by Type of Admission

State Totals	Hospital	Rehab Facility	Physician	Payor (HMO, PPO, etc.)	Family/Friend/Self	Nursing Home	Other	Total
Intermittent	33,740	6,426	22,736	55	240	4,577	5,336	73,110
Personal Care	139	29	192	227	805	23	651	2,066
Extended Care	25	0	2	0	9	0	1	37
Total	33,904	6,455	22,930	282	1,054	4,600	5,988	75,213

Table 8. 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	46.15%	8.79%	31.10%	0.08%	0.33%	6.26%	7.30%	100.00%
Personal Care	6.73%	1.40%	9.29%	10.99%	38.96%	1.11%	31.51%	100.00%
Extended Care	67.57%	0.00%	5.41%	0.00%	24.32%	0.00%	2.70%	100.00%
Total	45.08%	8.58%	30.49%	0.37%	1.40%	6.12%	7.96%	100.00%

Staffing

Home Health staffing is distributed among full time, part time, and contract labor (64%, 29%, and 7%, respectively). The percentage of staff in a particular field can vary widely from each of the categories.

RNs account for 20% of all full time employees. Over three-fourths of the RNs are employed full time (76%), while 23% are part time, and only 1% are contract.

The vast majority of the clerical staff (88%) is made up of full time employees, with 11% being part time, and 1% being contract. Overall 10% of the home health staff are clerical.

Physical and occupational therapists are employed mainly on a full-time basis, while speech therapists are more part time workers. Of the therapists, physical therapists account for over double the number of speech and occupational therapists (8% vs. 1% and 3%). Contract labor accounts for 14% of the physical therapists, 23% of the speech therapists, and 15% of the occupational therapists.

Overall, personal care aides account for almost half (49%) of all Home Health employees, but compose 68% of contract workers. They are distributed among full time employment (53%), part time employment (37%), and contract labor (10%).

Table 9. 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	665	265	279	24	75	19	174	1,340	465	3,306
Part Time	196	70	78	35	42	17	76	930	57	1,501
Contract	8	5	60	18	21	1	0	251	5	369
Total	869	340	417	77	138	37	250	2,521	527	5,176

Table 10. 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	20.11%	8.02%	8.44%	0.73%	2.27%	0.57%	5.26%	40.53%	14.07%	100.00%
Part Time	13.06%	4.66%	5.20%	2.33%	2.80%	1.13%	5.06%	61.96%	3.80%	100.00%
Contract	2.17%	1.36%	16.26%	4.88%	5.69%	0.27%	0.00%	68.02%	1.36%	100.00%
Total	16.79%	6.57%	8.06%	1.49%	2.67%	0.71%	4.83%	48.71%	10.18%	100.00%

Unduplicated Admissions

Table 11. Unduplicated Admissions

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	39,631	4,558	17,379	283	49	61,900
Personal Care	4	2,862	544	301	34	3,745
Extended Care	1	43	8	1	0	53
Total	39,636	7,463	17,931	585	83	65,698

Table 12. Unduplicated Admissions Percentage

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	64.02%	7.36%	28.08%	0.46%	0.08%	100.00%
Personal Care	0.11%	76.42%	14.53%	8.04%	0.91%	100.00%
Extended Care	1.89%	81.13%	15.09%	1.89%	0.00%	100.00%
Total	60.33%	11.36%	27.29%	0.89%	0.13%	100.00%

Hospice Agencies and Facilities

Act 396 of 1997 required separate Permits of Approval for hospice agencies and hospice facilities 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.

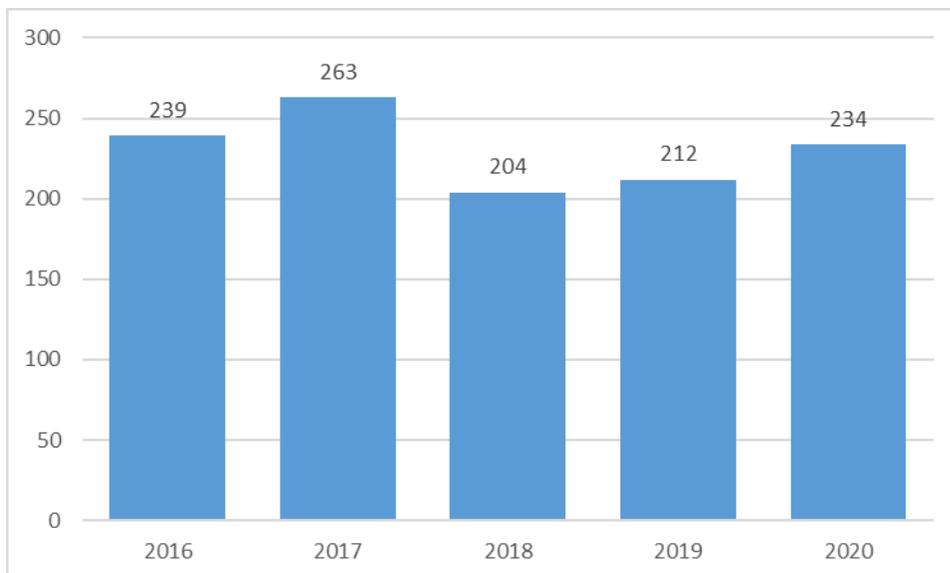
Although the number of deaths served by hospice was beginning to grow in Arkansas, there is an uneven distribution of the number served. In some areas of the state there appears to be a slower willingness to accept hospice services or to accept a death diagnosis that defines hospice. In some cases, there 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

