HEALTH SERVICES PERMIT AGENCY

SFY 2024 ANNUAL REPORT

SURVEY RESULTS FROM CY 2023

Presented by: Sandra Hollowell, 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 Home Care 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 three (3), including the Health Program Administrator, Sandra Hollowell, the Health Program Supervisor, Traci Harris, and the Fiscal Support Supervisor, Jennifer Cooper.

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 $0.10 a page for copying. The total deposit for FY 2024 was $18,035.94.

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 2024 was $61,072.00 and the budget for 2024 was comprised of 96% SGR and 4% POA fund balance.

Table 1. ***Health Services Permit Agency Fiscal Year 2024 Budget and Revenue***

844 – HSPA	FY 2024
APPROVED BUDGET	$511,244.00
GENERAL REVENUE	$438,172.00
POA & COPY FEES	$18,035.94
TOTAL REVENUE	$511,108.27
TOTAL EXPENSES	$449,924.70

PERMIT OF APPROVAL REVIEW PROCESS

Fiscal Year 2023 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://www.arhspa.org.

MEETINGS

The Commission meets at least quarterly; however, meetings may occur more frequently to respond to appeals and requests from the public. The Commission met four (4) times during FY 2023. 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 2023, there was one (1) appeal of an Agency 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 2023, thirteen (13) applications were approved, five (5) were denied. Zero (0) were withdrawn or returned. Agency decisions resulted in the approval of $ 81,122,500.00 in capital projects.

Table 3. ***Fiscal Year 2023 Applications***

Type of Project	Number of Apps	Approved Capital Expenditures	Approved	Denied	Withdrawn/ Returned
RCF's (moratorium)	0	NA	0	0	0
Nursing Facilities	4	$ 38,350,000.00	4	0	0
PRTF's (moratorium)	0	NA	0	0	0
Home Health	5	$ 25,000.00	1	4	0
Assisted Living	7	$ 42,747,500.00	6	1	0
Hospice Agencies	2	$ 0	2	0	0
Hospice Facilities	0	$ 0	0	0	0
Totals	**18**	**$81,122,500.00**	**13**	**5**	**0**

Table 4 illustrates the total applications received from FY 2013 - FY 2023 that the POA applications are averaging twenty-four (24) 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 2012 – FY 2023***

Type of Projects	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Nursing Facilities	13	13	7	5	8	3	4	16	6	5	4
RCF (Moratorium 07/05)	0	0	0	0	0	0	0	0	0	0	0
Assisted Living	17	17	27	9	20	8	11	5	6	3	7
Home Health	1	5	1	2	10	2	0	1	3	0	5
Hospice	6	1	0	0	0	0	0	0	3	0	2
Hospice Facility	0	0	0	7	0	0	0	0	0	0	0
PRTF (Moratorium 02/08)	0	1	0	0	0	0	0	0	0	0	0
ICF (Moratorium 03/94)	0	0	1	0	0	0	0	0	0	0	0
Total	**37**	**37**	**36**	**23**	**38**	**13**	**15**	**22**	**18**	**8**	**18**

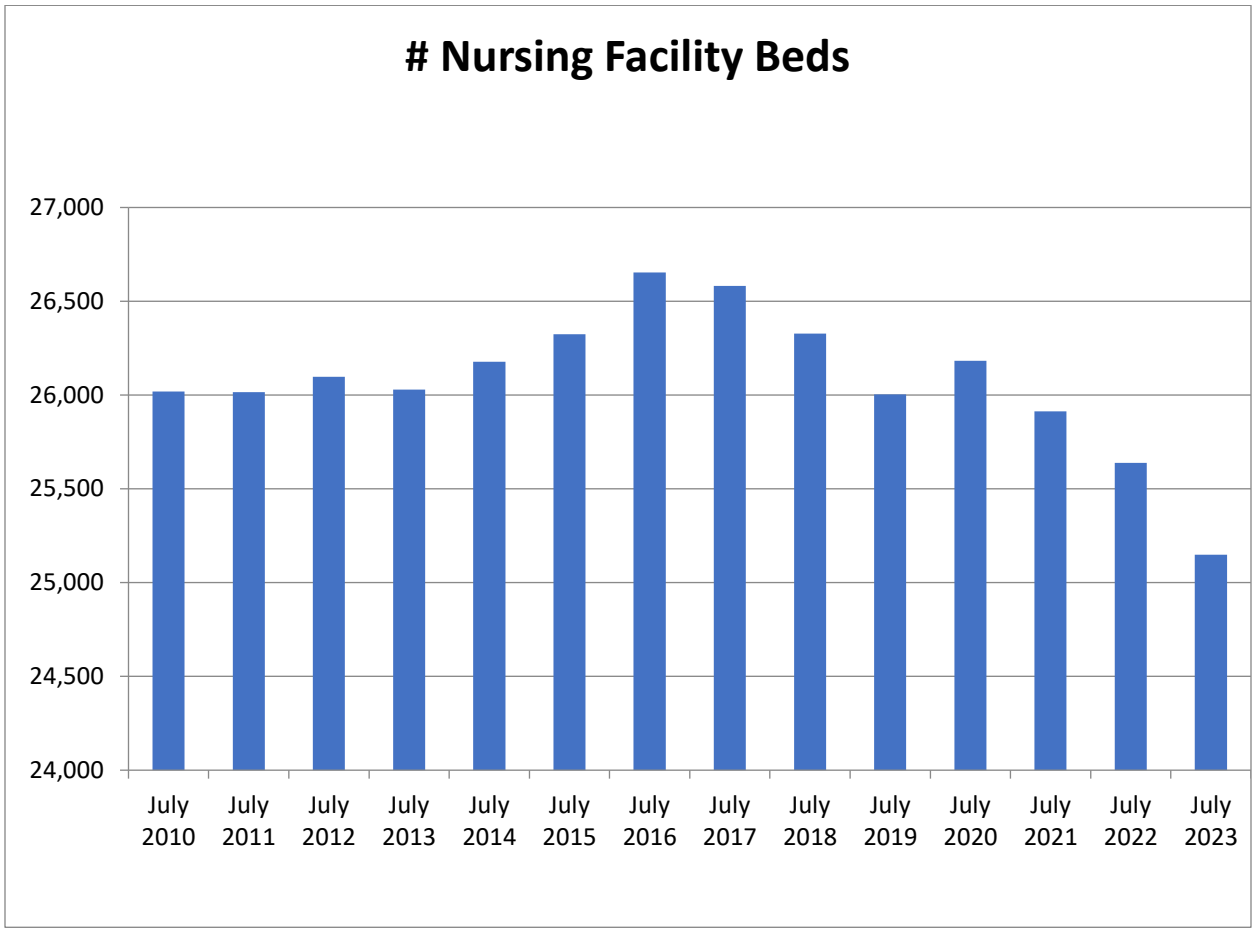
NURSING FACILITIES

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 2022, the Nursing Facility net need was (-616) and the bed need as of July 2023 is (129).

Figure 1. ***Number of Nursing Facility Beds 2010-2023***



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

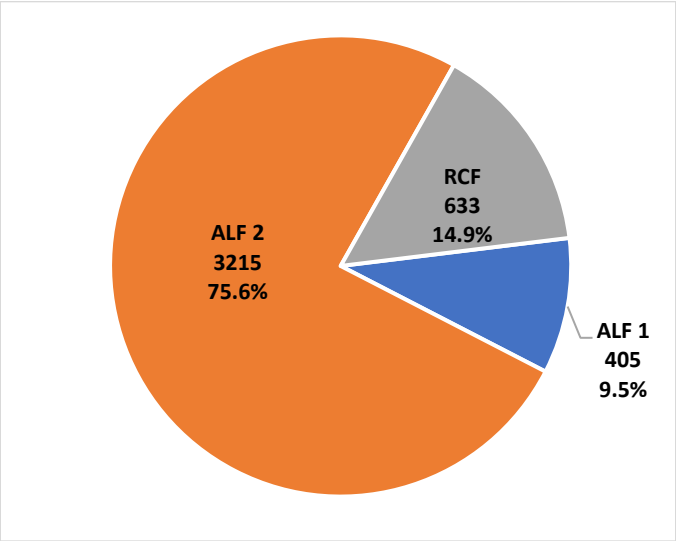
The report below represents data collected via an Internet based survey of Assisted Living Facilities (ALF) and Residential Care Facilities (RCF) in Arkansas. This survey was conducted in 2025, but the questions pertain to residential occupancy occurring in 2023. The purpose of the mandatory survey was 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. Overall, there were a total of 68 facilities who completed this year's survey. The survey results include 17 RCFs, 4 ALF Level 1, 46 ALF Level 2, and 1 facility with both ALF Level 1 and 2 license types. This year there are no facilities with both RCF and ALF license types. In order to protect the confidentiality of the patients in the single facility that is both ALF 1 and 2 this data will be excluded any time the data is broken out into facility type.

Survey Results

There were 4,253 licensed ALF and RCF beds and 3,240 rooms reported in the survey. The average number of beds per facility was 62.5, with 1.31 beds per room. There were 6 facilities that had 20 or fewer beds, while 18 facilities had 80 or more beds. There was at least one reported RCF or ALF in 35 of the 75 counties in Arkansas.

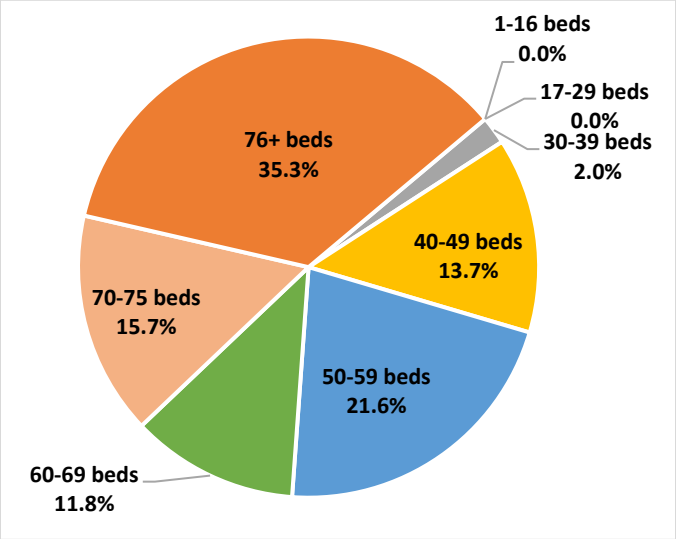
Figure 1. ***ALF and RCF Licensed Beds***



ALF

For 2023, survey responses show a total of 3,620 ALF beds (405 ALF Level 1; 3,215 ALF Level 2). The average bed count for an ALF was 71 beds, with 1.28 beds per room.

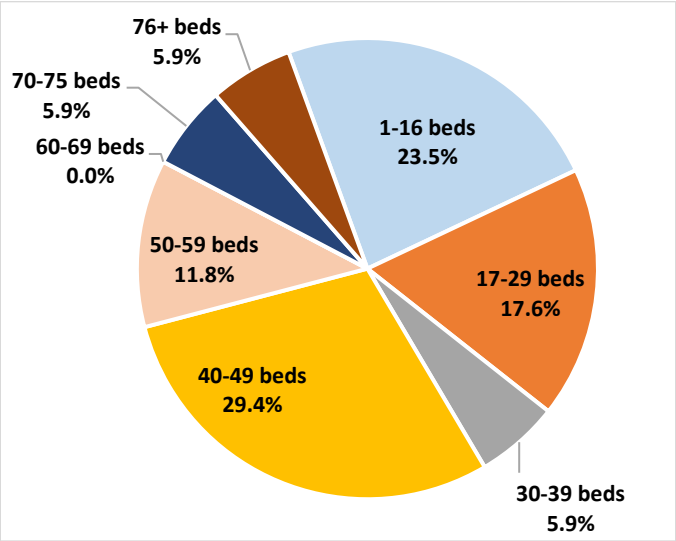
Figure 2. ***Assisted Living Facilities by Number of Beds***



RCF

There were 633 RCF beds reported in 2023. The average number of beds per RCF was 37.2, and the average number of beds per room for RCFs was 1.54. This appears to mean that RCFs are smaller on average than ALFs, but they house more residents per room.

