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**HSC Regulation 001. Health Services Permit Commission
Policies and Procedures (10/05)**

SECTION I. INTRODUCTION

A. Organization

Section 1. The Arkansas Health Services Permit Commission, hereinafter referred to as the Commission, and the Arkansas Health Services Permit Agency, hereinafter referred to as the Agency, are governed by Ark. Code Ann. § 20-8-101 et seq.

Section 2. The administrative offices for the Commission are located at Freeway Medical Tower, 5800 West 10th Street, Suite 805, Little Rock, Arkansas.

B. Officers

Section 1. Number. Officers of the Commission shall be a Chair and a Vice Chair.

Section 2. Terms of Office. The terms of the Commission Chair and Vice Chair shall be for one year. Officers may succeed themselves.

Section 3. Chair. The Chair shall have general supervision and management of the affairs of the Commission subject to the control of the members. He or she shall chair all meetings of the members; and perform all duties incident to the office of the Chair and all such other duties as from time to time may be assigned by the members.

Section 4. Vice Chair. The Vice Chair shall in the absence or disability of the Chair, perform the duties and exercise the powers of such office. The Vice Chair shall perform such other duties and have such other powers as the Chair or the members may from time to time prescribe.

C. Meetings

Section 1. Notice of Meetings. Formal notice of regular quarterly meetings should be communicated to members at least 10 working days prior to the meeting and additionally the news media and those who formally request notice from staff. The agenda for the meeting should be approved by the Chair and provided to the members, along with supporting materials, in sufficient time to permit review prior to a regular quarterly meeting.

Section 2. Special Meetings. Special meetings of the Commission may be required from time to time. Such meetings are subject to call of the Chair, the Vice Chair, or three or more members. The call to a special meeting should state the location and time, and the

subject matter to be covered at such meeting. The call to a special meeting should be provided to members at least 24 hours prior to the meeting.

Section 3. Quorum and Manner of Action. A quorum shall be not less than five of the duly appointed members of the Commission. All actions of the Commission shall be decided by a simple majority of the members present and voting but no action may be taken without four votes for or against a motion with no proxy voting permitted.

Section 4. Robert's Rules of Order. Unless otherwise covered by the Policies and Procedures of the Commission, the latest edition of Robert's Rules of Order shall govern the conduct of any meeting.

Section 5. Written Minutes. The minutes of meetings shall be prepared and kept by Agency staff and written copies mailed to members.

D. Committees of the Commission

Section 1. The Chairperson may establish and create from time to time such committees as shall be necessary to carry out the affairs and further the purposes of the Commission. The Commission may have standing committees, ad hoc committees, or any other committees determined by the Chairperson. The Chairperson shall appoint the membership to all committees.

E. Conflict of Interest

Section 1. Announcing a Conflict of Interest. No member of the Commission shall use such membership for purposes which are motivated by private gain, including gain for organizations or institutions with which the individual is associated in any capacity. Annually a disclosure statement shall be filed with the Agency listing all professional interests in the health field; any financial interest in the health industry; and any fiduciary interest held in a health institution, organization, or agency. There shall be a conflict of interest when the member or his/her organization or institution is the applicant or is a party to the adjudication process. When a conflict arises for a member in the course of business of the Commission, the individual member should declare the conflict.

Section 2. Voting Abstention. Any member who declares a conflict of interest, or who is found to have a conflict should neither participate in debate nor vote on the issue in question.

SECTION II. DEFINITIONS

- A. "Affected person" - includes, at a minimum, the applicant, appropriate state agencies, any person residing within the proposed service area or any

person who regularly uses health care facilities within the proposed service area who has notified the Agency in writing requesting notification of the review, health care facilities located in the service area in which the project is proposed to be located, and legal representatives of such persons.

- B. "Agency" - the Health Services Permit Agency
- C. Assisted Living Facility means any building or buildings, section or distinct part of a building, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide assisted living services for a period exceeding twenty-four (24) hours to more than three (3) adult residents of the facility who are not relatives of the owner or administrator. Assisted living facility includes those facilities which provide assisted living services either directly or through contractual arrangements or which facilitate contracting in the name of residents.
- D. "Commission" - the Health Services Permit Commission
- E. "Commissioner" - a duly appointed member of the Health Services Permit Commission.
- F. "Conversion of Services" - an alteration of the category of services offered by a health facility.
- G. "Director" - the director of the Health Services Permit Agency.
- H. "Health Facility or Health Facilities" - "a long-term care facility" as defined by ACA Section 20-10-101(8), the Long Term Care Facilities and Services Act, or a "home health care services agency" as defined by ACA Section 20-10-801, the Home Services Act. The terms "health facility" or "health facilities" does not mean a "hospital", as defined by and licensed pursuant to ACA Section 20-9-201(3) the Hospital and Health Facilities Licensure Act. Nothing in the Act or these regulations shall be deemed to require a Permit of Approval for or otherwise regulate the licensure of in any manner of a hospital except when a hospital seeks to add long-term care beds or convert acute beds to long term care beds or add or expand home health services. The term "health facility" does not include offices of private physicians, outpatient surgery or imaging centers, or establishments operated by the federal government or any agency thereof, or free-standing radiation therapy centers, or any facility which is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination.