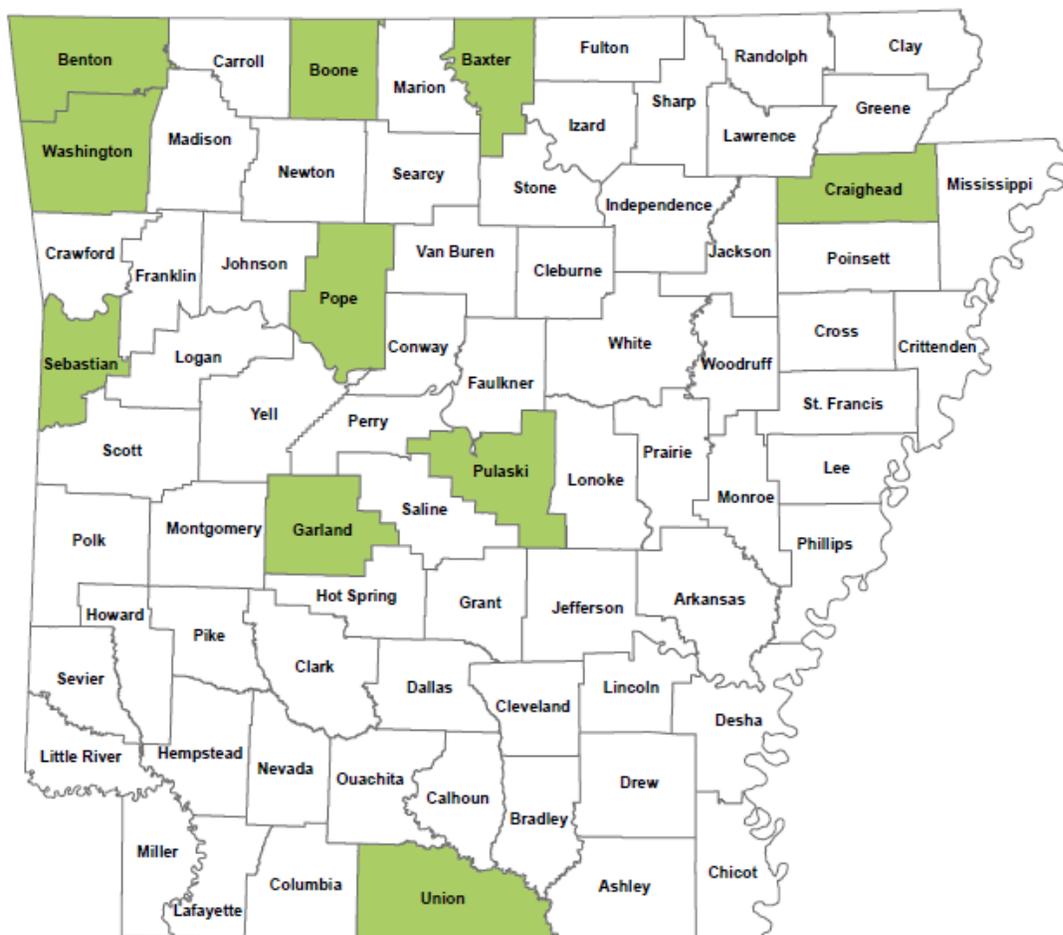
As illustrated on the graph below, the annual surveys show an increase in number of inpatient hospice beds from 2016-2017, then a substantial decrease in 2018. Since 2018 there has been a gradual increase in inpatient beds reported annually.

Figure 8. Number of Survey Reported Licensed Hospice Inpatient Beds 2016-2020



According to the 2020 survey, there are now hospice facilities with inpatient beds in 10 of Arkansas's 75 counties (see the map below). There were 234 licensed beds reported across the 13 facilities.

Figure 9. Counties with Hospice Inpatient Beds in Arkansas



Admissions

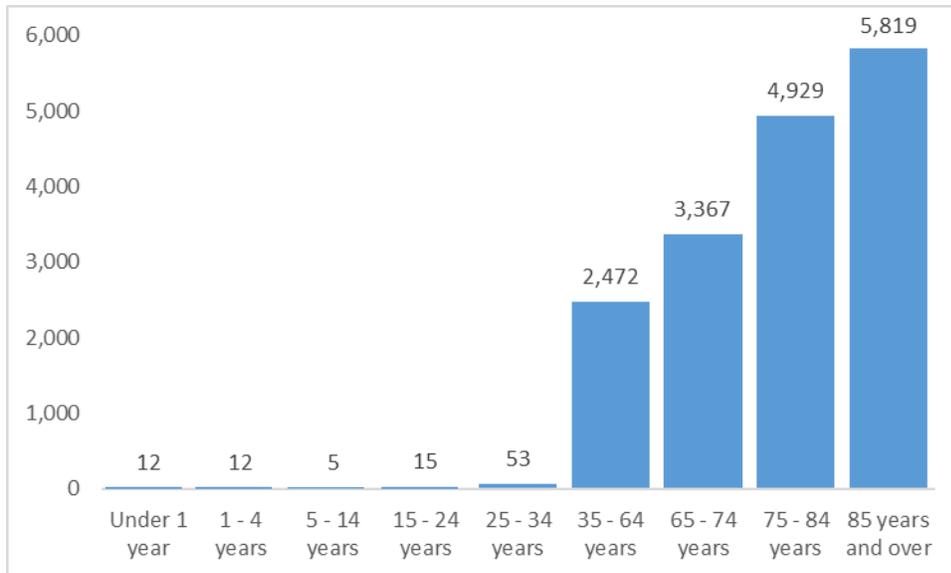
A total of 16,684 unduplicated hospice admissions was reported statewide on the survey for 2020. When considering admissions by race/ethnicity, the overwhelming majority of these admissions are White patients (85%), with the next largest racial/ethnic group being Black patients (9%). The remaining 5.4% of admissions are spread throughout the other race groups with 3.5% being Unknown (see table below).