Figure 3. ***Residential Care Facilities by Number of Beds***



County Bed Count Sizes

According to reported bed counts, the counties with the six highest (Pulaski, Benton, Sebastian, Washington, Craighead, Baxter), six in the middle (Cleburne, Hot Spring, Ashley, Polk, Grant, Scott), and the seven lowest counts (Phillips, Montgomery, Miller, Poinsett, Pike, Yell, Woodruff) in the state were examined. Woodruff County had the fewest beds reported. The top six counties accounted for 45% of all beds reported in Arkansas. The average bed count for the top ranked counties were significantly larger, 318.8 average beds, than the middle and lower groups. The middle group of six counties has an average bed count of 74.2 and the seven lowest counties had an average bed count of 34.1.

Occupancy Rates

The average estimated occupancy rate reported by the facilities was 67.3% (N=64 values reported). This survey round reported no zero estimates, but there were four response records with no estimate whatsoever. This year the design of the occupancy rate calculation was changed to encourage more responses by making the calculation simpler. In prior surveys there were several questions used as inputs to calculate resident occupancy days (RODs), as that was believed to be the most accurate way to determine occupancy rates. However, this method proved to be very difficult to understand for many survey respondents. The new method takes an average occupied bed count for each month, either an average of daily counts or some other official monthly average calculated by the responding facility, and then determines from those twelve counts an average occupied bed count for the survey year. This yearly average is then divided by the number of that facility's licensed beds, thus giving a new calculation for occupancy rates.

Using this new method, the average occupancy rate across all 68 reporting facilities was 70.5% (N=68 values reported). The survey strongly encouraged the responders to enter a non-zero amount for each month, even if it was just a ballpark estimate. Unfortunately, there were two response records that reported zeros for each month. After removing the two facilities that reported zeros for occupied beds every month, the average occupancy rate percentage jumps to 72.7% (N=66 non-zero rates reported).

Admissions by Age and Gender

Females accounted for 62.3% of the total admissions to ALFs and RCFs reported for 2023. For ALF Level 1 admissions, women outnumbered men in all age categories. The females admitted outnumbered the males for ALF Level 2 as well, and the differences were especially significant in the age groups 75-84 and 85+. RCF admissions were higher amongst men than women in the less than 65 years old age group, but not by a significant amount.

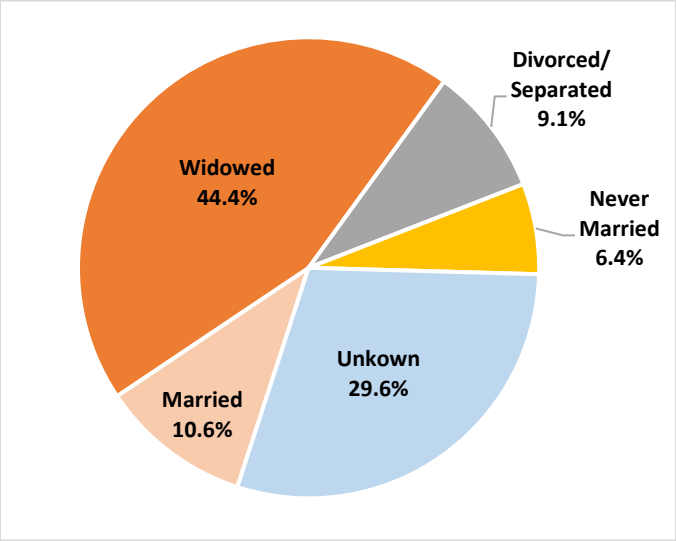
Table 1. ***Admissions by Age and Gender by Facility Type***

Age	M ALF 1	F ALF 1	M ALF 2	F ALF 2	M RCF	F RCF	Total
<65	0	0	31	40	27	25	**123**
65-74	10	11	77	124	8	9	**239**
75-84	23	28	105	215	9	17	**397**
85+	8	16	140	275	17	35	**491**
Total	**41**	**55**	**353**	**654**	**61**	**86**	**1,250**

Admissions by Marital Status and Race

Approximately 44.4% of all reported admissions were widowed, 10.6% were married, 6.4% were never married, and 9.1% were divorced or separated. Residents were overwhelmingly White (67.6%) vs. African American (2.2%). Of the 35 counties with either an ALF and/or RCF, only 12 distinct counties reported African American admissions. Unfortunately, many responders reported significant counts for both admissions by marital status and admissions by race as "Unknown."

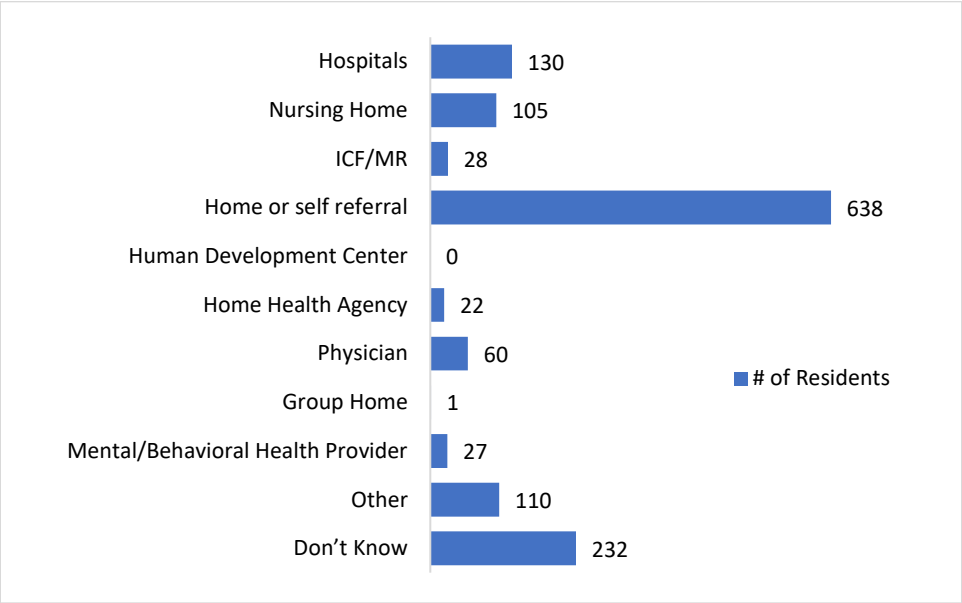
Figure 4. ***Number of Admissions by Marital Status***



Referral Sources

Approximately 47.2% of referrals came from home or self-referrals, followed by "Don't Know" at 17.1% (see Figure 5, below for the counts). Hospitals (9.6%), Other (8.1%), and nursing homes (7.8%) were the next highest categories. The "Other" category is often stated as other assisted living facilities, family, rehab facilities, independent and paid referral sources/agencies.

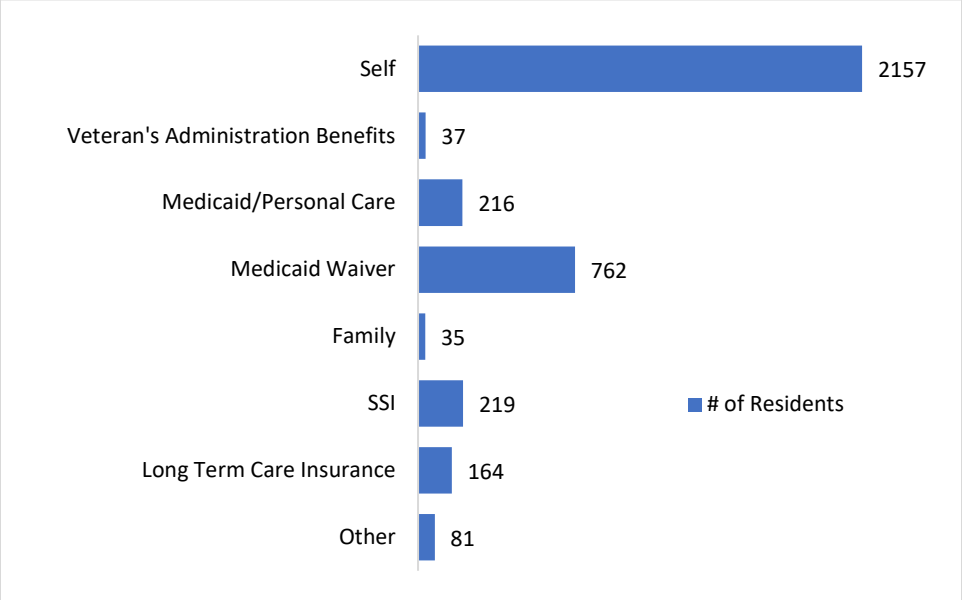
Figure 5. ***Referral Source of Residents***



Residential Reimbursement

The top reported methods of payment for residents of ALFs and RCFs are: Self pay (58.8%), Medicaid Waivers (20.8%), SSI (6.0%), and Medicaid/Personal Care (5.9%).

Figure 6. ***Source of Payment by Residents***



According to the survey results, those who reported accepting Medicaid Waivers were overwhelmingly Assisted Living Level 2 Facilities. Only one RCF reported accepting Medicaid Waivers. Of the 46 ALF 2 facilities, 28 accepted Medicaid Waivers. The average number of waivers per facility that reported Medicaid Waivers was 26.3, with a range between 4 and 66.