- I. "Home Health Agency" - any person, partnership, association, corporation or other organization whether public or private, proprietary or non-profit that provides home health care services. (See "Home Health Services")
- J. "Home Health Services" - the providing or coordinating 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. In order to be subject to Permit of Approval review such services must meet the definitions contained in Act 956 of 1987.
- K. "Hospice" or "Hospice program" means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, and which employs an interdisciplinary 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 on the basis of need, regardless of ability to pay.
- L. "Intermediate Care Facility for the Mentally Retarded" (ICF-MR)
 - 1. ICF-MR 16 beds or more - a facility with sixteen (16) or more beds that provides in a protective residential setting, diagnosis, active treatment and rehabilitation of persons with mental retardation or persons with related conditions. This includes both public and privately operated ICF-MRs.
 - 2. ICF-MR 15 beds or less - a facility with from four (4) to fifteen (15) beds that provides in a protective residential setting, diagnosis, active treatment and rehabilitation of persons with mental retardation or persons with related conditions.
- M. "Life Care Facility" - "Life care" means continuing care as defined in Arkansas Code 23-93-103(2) except that no additional charges are made for nursing care or personal care beyond those charged all residents of the facility who are not receiving nursing care or personal care services.
- N. "Long term care" - means non-acute care provided over a 24 hour period for 25 or more consecutive days.
- O. "Long Term Care Facility" - means a nursing home, residential care facility, post-acute head injury retraining and residential care facility,

or any other facility which provides long-term medical or personal care. Permit of Approval review is not required of hospitals as defined by and licensed pursuant to ACA 20-9-201(3) except when a hospital seeks to add long term care beds or convert acute care beds to long term care beds or add or expand home health services.

- P. "Medical Care" - means the services that are performed at the direction of a physician in behalf of patients by physicians, nurses and other professional and technical personnel.
- Q. "Nursing Home" - institution, or other place for the reception, accommodation, board, care, or treatment of more than three (3) unrelated individuals, who, because of physical or mental infirmity are unable to sufficiently or properly care for themselves, and for which reception, accommodation, board, care, and treatment, a charge is made. The term "Nursing Home" shall not include the offices of private physicians and surgeons, boarding homes, or hospitals, or institutions operated by the Federal Government.
- R. "Permit of Approval" - a permit issued by the Commission, through the Agency, to an individual, organization or health care facility approving a health care project subject to review under Act 1800 of 2001, and the rules of the Commission.
- S. "Person" - an individual, a trust or estate, a partnership, corporation (including associations, joint stock companies, and insurance companies), the State, or a political subdivision or instrumentality (including a municipal corporation) of the State, or any legal entity recognized by the State.
- T. "Personal Care" - means services which are defined as medically prescribed tasks pertaining to a person's functional abilities which enable the person to be treated on an outpatient basis rather than on an inpatient basis. Personal care is in no way to be considered medical care.
- U. "Physician" - a doctor of medicine or osteopathy legally authorized by the State to practice medicine and surgery.
- V. "Population of a county" - the population of a county will be based on the most recent Federal census unless circumstances are such, that the Commission feels it should look beyond the Census. A statewide planning agency should be utilized which will be the Bureau of Census designee.
- W. "Post-Acute Head Injury Retraining and Residential Care Facilities" - a building, or group of buildings if located contiguously and operated jointly, used or maintained to provide, for pay, Retraining and Rehabilitation for three (3) or more individuals who are disabled on

account of Head Injury and who are not in present need of in-patient diagnostic care in a hospital or related institution. (Rules and Regulations for Post-Acute Head Injury Retraining and Residential Care Facilities", OLTC, DHS)

- X. "Psychiatric Residential Treatment Facilities (PRTF) - 24-hour psychiatric residential treatment establishments with permanent facilities (other than a psychiatric inpatient hospital) which provides a structured, systematic therapeutic program of treatment, under the supervision of a psychiatrist, for emotionally disturbed children and/or adolescents, six to twenty-one years of age, grouped in an age appropriate manner.
- Y. "Residential Care Facilities" - a building or structure which is used or maintained to provide for pay on a 24-hour basis a place of residence and board for 3 or more individuals whose functional capabilities have been impaired but do not require hospital or nursing home care on a daily basis, but could require other assistance in activities of daily living.
- Z. Tangible assets – A tangible asset for the purpose of transferring a permit, legal title and right of ownership is property that may be felt or touched, and is necessarily corporeal, although it may be either real or personal.