Table 13. Hospice Admissions by Race/Ethnicity

	Number	Percent
Hispanic	140	0.8%
American Indian	35	0.2%
Black	1,574	9.4%
Asian	68	0.4%
Native Hawaiian	24	0.1%
White	14,212	85.2%
Another Race	27	0.2%
Multi-race	13	0.1%
Unknown	591	3.5%
Total	16,684	100.0%

The age of hospice patients is skewed toward the older age groups, with patients who are at least 35 years old representing over 99% of the unduplicated hospice admissions (see chart below). The two oldest age groups, 85 years and over and 75-84 years, had 5,819 and 4,929 admissions respectively. These two groups accounted for over half of the unduplicated admissions reported.

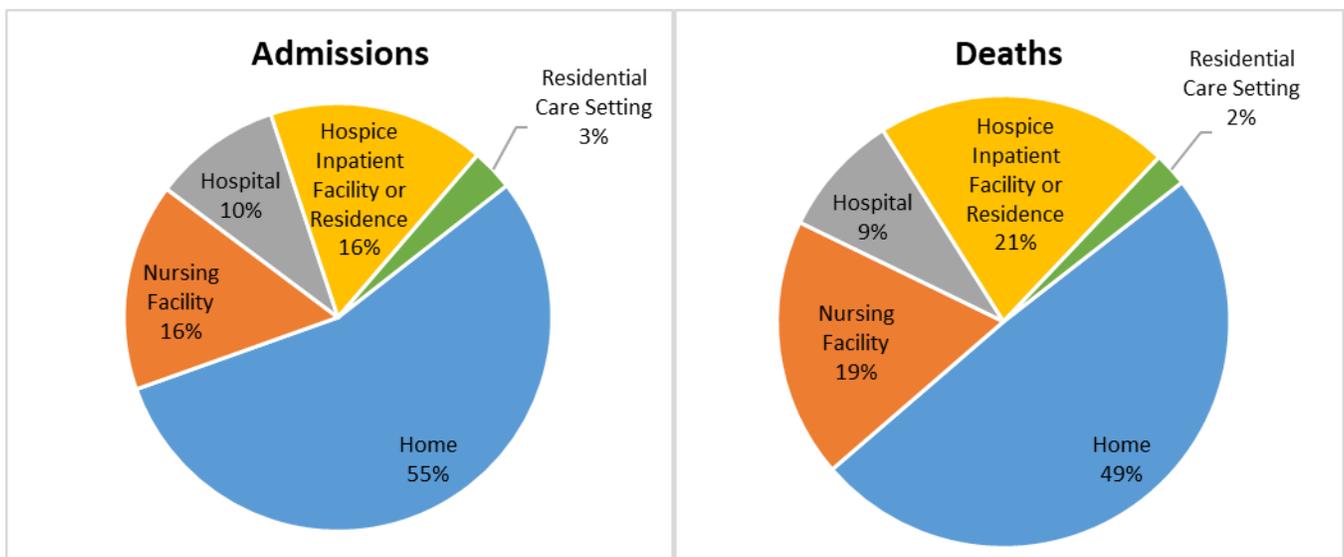
Figure 10. Hospice Admissions by Age



Admissions and Deaths by Location

There is a slight difference in the percentage of admissions and deaths by location. The largest difference is between admissions and deaths at Home. While Home accounts for approximately 55% of all admissions, it makes up 49% of the hospice deaths. Conversely Hospice Inpatient Facility and Nursing Facility had a larger share of deaths than admissions (see chart below).

Figure 11. Hospice Admissions and Deaths by Location



Primary Diagnosis

The primary diagnosis that makes up the highest percentage of the 16,684 unduplicated hospice admissions reported on the 2020 survey is neoplasms (30.3%). The other primary diagnoses that account for at least 10% of admissions are diseases of the circulatory system (23.4%), diseases of the nervous system (18.4%), and diseases of the respiratory system (13.2%) (see table below). The 2020 survey has a new diagnosis that has not been included before, acute respiratory distress syndrome due to the COVID-19 virus which has the code U07.1. This new diagnosis represents 0.8% of admissions. Since it is a new diagnosis and was not represented in the usual categories, those responding to the survey had to write in this diagnosis.

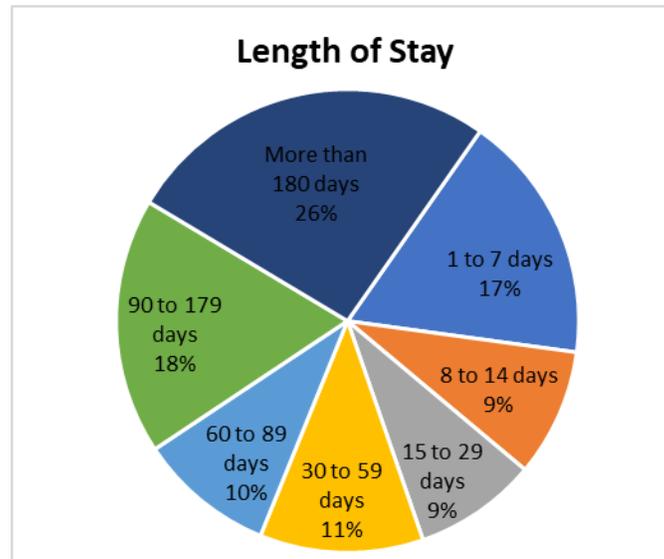
Table 14. Hospice Admissions by Primary Diagnosis