Table 2. ***Number of Medicaid Waivers by Facility***

Facility Name	County	Licensed Beds	Medicaid Waivers
The Pillars of the Community	Ashley	75	17
RiverLodge Assisted Living	Baxter	75	41
Autumn Place at Oak Ridge	Benton	40	33
Gardens at Osage Terrace	Benton	51	48
Maple Esplanade Assisted Living	Boone	78	33
The Plaza at Twin Rivers	Clark	55	8
StoneBridge of Heber Springs	Cleburne	89	25
St. Bernards Villa	Craighead	116	4
Hope's Creek Assisted Living	Crawford	118	56
Van Buren Legacy, LLC	Crawford	40	10
Daltons Place at Fordyce Assisted Living	Dallas	50	21
Grand Manor	Drew	55	18
Village Park of Conway, Inc.	Faulkner	47	14
Hope Haven Assisted Living	Hempstead	52	19
The Crossing at Malvern	Hot Spring	84	55
Eagle Mountain Assisted Living	Independence	58	10
Trinity Village Assisted Living	Jefferson	54	5

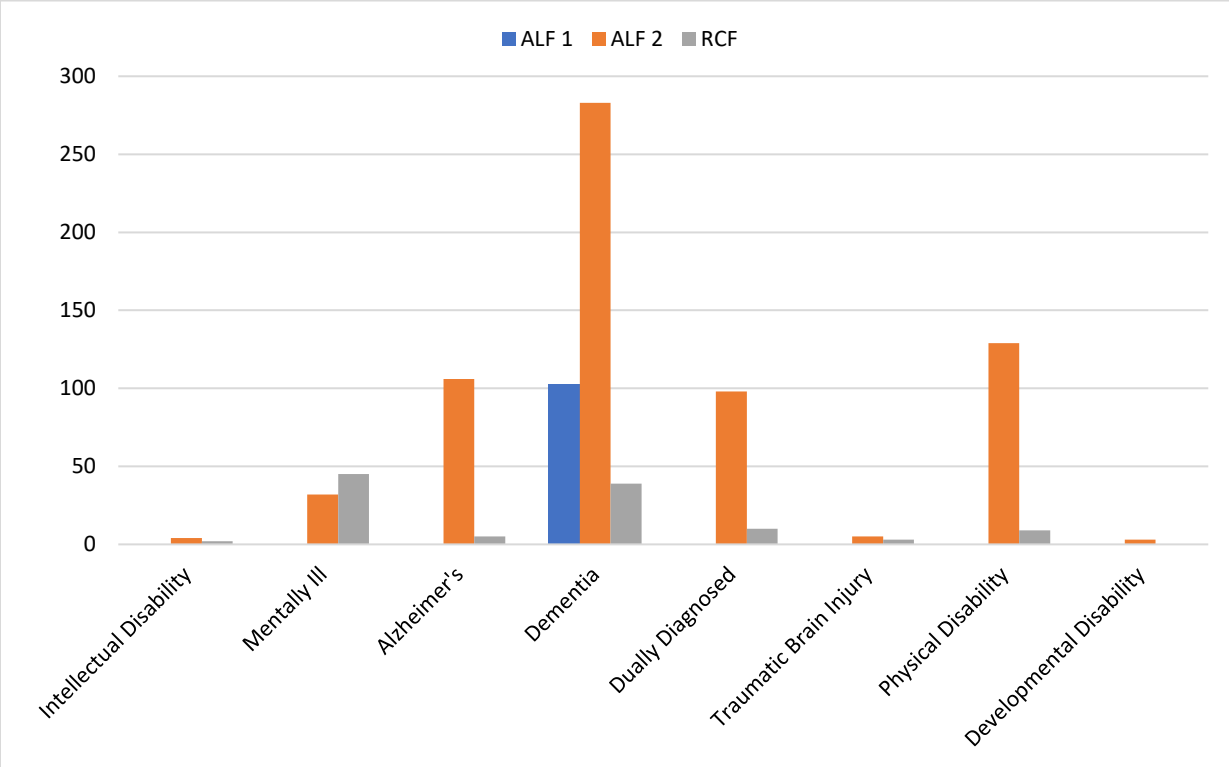
Dalton's Place Assisted Living	Lincoln	53	17
Countryside Assisted Living	Madison	106	66
Windsor Cottage Ltd	Miller	42	6
Montgomery County Assisted Living	Montgomery	42	15
Dougan's Oak Park	Pike	32	21
Plantation Homes of Poinsett County	Poinsett	40	22
Peachtree Assisted Living	Polk	70	24
The Manor, LLC	Pulaski	90	10
Four Seasons Assisted Living	Saline	50	39
Dalton's Place Waldron	Scott	58	32
Mercy Crest Assisted Living	Sebastian	102	37
Azalea Commons of Springdale	Washington	90	56
Total		**1,912**	**762**

Note: The table is sorted by County reported.

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 reported fewer residents that had a mental illness (32) vs. RCF (45). However, the ALFs had many more residents with Alzheimer's (ALFs 106 vs. RCFs 5) or dementia (ALFs 386 vs. RCFs 39). Also, this year's survey reported more ALF Level 2 residents with a physical disability at a count of 129.

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.

Unduplicated Admissions

A total of 56,545 unduplicated Home Health admissions were reported for 2023. Of the unduplicated admissions, 98.3% were intermittent and 1.6% were personal care. While there were some extended care admissions, they made up less than 0.1% of the total.

The principal payor sources for the unduplicated admissions were Medicare (57.3%), 3rd party (35.9%), and Medicaid (6.2%). Self-pay and charity combined equal less than 1% of the admissions. While the majority of unduplicated intermittent admissions were covered by Medicare (58.3%), most personal care and extended care admissions were paid by Medicaid (65.4% and 54.2%, respectively).

Table 3. ***Unduplicated Admissions by Principal Payor Source***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	32,404	2,881	20,167	121	36	**55,609**
Personal Care	13	596	102	190	11	**912**
Extended Care	0	13	9	2	0	**24**
Total	**32,417**	**3,490**	**20,278**	**313**	**47**	**56,545**

Table 4. ***Unduplicated Admissions Percentage by Principal Payor Source***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Intermittent	58.3%	5.2%	36.3%	0.2%	0.1%	**100.0%**
Personal Care	1.4%	65.4%	11.2%	20.8%	1.2%	**100.0%**
Extended Care	0.0%	54.2%	37.5%	8.3%	0.0%	**100.0%**
Total	**57.3%**	**6.2%**	**35.9%**	**0.6%**	**0.1%**	**100.0%**

Age

For most age groups over 18 years, intermittent admissions are in the tens of thousands while personal care admissions are only a couple hundred. Proportionally speaking, however, the age of admission for Home Health patients appears to be fairly similar regardless of whether the patient is an intermittent or personal care admission. The largest differences occur amongst 75-84 year olds where intermittent admissions are higher than personal care (31.1% vs. 26.5%), and for 65-74 year olds where there were more personal care admissions (28.8% personal care vs. 25.9% intermittent).

Table 5. ***Intermittent Admissions by Age***

State Totals	0-1	1-18	19-64	65-74	75-84	85+	Total
Number	166	271	13,954	16,634	19,981	13,289	**64,295**
Percentage	0.3%	0.4%	21.7%	25.9%	31.1%	20.7%	**100.0%**

Table 6. ***Personal Care Admissions by Age***

State Totals	0-1	1-18	19-64	65-74	75-84	85+	Total
Number	0	7	201	253	233	184	**878**
Percentage	0.0%	0.8%	22.9%	28.8%	26.5%	21.0%	**100.0%**

Referral Source

Most of the Home Health referrals were from hospitals (42.8%) and physicians (31.4%). The remaining 25.8% are spread out among five other categories.

Among Intermittent admissions, hospital referrals account for 43.3% of the admissions and physician referrals account for 31.6%. This closely mirrors the overall figures above, which makes sense when you consider that intermittent admissions account for 98.7% of the total admissions.

Personal Care admission referrals are distributed among the largest categories of Family/Friend/Self (48.0%), Physician (17.3%), and Payor (HMO, PPO, etc.) (13.0%).

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	29,774	6,084	21,738	263	140	6,697	4,126	**68,822**
Personal Care	35	12	154	116	427	58	87	**889**
Extended Care	14	0	2	1	4	0	2	**23**
Total	**29,823**	**6,096**	**21,894**	**380**	**571**	**6,755**	**4,215**	**69,734**

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	43.3%	8.8%	31.6%	0.4%	0.2%	9.7%	6.0%	**100.0%**
Personal Care	3.9%	1.3%	17.3%	13.0%	48.0%	6.5%	9.8%	**100.0%**
Extended Care	60.9%	0.0%	8.7%	4.3%	17.4%	0.0%	8.7%	**100.0%**
Total	**42.8%**	**8.7%**	**31.4%**	**0.5%**	**0.8%**	**9.7%**	**6.0%**	**100.0%**

Staffing

Home Health staffing is distributed among full-time, part-time, and contract labor (67.3%, 30.7%, and 2.0%, respectively). The percentage of staff in a particular field vary widely for each of the categories.

RNs account for 24.5% of all Home Health employees. Nearly three-fourths of the RNs are employed full time (74.1%), while 25.0% are part time, and only 0.8% are contract.

The overwhelming majority of the clerical staff (95.7%) is made up of full-time employees, with 3.6% being part-time, and 0.7% being contract. Overall, 17.9% of the Home Health staff are clerical.

Physical, speech, and occupational therapists account for 19.2% of the overall Home Health staff, with physical therapists being the largest group (453). The distribution of part-time, full-time, and contract workers varies across the different types of therapists. The majority of the physical therapists (72.0%) and occupational therapists (60.0%) are employed on a full-time basis. Speech therapists are spread more evenly with 44.6% being part-time employees and 38.5% being full-time. Contract labor accounts for 6.6% of the physical therapists, 16.9% of the speech therapists, and 8.5% of the occupational therapists.

Overall, personal care aides account for 23.8% of all Home Health employees, but compose 48.9% of part-time workers. Personal care aides are distributed among part-time employment (63.2%) and full-time employment

(36.8%), with no contract labor. The number of personal care aides reported for 2023 is 804, which is 23.7% less than the 1,054 reported for 2022.

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	613	258	326	25	78	13	83	296	580	**2,272**
Part Time	207	87	97	29	41	11	36	508	22	**1,038**
Contract	7	2	30	11	11	1	1	0	4	**67**
Total	**827**	**347**	**453**	**65**	**130**	**25**	**120**	**804**	**606**	**3,377**

Table 10. ***Staffing Information Percentage by Professional Discipline***

State Totals	RN	LPN	Physical Therapist	Speech Therapist	Occupational Therapist	Medical Social Worker	Home Health Aide	Personal Care Aide	Clerical Staff	Total
Full Time	27.0%	11.4%	14.3%	1.1%	3.4%	0.6%	3.7%	13.0%	25.5%	**100.0%**
Part Time	19.9%	8.4%	9.3%	2.8%	3.9%	1.1%	3.5%	48.9%	2.1%	**100.0%**
Contract	10.4%	3.0%	44.8%	16.4%	16.4%	1.5%	1.5%	0.0%	6.0%	**100.0%**
Total	**24.5%**	**10.3%**	**13.4%**	**1.9%**	**3.8%**	**0.7%**	**3.6%**	**23.8%**	**17.9%**	**100.0%**

Table 11. ***Staffing Information Percentage by Full Time, Part Time, and Contract Staff***

State Totals	Full Time	Part Time	Contract	Total
RN	74.1%	25.0%	0.8%	**100.0%**
LPN	74.4%	25.1%	0.6%	**100.0%**
Physical Therapist	72.0%	21.4%	6.6%	**100.0%**
Speech Therapist	38.5%	44.6%	16.9%	**100.0%**
Occupational Therapist	60.0%	31.5%	8.5%	**100.0%**
Medical Social Worker	52.0%	44.0%	4.0%	**100.0%**
Home Health Aide	69.2%	30.0%	0.8%	**100.0%**
Personal Care Aide	36.8%	63.2%	0.0%	**100.0%**
Clerical Staff	95.7%	3.6%	0.7%	**100.0%**
Total	**67.3%**	**30.7%**	**2.0%**	**100.0%**

Visits by Professional Discipline and Payor Source

There were 676,559 skilled nursing visits reported for 2023 and a total of 1,174 Registered Nurses and Licensed Practical Nurses (827 and 347, respectively) that worked for the Home Health agencies in the state. That averages to 576 nursing visits per nurse per year or 1.58 visits per nurse per day.

Physical therapy visits accounted for the second largest number of visits to patients' homes. There were 492,693 physical therapy visits reported for 2023, which is 34.1% of all visits. There were 453 physical therapists, which constitute 13.4% of the Home Health employees in the state.

The number of Home Health aide visits and "Other" visits reported for 2023 are both much lower than number of visits reported for 2022. There were 90,146 Home Health aide visits reported for 2023, which is down 48.6% from the 175,230 visits reported in 2022. The "Other" visits reported in 2023 were 42,546. This represents a decrease of 67.0% from the 129,004 reported in 2022. This may be due to incorrect reporting from some agencies who have reported large numbers of these visits in the past, but are not reporting any of these visits in 2023. This reporting issue also has an effect on the decrease in the number of visits by Self-Pay payor source.