SECTION III. SCOPE OF REVIEW

The Agency (under the direction of the Commission or appropriate Court) will issue, deny or withdraw Permits of Approval. Using the Commission's rules and procedures, the Agency may exempt appropriate projects from review. Each recommendation of the Agency must be based on the completed application and its relationship to adopted standards and criteria. Each review decision of the Commission must be consistent with adopted standards, criteria and the record of the review.

A. PROJECTS REQUIRING PERMIT OF APPROVAL REVIEW INCLUDE BUT ARE NOT LIMITED TO:

1. Nursing Home Construction

All proposals for conversion of services or alteration or renovation or construction having an associated capital expenditure of \$500,000 or more.

2. Additional Beds

Unless exempted by the Act or by the Commission, all health facilities seeking to add new Long Term Care (LTC) beds or otherwise expand LTC bed capacity shall apply for a Permit of Approval.

3. Home Health Services

Unless exempted by the Act or by the Commission, all health facilities seeking to add home health services or expand existing home health service areas shall apply for a Permit of Approval. This includes changes in license designation.

4. Hospice

Unless exempted by statute or by the Commission, all hospices or hospice programs shall apply for a Permit of Approval.

5. Cost Overrun

Any increase in cost in an approved project or cost of renovation or construction or alteration of a health facility is deemed a cost overrun and must be documented and filed with the agency. (During the course of review, the reasonableness of the proposed capital expenditure will be evaluated. A reasonable contingency cost in anticipation of a possible increase in cost due to inflation or other unforeseen factors will be allowed as part of the proposed capital expenditure).

B. PROJECTS REQUIRING APPROVAL BY THE COMMISSION:

1. Movement of Existing LTC beds –

(a) any movement of LTC beds from one site to another site within the service area must be approved by the Commission. The applicant should submit the request in writing to the Agency. Any proposed movement of beds is subject to the time limitations in Section VI.A and the reporting requirements of Section VI.B of the Commission's Procedures. Failure to comply with these requirements will result in the withdrawal of permission to move the beds.

(b) Movement of Site Location of Permit of Approval Any movement of a site location for a project approved by the Commission for an existing Permit of Approval is subject to review. The applicant shall submit a request to the Agency in writing, detailing all information required in the original application regarding a site, the reasons for relocating the site from the original application approved, any additional costs associated with the relocation, and the time remaining for completion under

various rules and regulations of the Commission regarding implementation of a Permit of Approval. The Commission, at its next regularly-scheduled meeting, must approve the relocation before site location change is made. The relocation shall not extend the deadline for implementation of a Permit of Approval.

(c) Transfer of Permit of Approval, legal title, or right of ownership – A permit of approval may only be transferred if the entity presently holding the permit, legal title, or right of ownership has tangible assets of at least two thousand five hundred dollars (\$2,500) that will be transferred with the permit, legal title or right of ownership, and then only with the approval of the Commission. The applicant must provide proof of tangible assets. Any person requesting approval to receive a Permit of Approval via transfer from an existing permit holder must submit an application for a permit of approval to the Agency in accordance with Section V – Procedures for Review. A permit of approval may not be transferred to a county other than the county where the current permit of approval is located unless authorized in the applicable methodology.

C. PROJECTS EXEMPT FROM PERMIT OF APPROVAL PROCESS:

1. Capital Expenditures less than adopted thresholds

Projects proposed for the construction, expansion, or alteration by or on the behalf of a nursing home which have an associated capital expenditure of less than \$500,000 and do not add LTC beds or home health services.

2. Hospitals Licensed in Arkansas are not subject to review except when a hospital seeks to add long-term care beds or convert acute beds to long-term beds or add or expand home health services.

3. Conversion of Services or New Services

A conversion of services offered in an existing health facility or alteration or renovation of an existing health facility having an associated capital expenditure of less than \$500,000 for nursing homes and not resulting in additional bed capacity.

4. Acquisition of a Health Facility

The obligation of a capital expenditure to acquire an existing

health care facility shall not require a Permit of Approval. Such an exemption applies to an acquisition by purchase, lease, donation or transfer of ownership.

5. Religious Facilities

Any facility which is conducted by and for those who rely exclusively upon treatment by prayer alone for healing in accordance with the tenets or practices of any recognized religious denomination.

6. Outpatient Surgery Centers

7. Imaging Centers

8. Free Standing Radiation Therapy Centers

D. EXPEDITED REVIEWS

An expedited review is an exception to the normal procedures for Permit of Approval review. If a proposal meets the criteria for expedited review (See below) then that application may be submitted at anytime without regard to the published batching cycles. The Agency may take action on the proposal 30 days after notice of expedited review has been given to the public.