	New Admissions	Percent
Certain infectious and parasitic diseases (A00-B99)	309	1.9%
Neoplasms (C00-D49)	5,061	30.3%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	23	0.1%
Endocrine, nutritional and metabolic diseases (E00-E89)	444	2.7%
Mental, Behavioral and Neurodevelopmental disorders (F01-F99)	130	0.8%
Diseases of the nervous system (G00-G99)	3,076	18.4%
Diseases of the eye and adnexa (H00-H59)	0	0.0%
Diseases of the ear and mastoid process (H60-H95)	0	0.0%
Diseases of the circulatory system (I00-I99)	3,902	23.4%
Diseases of the respiratory system (J00-J99)	2,210	13.2%
Diseases of the digestive system (K00-K95)	543	3.3%
Diseases of the skin and subcutaneous tissue (L00-L99)	12	0.1%
Diseases of the musculoskeletal system and connective tissue (M00-M99)	44	0.3%
Diseases of the genitourinary system (N00-N99)	477	2.9%
Pregnancy, childbirth and the puerperium (O00-O9A)	0	0.0%
Certain conditions originating in the perinatal period (P00-P96)	2	0.0%
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	14	0.1%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	142	0.9%
Injury, poisoning and certain other consequences of external causes (S00-T88)	97	0.6%
External causes of morbidity (V00-Y99)	72	0.4%
Acute respiratory distress syndrome (ARDS) due to the COVID-19 virus (U07.1)	126	0.8%
Total	16,684	100.0%

Length of Stay

According to the 2020 survey, the majority of patients were in hospice care for either more than three months or less than a week (see chart below). Approximately a quarter of the patients (26%) were in hospice care for more than 180 days. The next largest group of patients stayed in care for 90 to 179 days (18%), followed by 1 to 7 days (17%). The overall average length of stay for a patient was 61.2 days.

Figure 12. Hospice Patients by Length of Stay



Staffing

Direct Clinical Nursing staff represent the largest discipline employed (40.6%) followed by Hospice Aides (24.3%), according to the 2020 survey (see tables below). While Paid Physicians make up only 4% of the overall staffing, they comprise a majority of the contract workers (65.1%).

Hospice staffing is comprised of 87% full time workers, 9% part time workers, and 4% contract workers. Direct and Indirect Clinical Nursing along with Social Services and Hospice Aides all have over 90% of their respective disciplines employed full time. Conversely, Paid Physicians are majority contract workers (60%) with only 36% employed full time. Nurse Practitioners are split evenly between full time (35%), part time (30%), and contract workers (35%).

Table 15. Hospice Staffing Information

State Totals	Nursing – Direct Clinical	Nursing – Indirect Clinical	Nurse Practitioner	Social Services	Hospice Aides	Physicians – Paid	Chaplains	Other Clinical	Bereavement	Total
Full Time	437	77	8	100	258	17	74	13	37	1,021
Part Time	40	2	7	7	27	2	14	2	9	110
Contract	0	1	8	1	0	28	0	5	0	43
Total	477	80	23	108	285	47	88	20	46	1,174

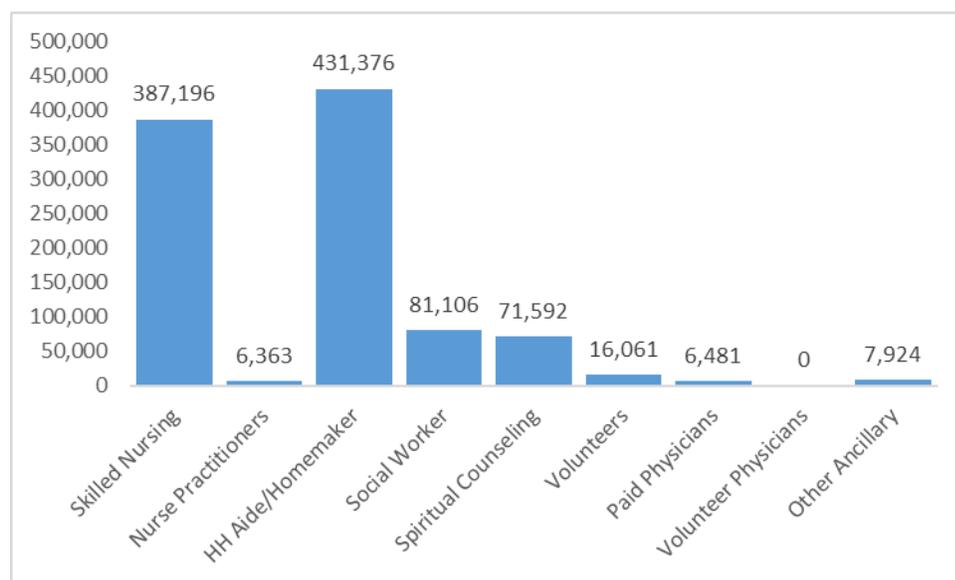
Table 16. Hospice Staffing Information Percentage

State Totals	Nursing – Direct Clinical	Nursing – Indirect Clinical	Nurse Practitioner	Social Services	Hospice Aides	Physicians – Paid	Chaplains	Other Clinical	Bereavement	Total
Full Time	42.8%	7.5%	0.8%	9.8%	25.3%	1.7%	7.2%	1.3%	3.6%	100.0%
Part Time	36.4%	1.8%	6.4%	6.4%	24.5%	1.8%	12.7%	1.8%	8.2%	100.0%
Contract	0.0%	2.3%	18.6%	2.3%	0.0%	65.1%	0.0%	11.6%	0.0%	100.0%
Total	40.6%	6.8%	2.0%	9.2%	24.3%	4.0%	7.5%	1.7%	3.9%	100.0%

Patient Visits

A total of 1,008,099 patient visits were reported on the 2020 survey. 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 combined account for 81% of patient visits. The remainder of the visits is led by social workers (8%) and spiritual counselors (7%).