The majority of all the Home Health visits reported for 2023 were paid for by Medicare (58.4%), followed by 3rd Party (31.9%) and Medicaid (9.4%). Medicare was the primary payor source for visits from all but one of the professional disciplines listed. "Other" visits were primarily paid for by Medicaid (88.9%).

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

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	399,574	42,245	233,284	1,060	396	**676,559**
Physical Therapy Visits	308,679	18,610	164,990	318	96	**492,693**
Speech Pathology Visits	20,185	238	9,136	30	9	**29,598**
Occupational Therapy Visits	68,928	371	35,431	110	42	**104,882**
Medical Social Services Visits	4,495	218	3,806	41	22	**8,582**
Home Health Aide Visits	41,284	35,609	10,915	2,191	147	**90,146**
Other	19	37,820	2,995	1,712	0	**42,546**
Total	**843,164**	**135,111**	**460,557**	**5,462**	**712**	**1,445,006**

Table 13. ***Visits by Professional Discipline by Payor Source Percentage***

State Totals	Medicare	Medicaid	3rd Party	Self-Pay	Charity	Total
Skilled Nursing Visits	59.1%	6.2%	34.5%	0.2%	0.1%	**100.0%**
Physical Therapy Visits	62.7%	3.8%	33.5%	0.1%	0.0%	**100.0%**
Speech Pathology Visits	68.2%	0.8%	30.9%	0.1%	0.0%	**100.0%**
Occupational Therapy Visits	65.7%	0.4%	33.8%	0.1%	0.0%	**100.0%**
Medical Social Services Visits	52.4%	2.5%	44.3%	0.5%	0.3%	**100.0%**
Home Health Aide Visits	45.8%	39.5%	12.1%	2.4%	0.2%	**100.0%**
Other	0.0%	88.9%	7.0%	4.0%	0.0%	**100.0%**
Total	**58.4%**	**9.4%**	**31.9%**	**0.4%**	**0.0%**	**100.0%**

Hospice Services 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.

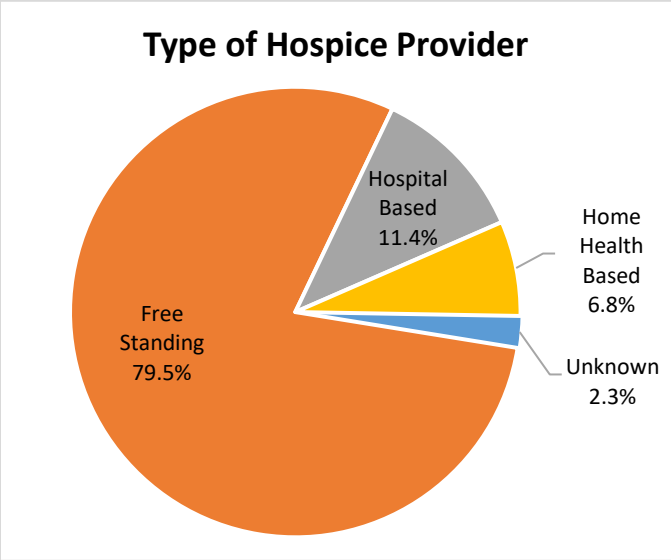
Arkansas Hospice Survey Results

In 2024 a survey was taken of licensed hospice providers in Arkansas. All data resulting from the survey cover the events which occurred in 2023, such as admissions, discharges, deaths, patient days and visits.

A total of 44 hospice providers completed the annual survey for 2023. These providers vary by type, ownership, tax status, and whether or not they have licensed inpatient beds.

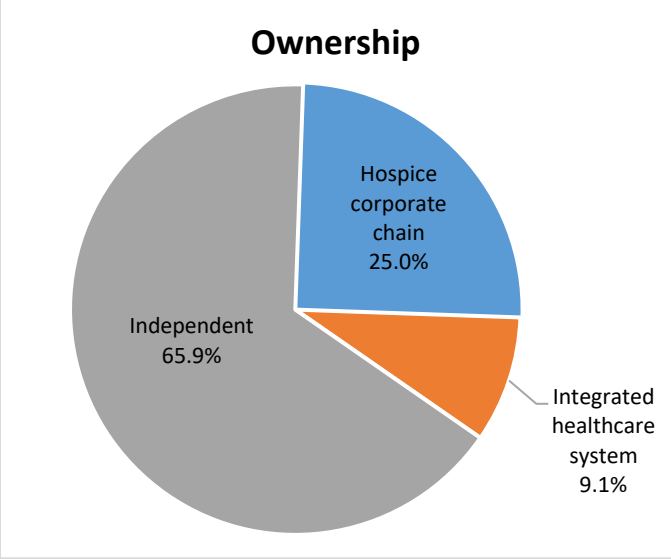
Over three-fourths of the hospice providers (79.5%) are free standing, while 11.4 % are hospital based and 6.8% are home health based.

Figure 8. ***Hospice Providers by Type***



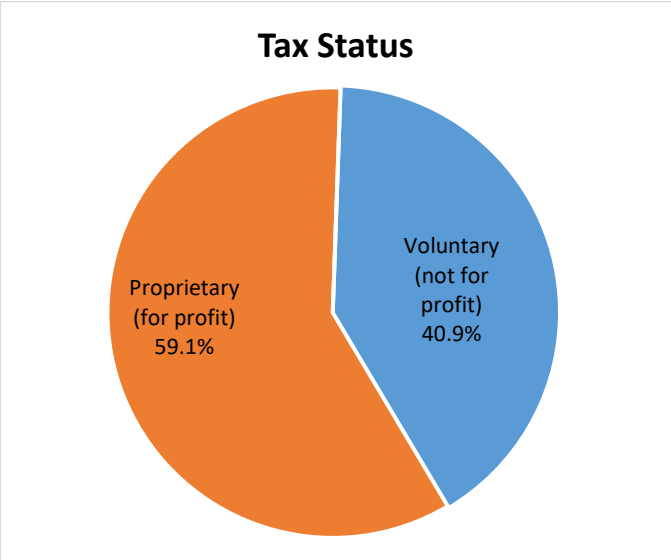
Ownership of the hospice providers is a majority independent (65.9%), while 25.0% are owned by a hospice corporate chain, and 9.1% are owned by an integrated healthcare system.

Figure 9. ***Hospice Providers by Ownership***



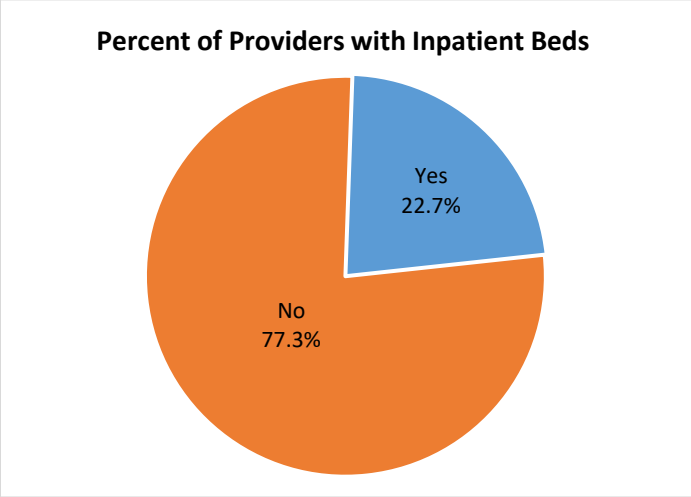
The reporting hospice providers are split between 59.1% with a proprietary (for profit) tax status and 40.9% with a voluntary (not for profit) tax status.

Figure 10. ***Hospice Providers by Tax Status***



Less than one-quarter (22.7%) of the hospice providers have licensed inpatient beds. The following section will be specific to those inpatient facilities.

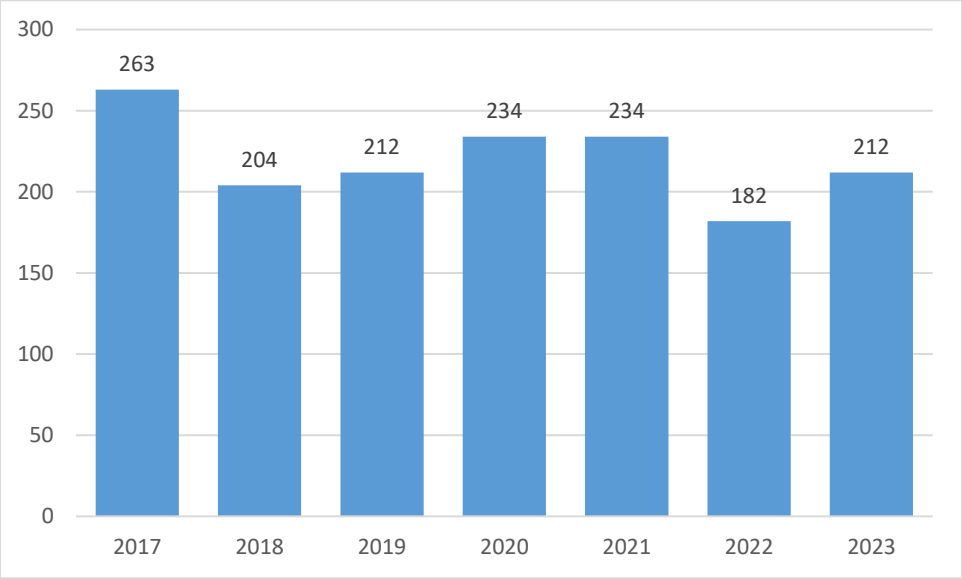
Figure 11. ***Percent of Hospice Providers who have Licensed Inpatient Beds***



Inpatient Facilities

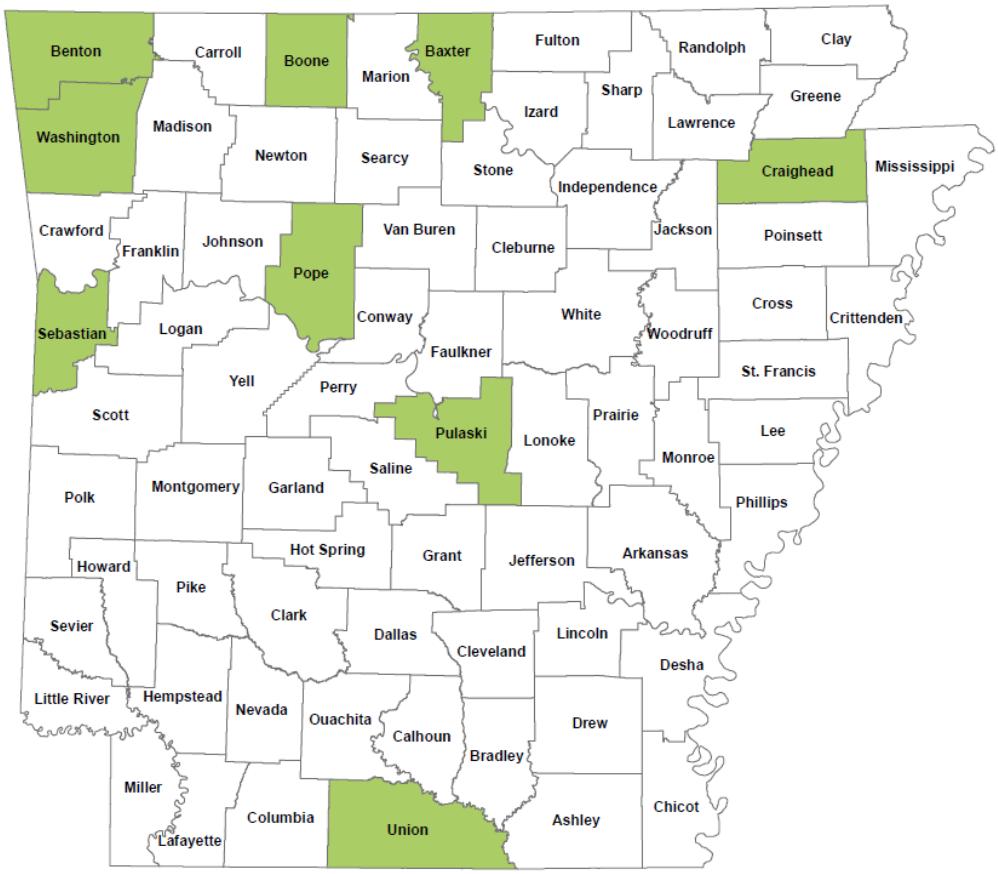
As illustrated on the graph below, the annual surveys show a substantial decline in the number of inpatient hospice beds reported from 2017 to 2018. Then there was a gradual increase in inpatient beds reported annually from 2018 until 2020. From 2020 to 2021 there was no change. For 2022, there was a significant drop (-22.2%) in reported inpatient beds from 2021. The number of inpatient beds reported for 2023 increased from 2022 back to the amount reported in 2019.