1. The expedited review process will be utilized if the capital expenditure is required:
 - (a) to eliminate or prevent imminent safety hazards as defined by Federal, State, or local fire, building, or life safety codes or regulations, or
 - (b) to comply with State licensure standards, or
 - (c) to comply with accreditation or certification standards which must be met to receive reimbursement under Title XVIII of the Social Security Act or payments under a State plan for medical assistance approved under Title XIX of that Act, or
 - (d) to eliminate emergency circumstances that pose an imminent threat to public health, or
 - (e) to increase the cost of an approved project in order to

replace remodeling with new construction.

2. Those portions of a proposed project which do not comply with D.1. above are subject to the full review using established criteria, if that portion would otherwise have been subject to review.
3. Under no circumstances will additional beds, additional services, or expanded service areas be approved by the Agency under the expedited review process.

SECTION IV. CRITERIA FOR REVIEW

- A. The Agency and the Commission will utilize the following criteria in the review process.
 1. Whether the proposed project is needed or projected as necessary to meet the needs of the locale or area;
 2. Whether the project can be adequately staffed and operated when completed;
 3. Whether the proposed project is economically feasible; and
 4. Whether the project will foster cost containment through improved efficiency and productivity.

SECTION V. PROCEDURES FOR REVIEW

Although review procedures and criteria may vary according to the purpose for which a particular review is being conducted, the normal procedures are as follows:

A. Review Schedule

The Review Schedule below provides for the review of applications to be considered in the same review cycle. Applications which satisfy the requirements for expedited reviews may be submitted at anytime without regard to the established Review Schedule.

PERMIT OF APPROVAL

Review Schedule

Application submitted by:*	Applications placed under review by:	Agency Decision by:
November 1	December 1	February 28
February 1	March 1	May 30
May 1	June 1	August 30
August 1	September 1	November 30

*Proposed applications should be submitted no later than 4:30 P.M. on this day. This will allow the Agency one month to determine if the proposed application is complete. If the proposed application is determined complete it will be considered received and will go under review. If the application is not determined to be complete it will not go under review. The review cycle will not start until the application is declared complete, and official notification has been made placing the application under review. Please note if deadlines fall on a weekend or holiday the deadline will be extended to the next working day.

B. The Application/Review Process

The following are the steps of the application process. Each step must be completed before a decision on the project can be rendered.

1. Application Form. The appropriate application forms must be obtained from the Agency.
2. Pre-application conference/technical assistance. If needed, a meeting will be scheduled at the request of the applicant between the applicant and an Agency representative. The meeting is to assist the applicant and to provide guidance in the preparation of the application.
3. Submission of the Application and Appropriate Review Fee. The applicant is responsible for the timely submission to the Agency of an original and (2) copies of a completed application and the review fee. The application must be signed in blue ink. The review fee is \$1,000 for all reviews. In the event that an application decision results in a hearing before the Commission, the requesting party will be charged the prevailing agency cost per page to cover

the cost for the additional copies required for the hearing.

4. Determination of completeness. The Agency will determine the completeness of the application within 30 calendar days of the scheduled submission date and, if appropriate, notify the applicant of any additional information required for the review of the proposal. The Agency may allow up to an additional fifteen days to obtain additional information.

Any proposed application that does not address substantially any one of the criteria will have the proposal returned and will not be considered for review for that cycle.

5. Information and Requirements. Applicants subject to a review must submit to the Agency any information necessary for the review. The information requirements may vary according to the type of review and/or projects being reviewed. Please note that the Agency determination of completeness merely indicates that the questions on the form have been answered. This does not indicate that the application is approvable or that the responses to the questions are adequate or appropriate. The only additional information which may be submitted after the filing date is information specifically requested in writing by the Agency. This request will be limited to information necessary to complete the proposed application. An applicant may correct a mistake in an application within the first 30 days after the application is under review:

- (a) if no other application in the review cycle is considered as competitive; and
- (b) if the change does not effect the scope of the proposal, i.e., the change does not result in an increase in service area, services to be offered or the number of beds requested.

6. Notification of the Beginning of a Review.

- (a) Timely written notification will be sent to affected persons at the beginning of a review, and to any person who has requested being on the Agency's mailing list. Notification will include the proposed schedule for the review.
- (b) The date of notification is the date on which the notice is sent or the date on which the notice appears in a newspaper of general circulation, whichever is later.