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.

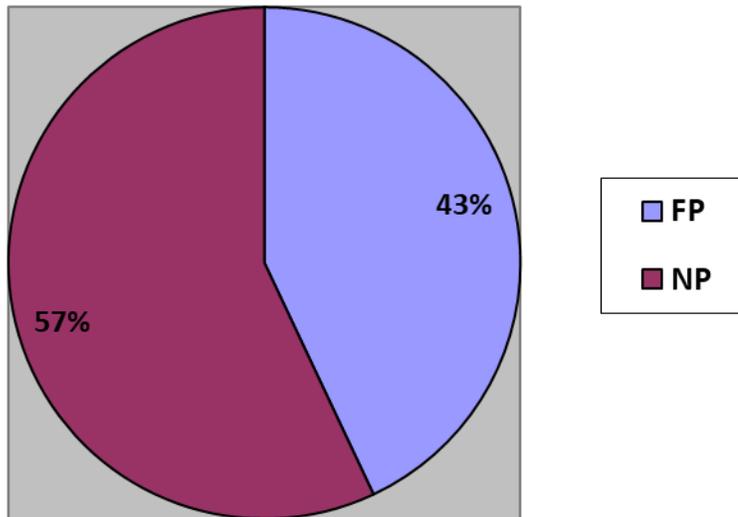
Survey Results

The respondents to the survey conducted in 2021 included seven PRTFs, which were made up of two for profits (FP) and five nonprofits (NP). This survey reports on events occurring in 2020. There were 410 licensed beds reported for 2020.

Licensed Beds

There were 410 licensed beds for 2020 reported in 2021's survey. The FPs accounted for 177 beds from their two facilities, and the NPs had 233 beds from five facilities.

Figure 14. Licensed Beds by Type of Facility



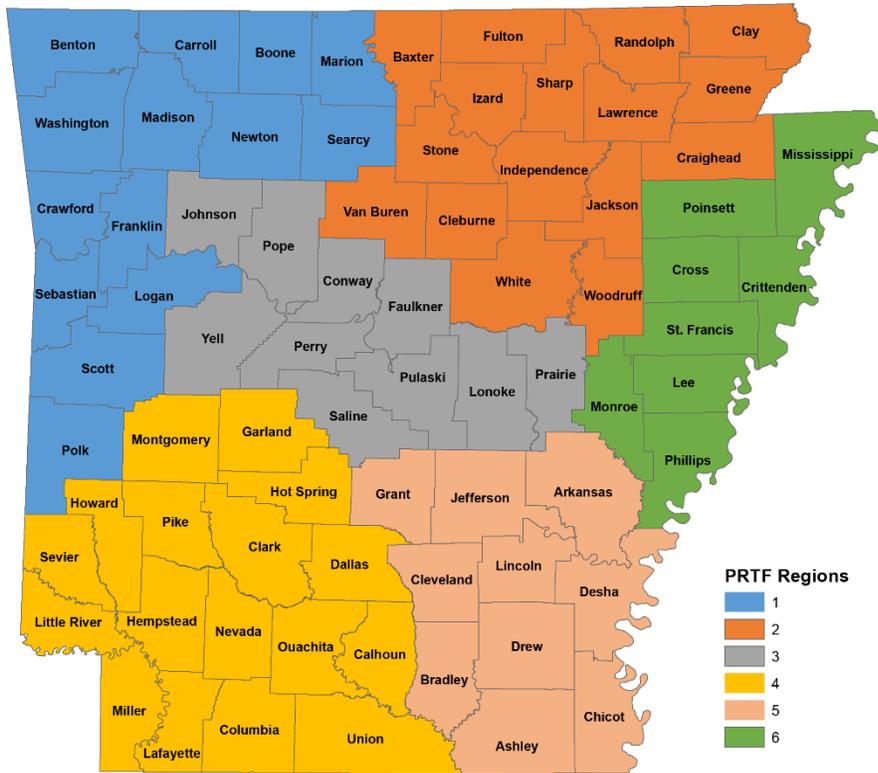
Payment Methods

In 2020, there were 86,671 total resident days and 694 admissions in the seven PRTFs. Arkansas Medicaid paid for 77,123 or 89%, 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 \$26,993,050.00 in 2020. The remaining 11% was covered by Medicaid (from a state other than Arkansas), "other" (as listed on the survey) forms of payment, private insurance, and CHAMPUS.