Figure 12. ***Number of Survey Reported Licensed Hospice Inpatient Beds 2017-2023***



According to the survey for 2023, there are hospice facilities with inpatient beds in 9 of Arkansas's 75 counties (see the map below). There were 212 licensed beds reported across the 11 facilities.

Figure 13. ***Counties with Hospice Inpatient Beds in Arkansas***



Admissions

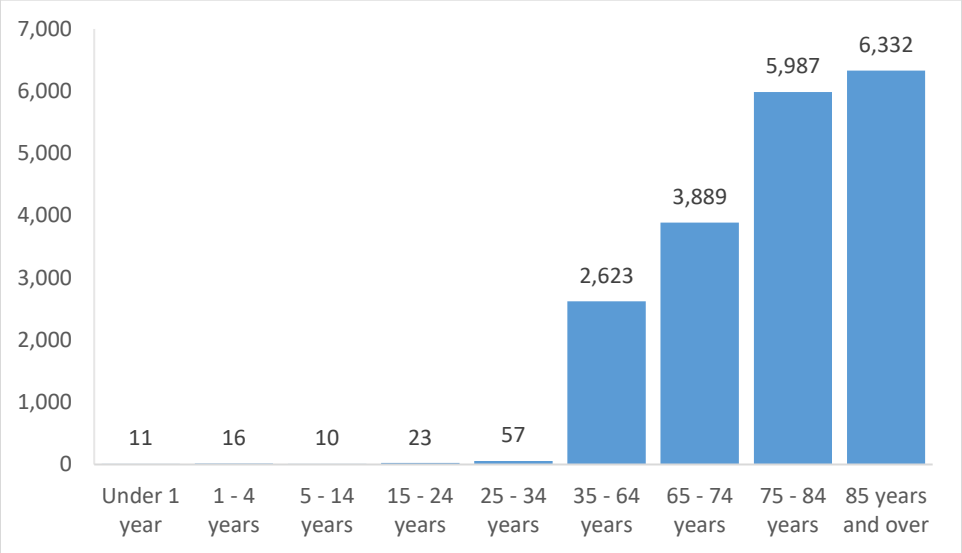
Statewide, there were a total of 18,948 unduplicated hospice admissions reported on the survey for 2023. When considering admissions by race/ethnicity, the overwhelming majority of these admissions are White patients (86.9%), with the next largest racial/ethnic group being Black patients (9.0%). The remaining 4.1% of admissions are spread throughout the other race groups with 1.6% being Unknown (see table below).

Table 14. ***Hospice Admissions by Race/Ethnicity***

	Number	Percent
Hispanic	209	1.1%
American Indian	82	0.4%
Black	1,712	9.0%
Asian	91	0.5%
Native Hawaiian	30	0.2%
White	16,462	86.9%
Another Race	33	0.2%
Multi-race	24	0.1%
Unknown	305	1.6%
Total	**18,948**	**100.0%**

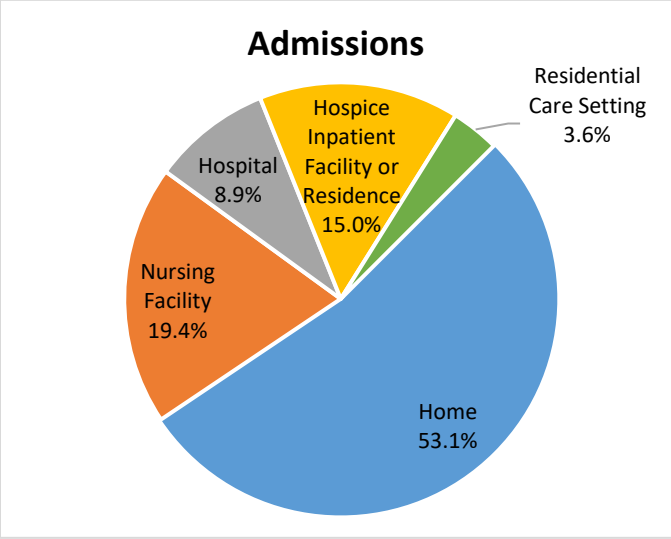
The age of hospice patients is skewed toward the older age groups, with patients who are at least 65 years old representing 85.5% of the unduplicated hospice admissions (see chart below). The two oldest age groups, 85 years and over and 75-84 years, had 6,332 and 5,987 admissions respectively. These two groups accounted for 65% of the unduplicated admissions reported.

Figure 14. ***Hospice Admissions by Age***



When looking at hospice admissions by location, the majority of admissions come from Home (53.1%) followed by Nursing Facility and Hospice Inpatient Facility or Residence (see chart below).

Figure 15. ***Hospice Admissions by Location***



Primary Diagnosis

The primary diagnosis that makes up the highest percentage of the 18,948 unduplicated hospice admissions reported for 2023 is neoplasms (28.1%). The other primary diagnoses that account for at least 10% of admissions are diseases of the circulatory system (26.6%), diseases of the nervous system (19.2%), and diseases of the respiratory system (13.6%) (see table below).

Table 15. ***Hospice Admissions by Primary Diagnosis***

	New Admissions	Percent
Certain infectious and parasitic diseases (A00-B99)	334	1.8%
Neoplasms (C00-D49)	5,316	28.1%
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)	651	3.4%
Mental, Behavioral and Neurodevelopmental disorders (F01-F99)	20	0.1%
Diseases of the nervous system (G00-G99)	3,646	19.2%
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)	5,037	26.6%
Diseases of the respiratory system (J00-J99)	2,568	13.6%
Diseases of the digestive system (K00-K95)	595	3.1%
Diseases of the skin and subcutaneous tissue (L00-L99)	9	0.0%
Diseases of the musculoskeletal system and connective tissue (M00-M99)	71	0.4%
Diseases of the genitourinary system (N00-N99)	341	1.8%
Pregnancy, childbirth and the puerperium (O00-O9A)	0	0.0%
Certain conditions originating in the perinatal period (P00-P96)	4	0.0%
Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	27	0.1%
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	115	0.6%
Injury, poisoning and certain other consequences of external causes (S00-T88)	137	0.7%
External causes of morbidity (V00-Y99)	17	0.1%
Factors influencing health status and contact with health services (Z00-Z99)	0	0.0%
COVID primary diagnosis	64	0.3%
Total	**18,948**	**100.0%**

Patient Days by Payment Source

A total of 1,649,717 patient days were reported on the survey for 2023. The overwhelming majority of these days are routine home care days (98.1%), followed by inpatient care days (1.2%) and respite care days (0.7%). Out of the total 1,649,717 patient days reported, only 2 patient days are continuous care days.

Hospice Medicare was the principal payment source for each different type of patient care days. Hospice Medicare accounted for 92.8% of routine home care days, 86.4% of inpatient care days, 95.2% of respite care days, and 100% of continuous care days for an overall 92.7% of the total patient care days. Inpatient care had the most variety in payment source with 86.4% being Hospice Medicare, 7.1% being managed care or private insurance, 4.4% being Hospice Medicaid, 1.1% being self-pay, 0.7% being Other, and 0.2% being uncompensated or charity care (see tables below).

Table 16. ***Patient Days by Payment Source***

State Totals	Routine Home Care	Inpatient Care	Respite Care	Continuous Care	Total
Hospice Medicare	1,501,937	17,557	10,479	2	**1,529,975**
Hospice Medicaid	54,667	899	273	0	**55,839**
Managed Care or Private Insurance	52,741	1,452	251	0	**54,444**
Self-Pay	3,606	230	2	0	**3,838**
Uncompensated or Charity Care	4,169	44	3	0	**4,216**
Other	1,257	148	0	0	**1,405**
Total	**1,618,377**	**20,330**	**11,008**	**2**	**1,649,717**

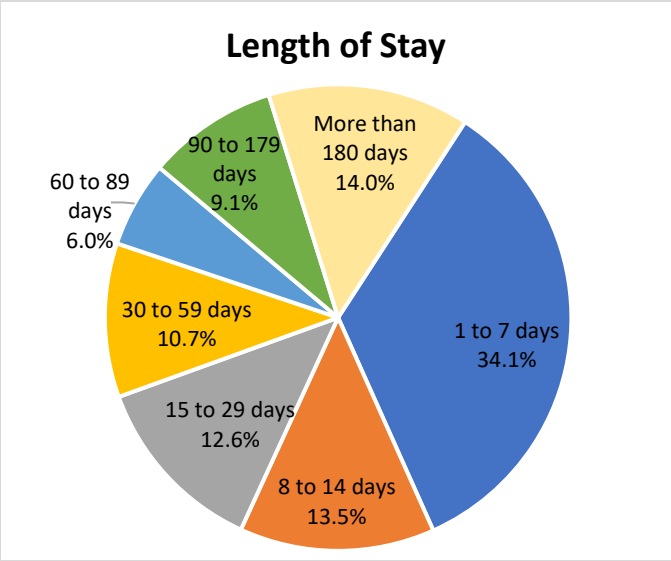
Table 17. ***Patient Days by Payment Source Percentage***

State Totals	Routine Home Care	Inpatient Care	Respite Care	Continuous Care	Total
Hospice Medicare	92.8%	86.4%	95.2%	100.0%	**92.7%**
Hospice Medicaid	3.4%	4.4%	2.5%	0.0%	**3.4%**
Managed Care or Private Insurance	3.3%	7.1%	2.3%	0.0%	**3.3%**
Self-Pay	0.2%	1.1%	0.0%	0.0%	**0.2%**
Uncompensated or Charity Care	0.3%	0.2%	0.0%	0.0%	**0.3%**
Other	0.1%	0.7%	0.0%	0.0%	**0.1%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Length of Stay

According to the survey, in 2023 the majority of patients were in hospice care less than a month (see chart below). A little over a third of the patients (34.1%) were in hospice care for 1 to 7 days. The next largest group of patients stayed in care for more than 180 days (14.0%), followed by 8 to 14 days (13.5%) and 15 to 29 days (12.6%). The overall average length of stay for a hospice care patient was 65.0 days.