- (c) Written notification to members of the public and third party payers will be provided through a newspaper of general circulation. Notification to all other affected persons will be by mail (which may be a copy of the notice or a newspaper).
- 7. Review Period. Arkansas Code Ann. § 20-8-104 provides that the Agency must approve or deny the application within 90 days from the date the application is deemed complete and submitted for review. An application is submitted for review when the Agency has received a completed application and has so notified the applicant and the public.
- 8. Availability of Reports; Methods for Obtaining Public Access. All applications under review and all other written materials essential to the review shall be accessible to the general public. The Agency will provide, upon request, notification of the status of reviews, findings, and other appropriate information. Depending on the amount of material requested there may be a charge for copying.
- 9. Opponents Written Comments. Opponents to applications have thirty (30) days from the Public Notice of the start of the review cycle to submit written comments to the Agency. These comments will be considered in, and will be attached to, the Agency's decision. An affected person or any other interested party must submit written notice of opposition to the Agency in order to receive notice of the Agency decision and preserve the right to appeal the Agency decision to the Commission. Applicants will be notified of these comments and will have until the fiftieth day of the review cycle to respond in writing to opponent's comments.
- 10. Informal Hearing During Review. The Director of the Agency may convene an informal hearing on any application under review.
- 11. Agency Decision. According to Arkansas Code Ann. § 20-8-104, the Agency must approve or deny the application within 90 days from the date the application is deemed complete and submitted for review. The criteria that the proposed project met or failed to meet shall be set forth in written findings to the applicant. Findings will be sent via certified mail to opponents who have written a letter of opposition and also to unsuccessful applicants.
- 12. Appeal for Hearing Before the Commission.
 - (a) Opponents of applications must submit a letter of opposition during the 30 day review period in order to be

eligible to request a hearing before the Commission. Any applicant or opponent seeking an appeal of the Agency's decision on a Permit of Approval shall file for a hearing within thirty (30) days of receipt of the Agency's decision. An appeal shall be written and documented on the Agency's Appeal Form for Permit of Approval Decisions. The grounds for the appeal must be indicated on the form and no additional grounds may be raised before the Commission. The form will be provided by the Agency.

- (b) When there is an application pending before the Agency or the Commission no additional applications will be placed under review for the same service or facility in the same service area until an appeal has been filed in circuit court or the time has expired for appeal to Circuit Court on the pending application.
- (c) Appeals to the Commission will be conducted in accordance with the State Administrative Procedure Act.
- (d) Appellant(s) will present their case first. The Appellee(s) will follow. The appellant(s) shall be given an opportunity to present rebuttal witnesses. Each side may cross-examine witnesses. (The time for cross-examination will not be counted as part of the suggested time frame). The following is the suggested time frame for appeals:

10 mins. for Opening Remarks for each side

40 mins. for presentation for each side

10 mins. for closing comments for each side
(the appellant(s) may reserve a portion of the time for rebuttal)

Each Commissioner will have a copy of the complete file. This is a part of the record; therefore, it is not necessary to introduce the application, findings, notices, etc. as exhibits in the administrative hearing.

- (e) The Commission will conduct a hearing within ninety (90) days of the agency decision and shall render its final decision within fifteen (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 on the Permit of Approval and shall

constitute the final decision of the Commission.

- (f) A hearing may be delayed through a continuance by either the applicant or the opponent(s) if the request is made in writing to the Agency at least (10) days before the date of the hearing. Neither the applicant nor the opponent(s) may request more than one continuance, i.e. there will be no more than one continuance per side. This language should not be read to deny any rights guaranteed by the Arkansas Code.

13. Ex Parte Contacts

After an application for Permit of Approval is filed with the Agency there shall be no ex parte contacts between:

- (a) an applicant or any person acting on behalf of the applicant (or holder of a Permit of Approval in a decision to withdraw a Permit) or any person opposed to the issuance (or in favor of withdrawal) of a Permit of Approval and
- (b) any member of the Commission.

An ex parte contact by an applicant or a person representing an applicant may be grounds for the withdrawal of the application from review.

NOTE: An ex parte communication is defined as oral or written communication not on the public record with respect to which reasonable prior notice to all parties is not given, but it shall not include requests for status reports on any matter or proceeding.

SECTION VI. CONTINUING EFFECT OF A PERMIT OF APPROVAL

A. Implementing a Permit of Approval

- 1. Applicants approved to construct a new facility or expand an existing facility have nine (9) months from the date of the issuance of the Permit (or from the date of the final judicial decision on the Permit of Approval application) to sign a construction contract. The construction contract shall specify that the foundation for the facility will be completed within six (6) months of the signing of the contract and that the facility will be completed within eighteen (18) months from the date of the signing. An application for licensure of the beds contained in the new construction must be made within eighteen (18) months from the date of the signing of construction contract. In the event that the construction contract is

not signed within nine (9) months, the foundation is not completed within six (6) months of signing the construction contract, or the project is not completed and an application for licensure not filed within eighteen (18) months of the date of signing of the construction contract the Permit must be terminated by the Agency. Appeals of the termination will be made to the Health Services Commission within thirty (30) days of notice of termination. Notice of the termination of a Permit will be through certified letter to the holder of the Permit. Notice of hearings on appeal of the termination will be by mail to the holder of the Permit and affected parties and legal notice in a newspaper of statewide coverage.