PRTFs and Host Counties

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

Figure 15. PRTF Regions



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 – NA
- Region 2 – 81%
- Region 3 – 85%
- Region 4 – 99%
- Region 5 – 87%
- Region 6 – NA
- State Total – 88%**

Figure 16. Overall Percentage of Patients Served by Number of Patients Per County

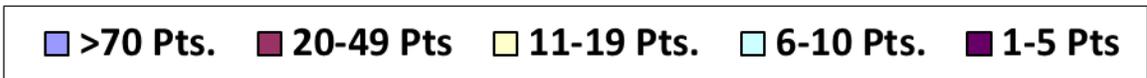
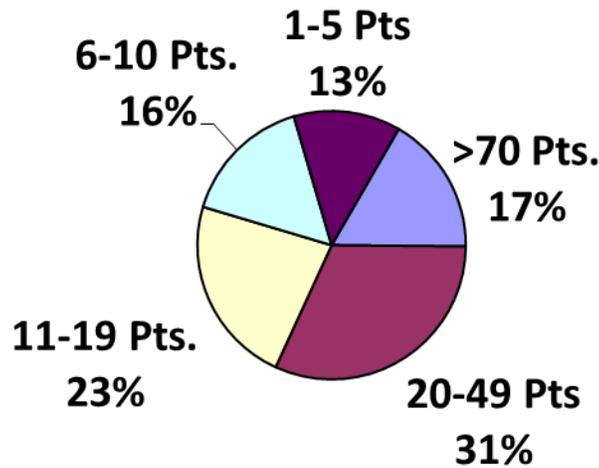


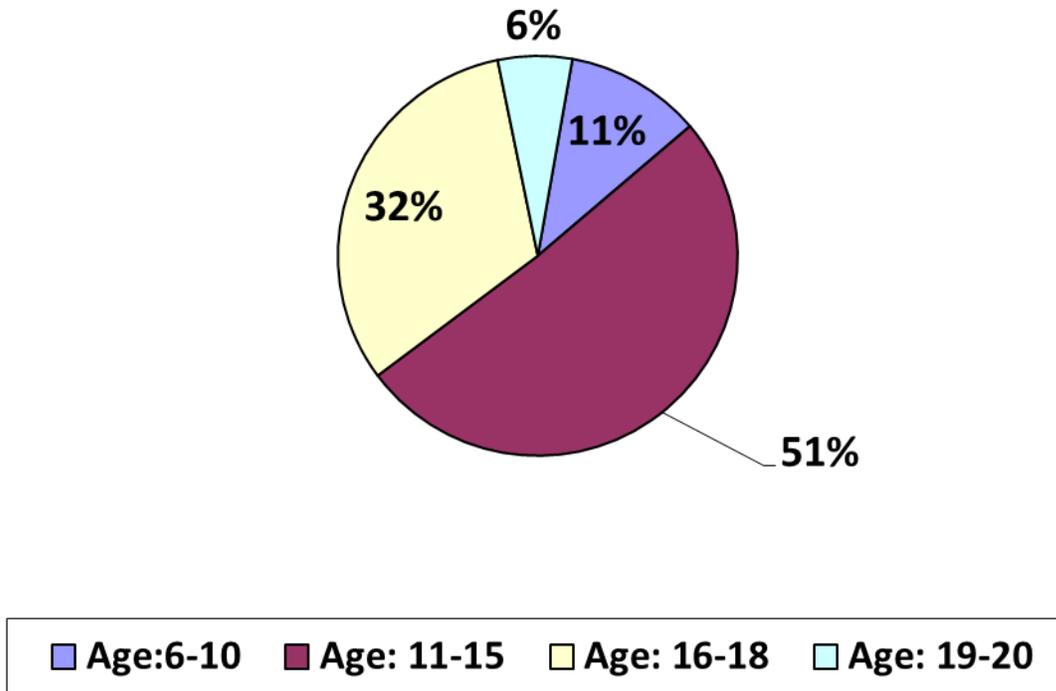
Table 17. Number of Patients Served Per County

Patients Per County	Total Patients Seen	County
>70 pts (1)	116	Pulaski
50-70 pts (0)	0	
20-49 pts (8)	226	Benton, Faulkner, Garland, Greene, Lonoke, Saline, Sebastian, White
11-19 pts (11)	158	Baxter, Craighead, Crawford, Independence, Jefferson, Miller, Poinsett, Pope, Union, Van Buren, Washington,
6-10 pts (15)	109	Boone, Cleburne, Columbia, Drew, Franklin, Grant, Hempstead, Hot Spring, Jackson, Johnson, Lafayette, Logan, Mississippi, Randolph, Yell
1-5 pts (37)	92	Arkansas, Ashley, Bradley, Carroll, Chicot, Clark, Clay, Cleveland, Conway, Crittenden, Cross, Dallas, Desha, Howard, Izard, Lawrence, Lee, Lincoln, Little River, Madison, Marion, Monroe, Montgomery, Newton, Ouachita, Perry, Phillips, Pike, Polk, Prairie, St. Francis, Scott, Searcy, Sevier, Sharp, Stone, Woodruff

Age

The 11-15-year-old range had the highest percentage of residents (51%), followed by 16–18-year-olds (32%), 11% of the residents were 6-10 years old, and only 6% was in the 19-20-year-old age group.