Figure 16. ***Hospice Patients by Length of Stay***



Staffing

Direct Clinical Nursing staff represent the largest discipline employed (52.2%) followed by Hospice Aides (17.5%), as reported for 2023 (see tables below).

Table 18. ***Hospice Staffing Information***

State Totals	Full Time	Part Time	Contract	Total
Nursing – Direct Clinical	1,211	44	69	**1,324**
Nursing – Indirect Clinical	125	4	3	**132**
Nurse Practitioner	35	23	41	**99**
Social Services	113	16	15	**144**
Hospice Aides	394	14	35	**443**
Physicians – Paid	42	0	42	**84**
Physicians – Volunteers	1	8	0	**9**
Chaplains	83	8	11	**102**
Other Clinical	103	0	50	**153**
Bereavement	38	5	3	**46**
Total	**2,145**	**122**	**269**	**2,536**

Table 19. ***Hospice Staffing Information Percentage by Professional Discipline***

State Totals	Full Time	Part Time	Contract	Total
Nursing – Direct Clinical	56.5%	36.1%	25.7%	**52.2%**
Nursing – Indirect Clinical	5.8%	3.3%	1.1%	**5.2%**
Nurse Practitioner	1.6%	18.9%	15.2%	**3.9%**
Social Services	5.3%	13.1%	5.6%	**5.7%**
Hospice Aides	18.4%	11.5%	13.0%	**17.5%**
Physicians – Paid	2.0%	0.0%	15.6%	**3.3%**
Physicians – Volunteers	0.0%	6.6%	0.0%	**0.4%**
Chaplains	3.9%	6.6%	4.1%	**4.0%**
Other Clinical	4.8%	0.0%	18.6%	**6.0%**
Bereavement	1.8%	4.1%	1.1%	**1.8%**
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Hospice staffing is comprised of 84.6% full-time workers, 4.8% part-time workers, and 10.6% contract workers (see table below). Indirect Clinical Nursing, Direct Clinical Nursing, and Hospice Aides all have over 85% of their respective disciplines employed full time. Paid Physicians are half contract (50.0%) and full-time workers (50.0%) with none employed part time. Nurse Practitioners are split between contract (41.4%), full-time (35.4%), and part-time workers (23.2%).

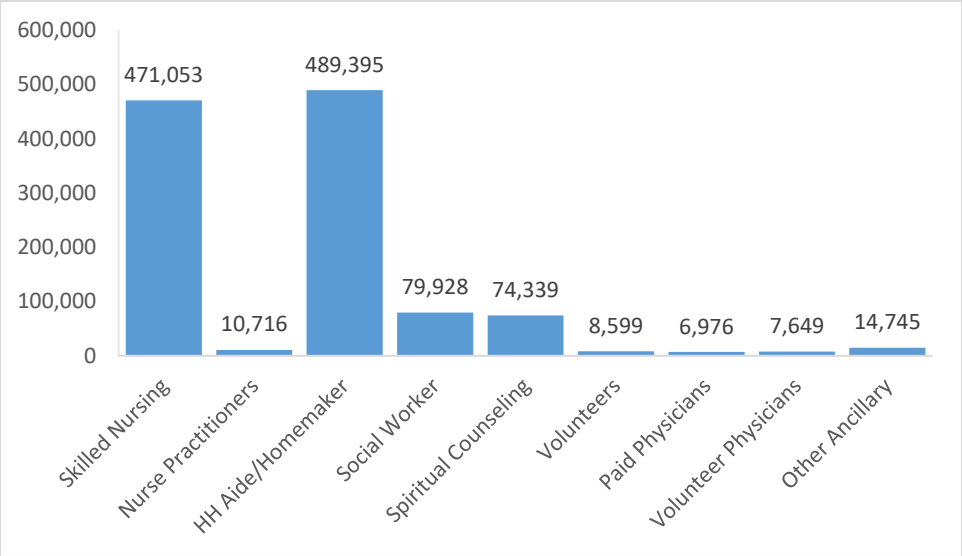
Table 20. ***Hospice Staffing Information Percentage by Full Time, Part Time, and Contract Staff***

State Totals	Full Time	Part Time	Contract	Total
Nursing – Direct Clinical	91.5%	3.3%	5.2%	**100.0%**
Nursing – Indirect Clinical	94.7%	3.0%	2.3%	**100.0%**
Nurse Practitioner	35.4%	23.2%	41.4%	**100.0%**
Social Services	78.5%	11.1%	10.4%	**100.0%**
Hospice Aides	88.9%	3.2%	7.9%	**100.0%**
Physicians – Paid	50.0%	0.0%	50.0%	**100.0%**
Physicians – Volunteers	11.1%	88.9%	0.0%	**100.0%**
Chaplains	81.4%	7.8%	10.8%	**100.0%**
Other Clinical	67.3%	0.0%	32.7%	**100.0%**
Bereavement	82.6%	10.9%	6.5%	**100.0%**
Total	**84.6%**	**4.8%**	**10.6%**	**100.0%**

Patient Visits

A total of 1,163,400 patient visits were reported for 2023. 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 82.6% of patient visits. The remainder of the visits is led by social workers (6.9%) and spiritual counselors (6.4%).

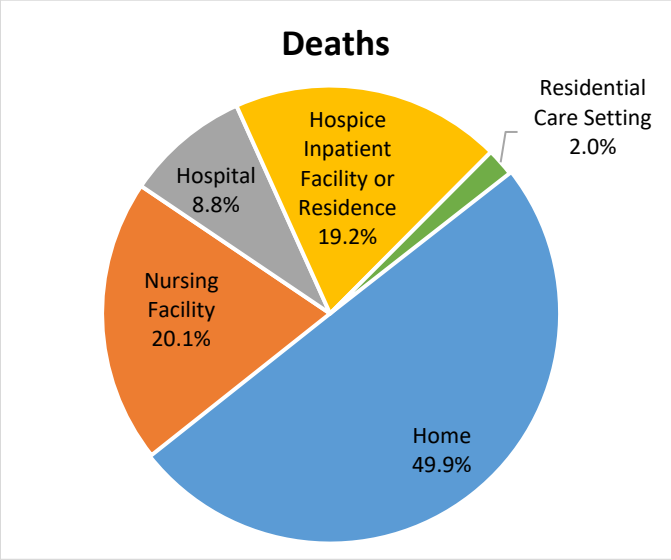
Figure 17. ***Patient Visits by Discipline***



Deaths by Location

Of the deaths reported on the survey, almost half of them (49.9%) occurred at Home. Nursing Facility (20.1%) and Hospice Inpatient Facility or Residence (19.2%) accounted for the next highest percentages of locations of deaths. The least often reported locations for deaths were Residential Care Setting (2.0%) and Hospital (8.8%).

Figure 18. ***Hospice Deaths by Location***



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.

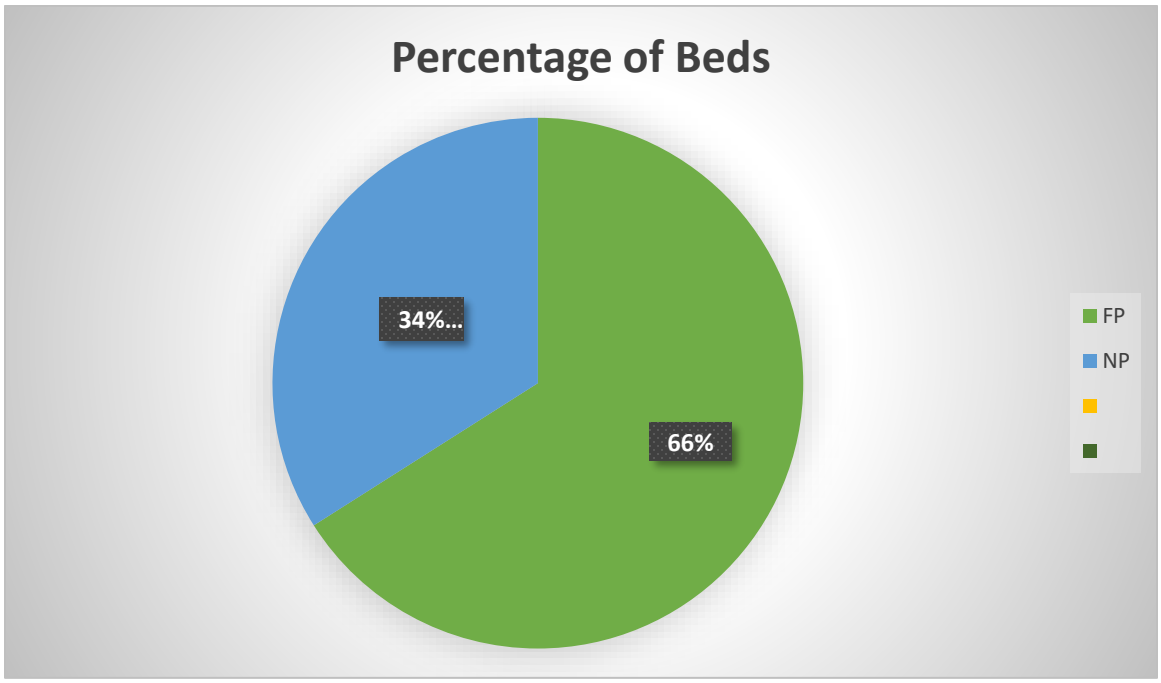
Survey Results

The respondents to the survey conducted in 2024 included ten PRTFs, which were made up of five (5) for profits (FP) and five (5) nonprofits (NP). This survey reports on events occurring in 2023. There were 560 licensed beds reported for 2023.

Licensed Beds

There were 560 licensed beds for 2023 reported in 2024's survey. The FPs accounted for 369 beds from their five facilities, and the NPs had 191 beds from five facilities.