2. Applicants that have made a preliminary application for a HUD insured loan on or before the 90th day following the issuance of their POA and have not received an approval from HUD by the start of the eighteenth month following the issuance of the POA may request an extension of the POA for up to an additional six months. In order to receive the extension the applicant must provide the Agency with a letter from HUD documenting: 1) the date of preliminary application and 2) that the delay in approval was not due to inaction or delays by the applicant. This request for an extension on the POA must be made at least three weeks prior to the end of the eighteenth month.
3. Projects not requiring construction or renovation must be licensed within one year of the date of the Permit of Approval (or within one year of the date of the final judicial decision on the Permit of Approval application).
4. After project approval, if the applicant wishes to change the approved project, the proposed changes are subject to Permit of Approval if they are such that in themselves they would be subject to review. If an applicant proposes a change that was a significant reason for the approval of the project then that proposed change must go before the Commission to determine whether the change shall require review.
5. A Permit of Approval once issued to an approved applicant, is not transferable to any other institution or party without approval of the Commission.
6. Extensions – The Commission may approve a request for extension of time if good cause is presented. Any request for an extension must be made in writing to the Agency prior to the expiration of the date on which the phase or project was to be

completed. Under no circumstances will an extension be granted for more than six months at a time. An applicant may request subsequent extensions.

7. The above stated timelines also apply to projects that were exempted from Permit of Approval review. The starting date for exempted projects will be the date of the exemption. (e.g. exempted construction projects will have nine (9) months from the date of exemption to sign a construction contract).

B. REPORTING

1. It will be the sole responsibility of the applicant to keep the Agency informed of its progress during the approval period. Documentary evidence of the signed construction contract, the construction of the foundation and the application for licensure must be submitted to the Agency. A progress report to the Agency on the project is required at the time the construction contract is due, at the time the foundation is due to be completed and every six months after that until the project is licensed. Failure to submit these progress reports may result in the approved party having to appear before the Commission to show cause why the permit should not be terminated.

C. TERMINATION OR SURRENDER OF A PERMIT OF APPROVAL OR LICENSE:

Any increase or decrease in beds or services due to the expiration, termination, revocation, or surrendering of a permit or the expiration, termination, revocation, or surrendering of a license must be recorded with the Agency at least sixty days prior to the deadline for filing applications for a review cycle in order to be considered in the review cycle.

SECTION VII. EXCEPTIONS TO USE OF PROCEDURES

- A. The Commission may approve an exception to any of the required review procedures by a favorable 3/4 (75%) vote of the full Commission.
- B. In approving a general exception the Commission will establish substitute procedures where appropriate.
- C. Upon receiving a written request for an exception, the Agency will follow

the notice and comment procedures and will submit copies of all comments received by the Commission with its request. Before approving the request, the Commission will:

1. review copies of the comments submitted by the Agency, and
2. determine that the procedures to be used are consistent with the purposes of the Act and will not adversely and substantially affect the rights of affected persons.

D. The Agency will distribute a notice of the approved exception and of any substitute procedures established under this Section.

SECTION VIII. ENFORCEMENT

The Commission may authorize the Agency to enjoin the construction or expansion of existing facilities or operation of any project commenced in violation of Act 593 as amended through action filed in the Chancery Court of the judicial district in which the project is located. In addition, the Commission will instruct the Agency to contact the appropriate licensure agency and request that the licensing agency make the facility cease operation.

SECTION XI. ELECTRONIC MAIL AND FACSIMILES

Fax copies will be accepted provided that a hard copy with an original signature is received at the Agency within 5 days of the fax copy. The Agency will not accept official correspondence via electronic mail for the purposes of applications, letters of opposition and appeals.

SECTION X. UTILIZATION REPORTS AND FINES

Act 1271 of 2005 authorizes the Health Services Permit Agency to collect utilization statistics annually from hospitals, nursing homes, outpatient surgery centers, home health agencies, assisted living facilities, residential care facilities and hospices. The Agency is also authorized to impose fines on nursing homes, home health agencies, assisted living facilities, residential care facilities, and hospices for the failure to timely submit reports of statistics as required by the Agency. The fines are:

- A. Up to one hundred dollars (\$100) for a report over thirty (30) days late;
- B. Two hundred fifty dollars (\$250) for a report over sixty days late;
- C. Five hundred dollars (\$500) for a report over ninety days late.

HSC REGULATION 500M. Assisted Living Methodology (10/03)

- A. ASSISTED LIVING FACILITY** means any building or buildings, section or distinct part of a building, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide assisted living services for a period exceeding twenty-four (24) hours to more than three (3) adult residents of the facility who are not relatives of the owner or administrator. Assisted living facility includes those facilities which provide assisted living services either directly or through contractual arrangements or which facilitate contracting in the name of residents.

SECTION II- SERVICE AREA is the county.

SECTION III- NEED

A. POPULATION BASED NEED

This methodology projects the need for Assisted Living beds at 15 beds per 1000 persons who are 65 years old and older. Need will be projected five years forward using the most recent census data available from the UALR Institute for Economic Advancement.