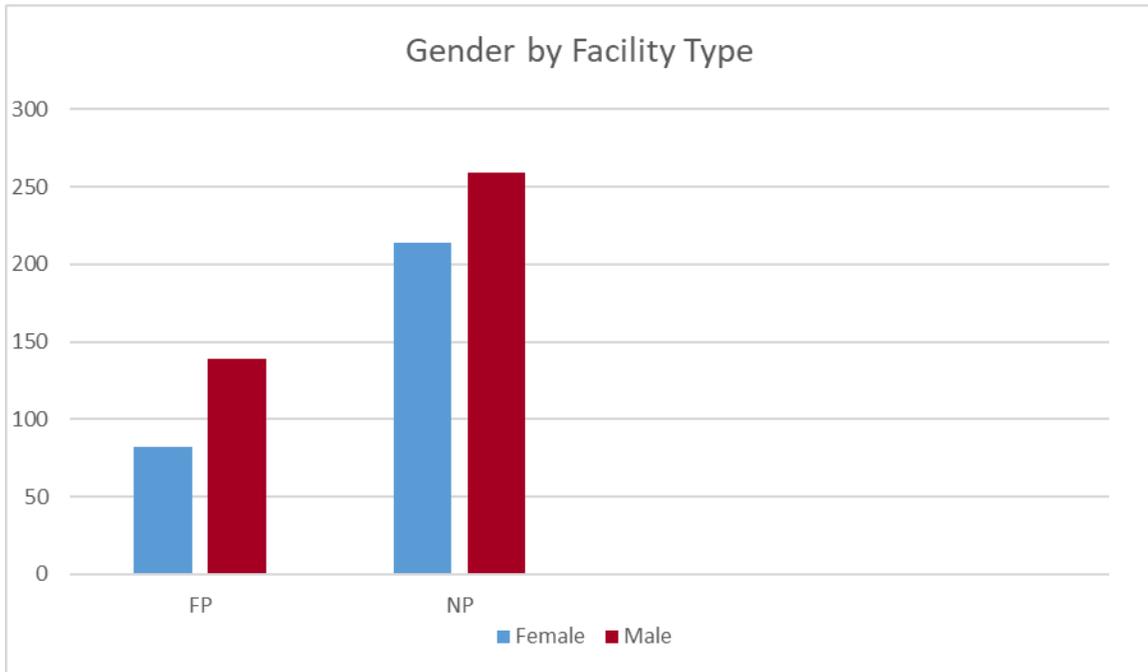
Figure 17. Residents by Age



Gender

Overall, there were more males than females being served in PRTFs. There were 398 boys between the ages of 6-20 and 296 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.

Figure 18. Gender by Facility Type



Race

According to 2020 population estimates 69.1% of children, in Arkansas, under the age of 18 are white and 17.6% are black, with the remaining 13.3% from other races. However, black children constitute a disproportionate 26% of the residents in PRTFs.

Figure 19. Population of PRTF Residents by Race

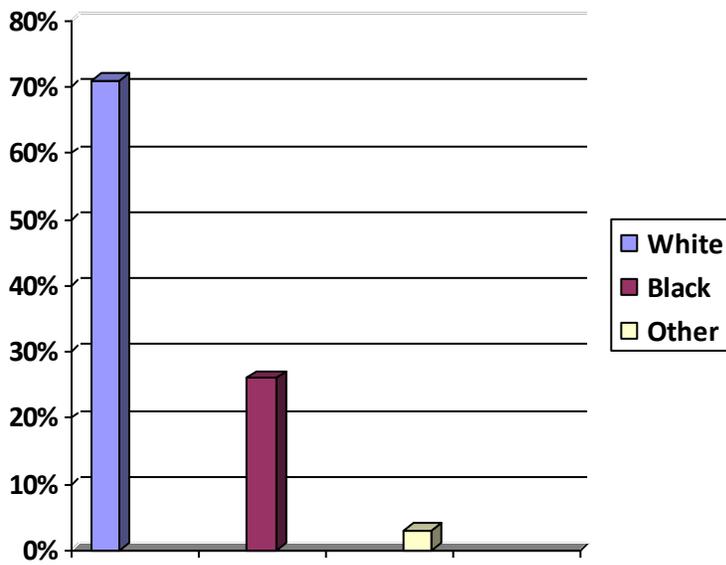
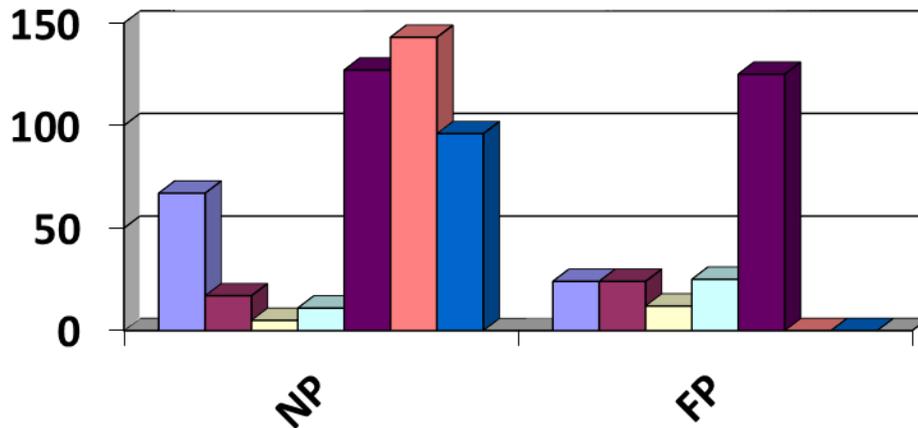
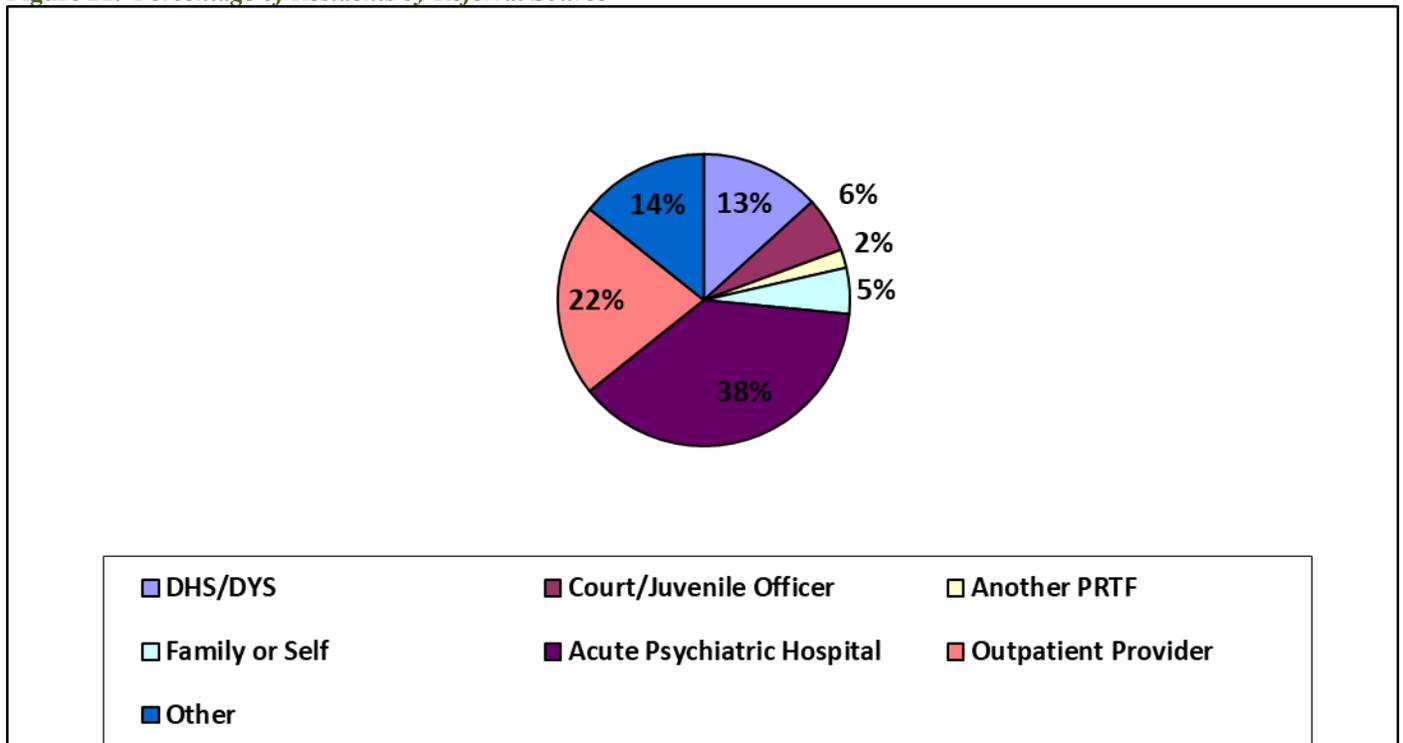