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



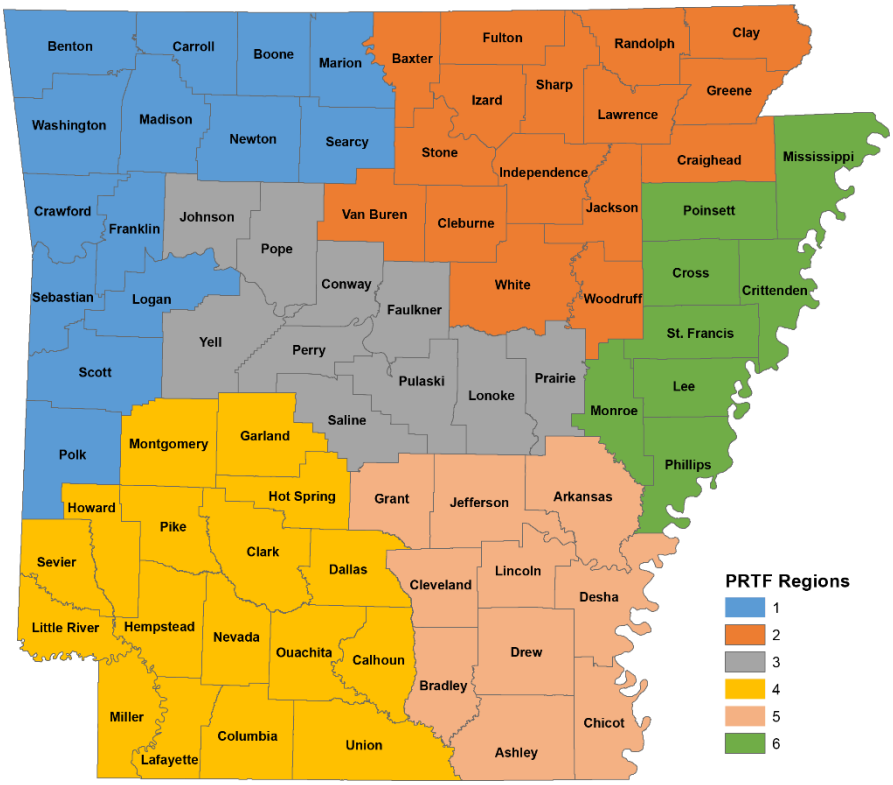
Payment Methods

In 2023, there were 106,343 total resident days and 694 admissions in the ten (10) PRTFs. Arkansas Medicaid paid for 97,797 or 92% of those days. The Medicaid cap for PRTFs is $430 per child per day; based on this rate, the potential cost to Arkansas Medicaid is $45,727,490.00 in 2023. The remaining 8% 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 ten (10) responding PRTFs around the State. Region 3, which includes Pulaski County, houses four (4) PRTFs. Region 5 has two (2) PRTFs; Regions 1,2, 4, and 6 had one (1) 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 – 100%
Region 2 – 52%
Region 3 – 82%
Region 4 – 100%
Region 5 – 87%
Region 6 – 85%
State Total – 84%

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

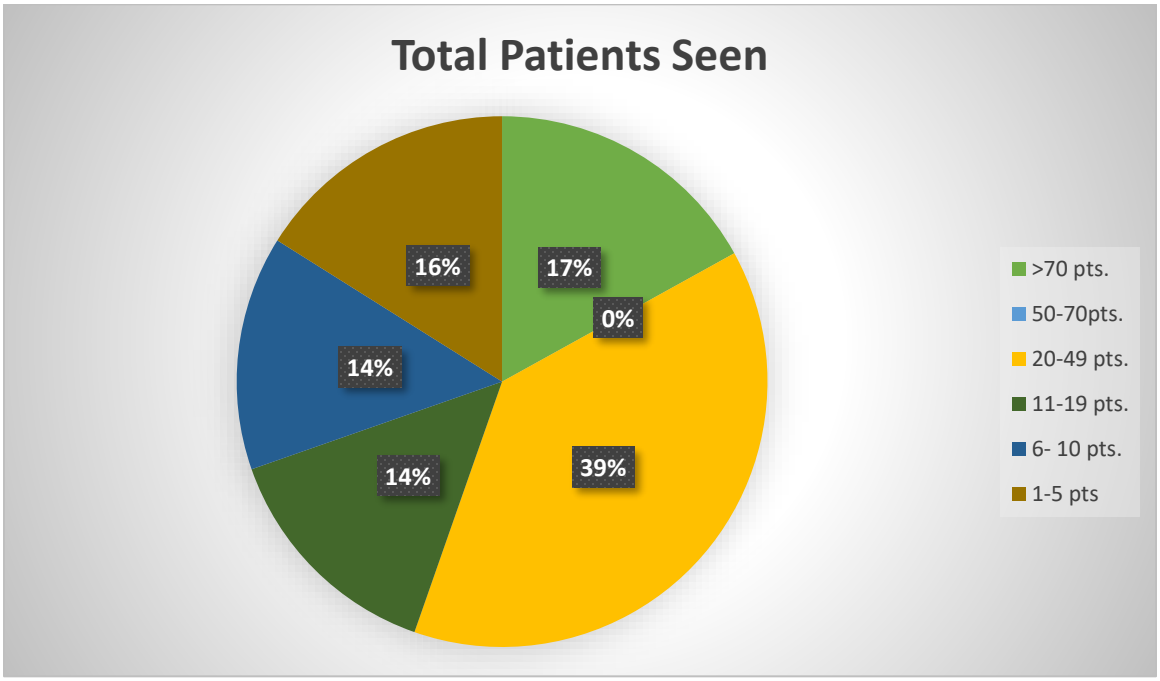


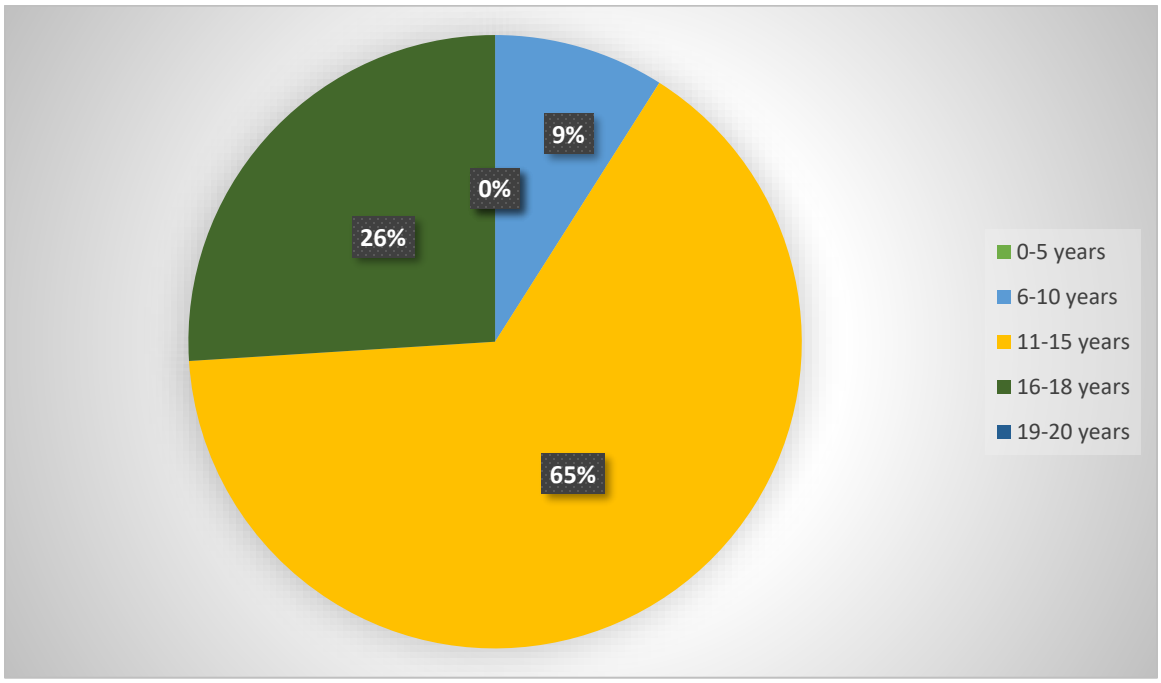
Table 17. Number of Patients Served Per County

Patients Per County		Total Patients Seen	County
>70 pts	(1)	130	Pulaski
50-70 pts	(0)	0	
20-49 pts	(10)	296	Benton, Craighead, Crawford, Faulkner, Garland, Greene, Saline, Sebastian, Washington, White
11-19 pts	(8)	108	Baxter, Crittenden, Grant, Hot Spring, Lonoke, Miller, Poinsett, Pope,
6-10 pts	(15)	111	Arkansas, Ashley, Boone, Bradley, Clark, Cleburne, Drew, Franklin, Independence, Jefferson, Johnson, Logan, Mississippi, Randolph, St. Francis
1-5 pts	(38)	123	Calhoun, Carroll, Chicot, Clay, Cleveland, Columbia, Conway, Cross, Dallas, Deshea, Fulton, Hempstead, Howard, Izard, Jackson, Lafayette, Lawrence, Lee, Lincoln, Little River, Madison, Marion, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Polk, Prairie, Scott, Sevier, Sharp, Stone, Union, Van Buren, Woodruff

Age

The 11-15-year-old range had the highest percentage of residents (65%), followed by 16–18-year-olds (26%), 9% of the residents were 6-10 years old. There were no residents served at the reporting facilities in the 0–5-year-old range or the19-20-year-old age group.

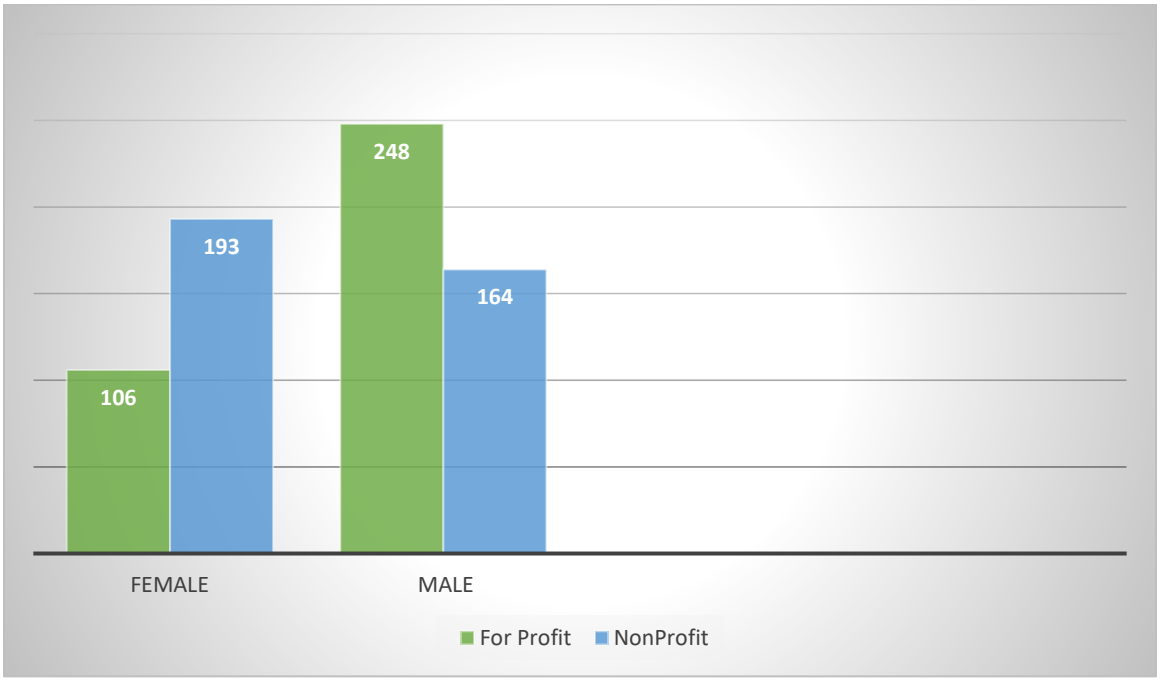
Figure 17. ***Residents by Age***



Gender

Overall, there were more males than females being served in PRTFs. There were 412 boys between the ages of 6-20 and 299 girls that were 6-20 years old. There were five facilities that had more female residents than males.

Figure 18. ***Gender by Facility Type***



Race

According to the most current population estimates 56% of children, in Arkansas, under the age of 18 are Caucasian/White and 25% are African American/Black, with the remaining 19% Hispanic and other races.