B. UTILIZATION BASED NEED

- A. Assisted Living Facilities may acquire 10% of their licensed beds or 10 beds, which ever is greater, if the applicant:
1. has an average occupancy of at least 90% or greater in the 2 most recent survey inspections available from the Department of Human Services Office of Long Term Care.
 2. has no approved but unlicensed beds at the time of the application.
 3. has no current Class A or Class B deficiencies from the DHS Office of Long Term Care.

SECTION IV- SIZE

While there is no required minimum size, the recommended minimum size for achieving basic operational efficiency is 40 beds. Smaller projects may be more feasible for counties or communities that do not have the population base to support a 40-bed facility. However, smaller facilities have higher costs and applicants proposing a facility smaller than 40 beds will be subject to a higher level of justification under the Market Study and the Financial Feasibility Section of the application.

SECTION V - CONVERSIONS

Nursing Homes that wish to convert beds to Assisted Living beds may convert a minimum of 10 beds and a maximum of 80 beds.

SECTION VI - PRIORITY

A. Priority for new construction or expansion will be given to an applicant who demonstrates that:

1. The proposed application will serve low-income elderly residents. *
2. Existing assisted living beds do not meet the needs of the low-income elderly in the service area and
3. Is able to provide documentation of pending application with Arkansas Finance Development Authority for tax credits.

** According to the National Housing Survey of Adults Age 60+: opinions, Attitudes, Perceptions and Behaviors, The greatest demand for seniors housing is from people with lower incomes.*

B. Applicants who document receipt of tax credit from the Arkansas Finance Development Authority will receive priority for Assisted Living Permits of Approval regardless of population based need. (See footnotes)

SECTION VII - UNFAVORABLE REVIEW

A. Existing facilities will have an unfavorable review if the following quality of care standards are not met:

1. No Nursing Home will be awarded a permit of approval if the existing facility has had an H level or higher deficiency according to the Office of Long Term Care in any inspection within the last 12 months preceding the date the application is placed under review or from the date the application is placed under review until the final decision of the Health Services Commission.
2. No Assisted Living or Residential Care Facility will be awarded a permit of approval if the existing facility has had more than two (2) Class A or Class B violations pursuant to ACA § 20-10-205 in any inspection within the last 12 months preceding the date the application is placed under review or from the date the application is placed under review until the final decision of the Health Services Commission.

VIII - REVIEW CRITERIA

- A. The Agency and the Commission will utilize the following criteria in the review process.
 1. Whether the proposed project is needed or projected as necessary to meet the needs of the population. Criteria includes:
 - a. Review of a detailed market feasibility study.
 2. Whether the project can be adequately staffed and operated when completed. Criteria includes:
 - a. Projected sources of staffing.
 3. Whether the proposed project is economically feasible.
 4. Whether the project will foster cost containment.

Footnotes:

The Arkansas Legislature adopted Act 1230 in 2001 that established Assisted Living in Arkansas. The Act “encourages the development of innovative and affordable facilities particularly for persons with low to moderate incomes.” Because federal laws and rules prohibit Medicaid from paying room and board costs other than in a nursing home, developing affordable Assisted Living is challenging. The main vehicle for developing affordable Assisted Living is the Low Income Tax Credit program. The Arkansas Finance Development Authority (AFDA) recognizes Assisted Living as a priority for Arkansas and has created a “set-a-side” from its Tax Credits specifically for affordable Assisted Living. However, Tax Credits alone are usually not adequate to build an affordable Assisted Living facility. Other financing mechanisms must be “layered” or combined with the Tax Credits. Chief among these are the HOME program and grants from the Federal Home Loan Bank. Unfortunately, the Federal Home Loan Program, the AFDA Tax Credit Program, and the Health Permit Agency all have different time tables for accepting and awarding applications. This makes the creation of affordable Assisted Living almost impossible. To eliminate barriers to affordable Assisted Living and to encourage innovative and affordable models as called for in Act 1230, the Arkansas Health Services Permit Agency (HSPA) will give priority to an applicant that receives Tax Credits from AFDA. AFDA Tax Credits are awarded on a competitive basis. Applicants must submit a marketing study documenting the need for affordable Assisted Living. Therefore, HSPA will accept approval of Tax Credits as establishing a need for affordable Assisted Living.