Figure 20. Resident Referral by Facility Type



Note: Other is made up of Juvenile Detention Center, Emergency Shelter, Physician (other than PCP admitting physician), Schools, and “Other.”

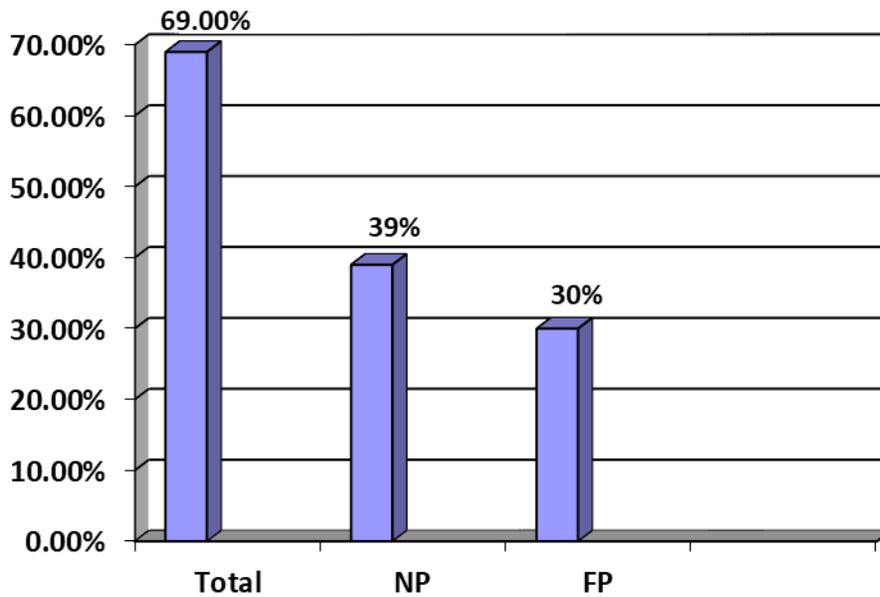
Figure 21. Percentage of Residents by Referral Source



Readmissions

Of the 694 PRTF admissions reported in 2020, 481 (69%) of the children had previously been admitted to a PRTF or psychiatric hospital (see Figure 22 below). NPs had a higher level of readmission than FPs.

Figure 22. 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 31% of their residents to their home. The NP facilities returned 69% of their residents to their home.

Average Length of Stay

The average length of stay for an Arkansas resident in a PRTF was 145 days, or 4.8 months (see Table 18 below). One facility had an average length of stay greater than six months. A FP had the longest length of stay at 217 days. The NP residents stayed for a little more than two months less (66 days).

Table 18. Average Length of Stay by Facility Type

Facility Type	Facility Name	Average LoS (days)	Average LoS (months)
FP	Millcreek of Arkansas	140.7	4.7
FP	Neuro-restorative Timber Ridge	217	7.2
FP Total		178.9	5.9
NP	Youth Home, Inc.	173.2	5.7
NP	United Methodist Children’s Home Dacus	118.5	3.6
NP	United Methodist Children’s Home Little Rock	104.2	3.5
NP	Centers for Youth and Families - Little Rock /Monticello	158.7	5.3
NP Total		110.9	3.7
All Facilities		144.9	4.8