Figure 19. ***Population of PRTF Residents by Race***

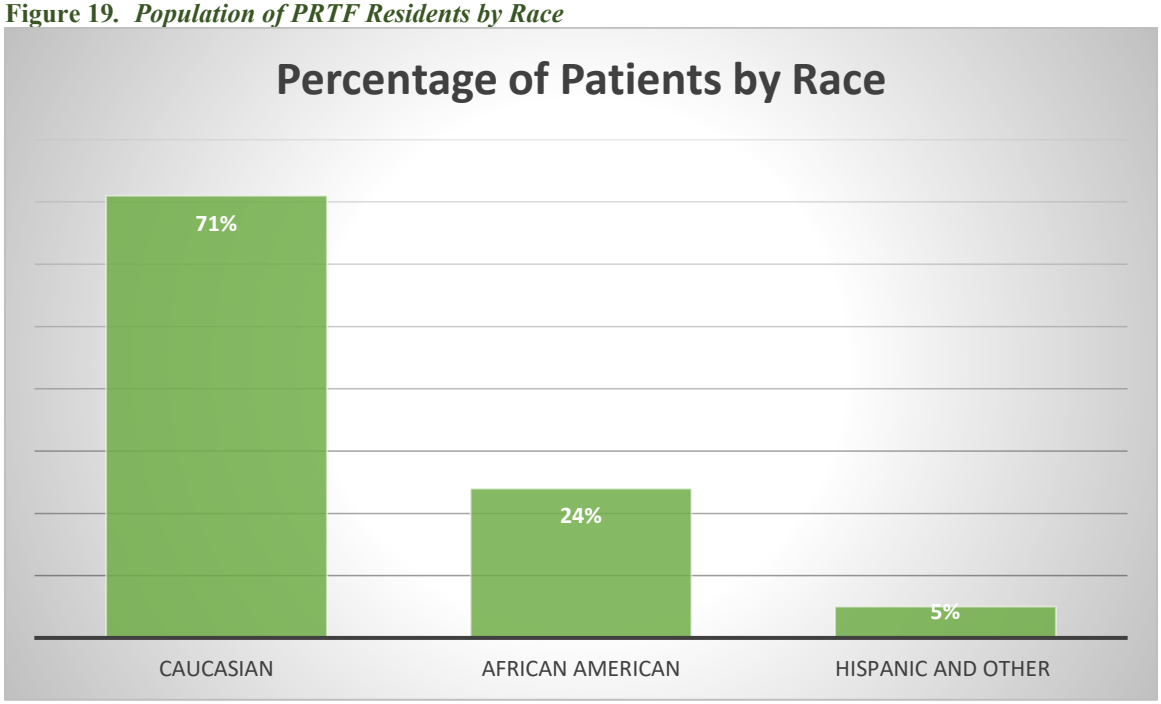
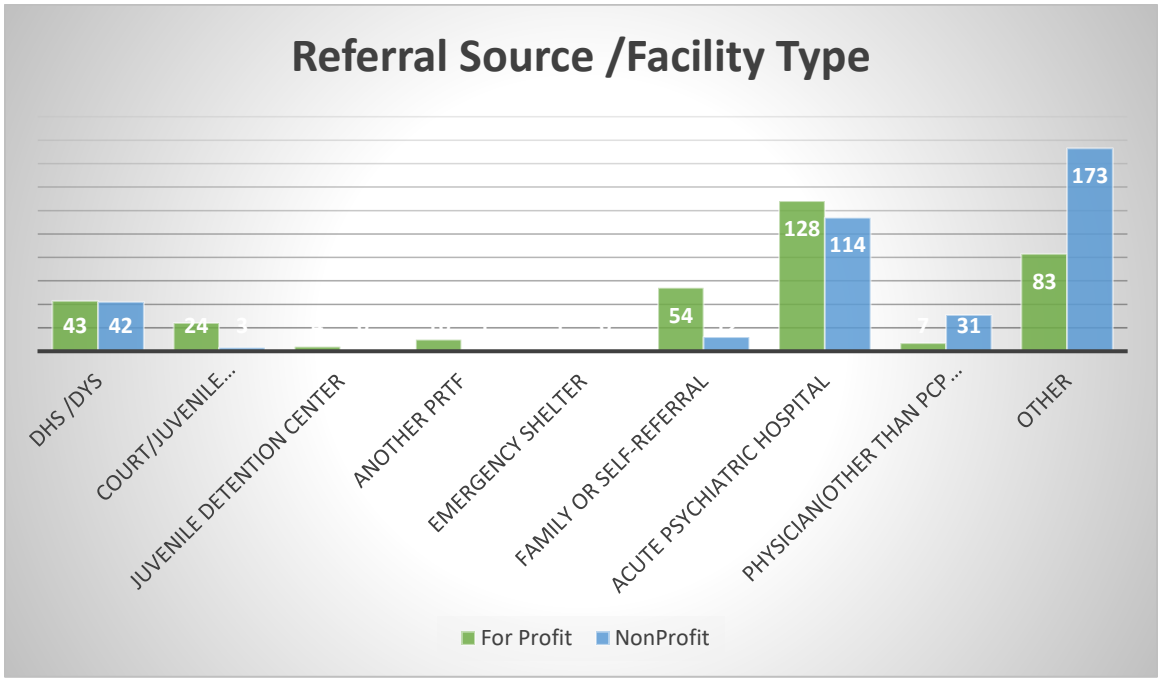
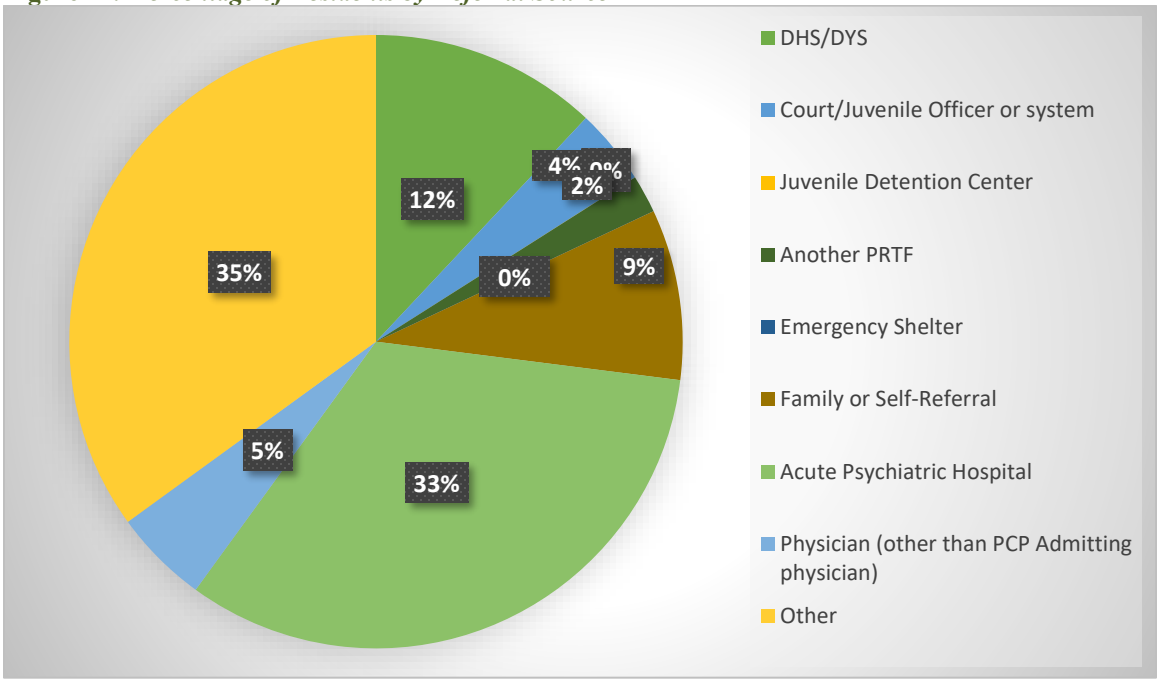


Figure 20. ***Resident Referral by Facility Type***



Note: Other is made up of referrals from other Mental Health providers, schools, outpatient programs, and crisis units at program.

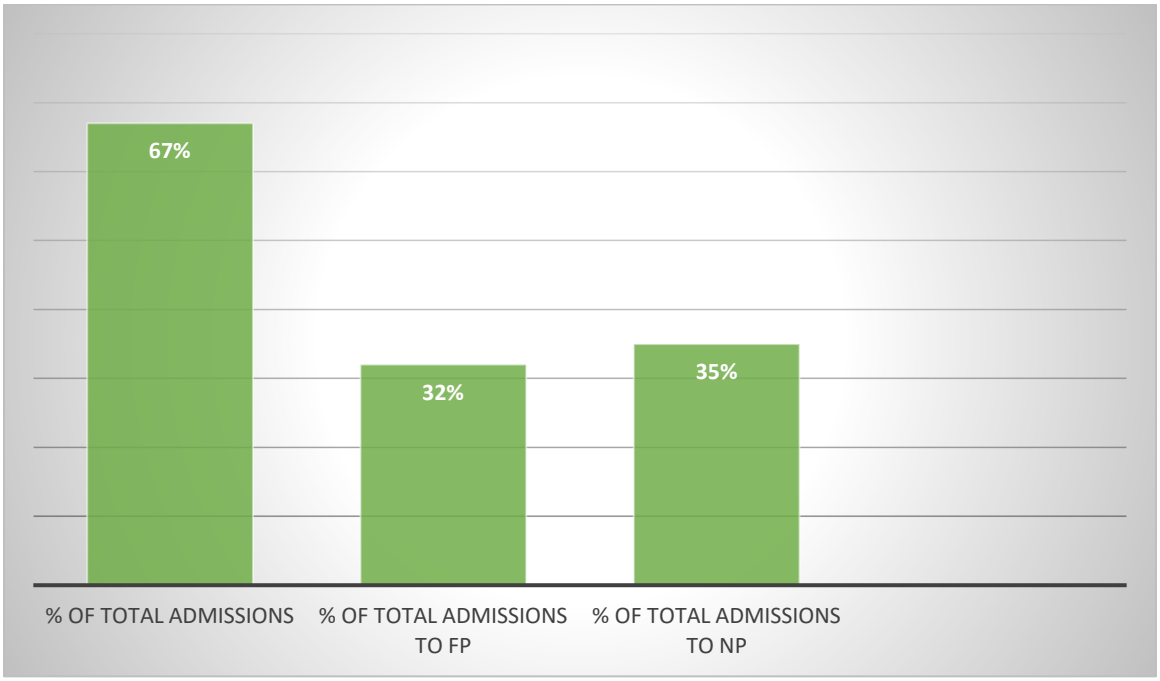
Figure 21. ***Percentage of Residents by Referral Source***



Readmissions

Of the 694 PRTF admissions reported in 2023, 464 (67%) 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 37% of their residents to their home. The NP facilities returned 38% of their residents to their home.

Average Length of Stay

The average length of stay for an Arkansas resident in a PRTF was 161.23 days, or 5.4 months (see Table 18 below). Two facilities had an average length of stay greater than six months. A FP had the longest length of stay at 251 days. The NP residents stayed for a little more than four months (128.30 days).

Table 18. ***Average Length of Stay by Facility Type***

Facility Type	Facility Name	Average LoS (days)	Average LoS (months)
FP	Perimeter Behavioral Health (Forrest City)	163.9	5.5
FP	Neurorestorative Timber Ridge	251.13	8.4
FP	Millcreek of Arkansas	169.49	5.6
FP	Yellow Rock Behavioral Health fka Piney Ridge	222.11	7.4
FP	Delta Family Health and Fitness Center for Children	164.13	5.4
FP Average		**194.15**	**6.5**
NP	Youth Home, Inc.	169.97	5.7
NP	Centers for Youth and Families - Little Rock	151.06	5.0
NP	Centers for Youth and Families - Monticello	106.85	3.6
NP	United Methodist Children's Home Dacus	121.65	4.1
NP	United Methodist Children's Home Little Rock	91.99	3.1
NP Average		**128.30**	**4.3**
All Facilities		**161.23**	**5.4**