HSC REGULATION 300M. Home Health Criteria

A. Methodology

1. Standards. The following is the standard to be used in the review of additional or expanded home health agencies. The methodology is based on the following assumptions: 1) More populated areas tend to have a higher population density, 2) Areas with higher population density can be served with fewer staff due to reduced travel time. Thus, it will take fewer staff to serve the same number of patients in a metropolitan area than it would to serve patients in a rural area.
 - a. An area* with up to 30,000 population may be approved for a maximum of two agencies.
 - b. An area with 30,000 to 50,000 population may be approved for a maximum of three agencies.
 - c. An area with 50,000 to 75,000 population may be approved for a maximum of four agencies.
 - d. An area with 75,000 to 110,000 population may be approved for a maximum of five agencies.
 - e. An area with 110,000 to 150,000 population may be approved for a maximum of six agencies.
 - f. An area with 150,000 to 250,000 population may be approved for a maximum of seven agencies.
 - g. An area with 250,00 to 400,000 population may be approved for a maximum of eight agencies.
 - h. An area with 400,000 and over population would be approved for a maximum of one agency per every 50,000 population.

*An area refers to the service area, or geographic area, served or proposed to be served by a Home Health Agency or an applicant.

2. Exception. Approvals may be granted when the methodology does not show a need if the applicant offers documentation to prove that existing agencies are not meeting the needs of the service area population.
3. Application for a change in licensure category. An agency with a "B" license that applies for a Permit of Approval to proceed with obtaining an

"A" license will have to meet published criteria including the standard of need. Such approval may not exceed the standard of need unless the applicant has provided evidence to support an exception as noted in 2.

4. Unfavorable Review. No application will be approved for a new home health agency or an expanded service area or change in license category if the applicant has suffered a condition level of deficiencies as determined by the Arkansas Department of Health in its last two annual surveys.

Small rural hospitals that do not have a home health agency may be approved for a home health agency to serve either the county in which the hospital is located or the townships within a twenty mile radius of the hospital. Small hospitals are defined as short term acute care hospitals of 50 or fewer licensed beds. Rural counties are defined as counties with a population of 25,000 or less in the last decennial census. Hospitals approved under this rule must have their home health agency licensed no later than twenty-four (24) months from the date of approval.

HSC REGULATION 400M. Hospice Methodology (10/05)

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 on the basis of need, regardless of the ability to pay.

HOSPICE PROGRAM -Hospice program is defined as a public agency or private organization or subdivision or either of these that is primarily engaged in providing care to terminally ill individuals (Code of Federal Regulations, Title 42, Volume 2, Part 418).

HOSPICE FACILITY - 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.

Hospice Agencies

This rule regulates the establishment of new hospice agencies and the expansion of existing hospice service areas.

A. NEED

1. The projected number of hospice patients will be 25% of the average of the total deaths that occurred in the county for the four most recent years available as calculated by the Center for Health Statistics.
2. The number of hospice patient deaths by county of residence from the previous reporting year will be subtracted from the number of projected hospice patients. The result will be the number of patients eligible for hospice for the projected year.
3. Numeric need for a new hospice is demonstrated if the projected number of patients eligible for hospice per calendar year is 25 or greater in the proposed service area (or expanded area).* The projections for the proposed area would have to indicate a need for 25 or more after the deaths for the existing hospices for the previous calendar year have been subtracted out from the total projected hospice patients.

B. REQUIREMENTS:

Applicants are required to provide a business plan including:

1. Documentation of financial support to provide cost efficient hospice care as measured by industry standards and published by The National Hospice and Palliative Care Organization or The National Association of Home Care and Hospice.
 2. A potential office location in the county in which the applicant is applying for a Permit, or documentation that research into a location for an office has been done. with the amount of rent reflected in the budget. An exception exists if an applicant has a hospice office in a contiguous county; in this case, the existing hospice office can serve as the address for the new application.
 3. A plan to educate physicians, hospital discharge planners and other appropriate health and social service providers about the need for timely referral of potential hospice patients.
 4. Agreement to provide timely and accurate reporting data to the Health Services Permit Agency as requested.
- C. Regardless of numeric need, no new hospice agency will be approved unless each hospice agency servicing the proposed service area has been licensed and operational for at least two years. This provision does not prohibit approval where a new license was granted to an Agency that purchased a hospice agency that had been serving the area for more than two years.

II. HOSPICE FACILITIES

This rule regulates the establishment of new hospice facilities and expansion of existing hospice facilities.

The objective of this Methodology is to ensure that an adequate supply of hospice beds are available and accessible while avoiding the proliferation of unneeded hospice facilities in the service area.*

- A. APPLICATION REQUIREMENTS are based on federal guidelines including Section 1861 of the Social Security Act that states that a hospice must provide all levels of hospice care and cannot choose to only operate an in-patient

facility. It must offer all levels of care including general in-patient, routine, respite and continuous care. The only eligible applicants for a Hospice Facility are those agencies that have operated a licensed Hospice Agency for at least one year prior to seeking application for a Hospice Facility.

- B. BED NEED – The calculations to determine the number of patients eligible for hospice services are the same as those found in Section I. A2.

The formula to determine the need for hospice beds is based on the federal allowance of 20% in-patient days and the Arkansas average of 5.6% in-patient days (5.2% general inpatient and 0.5% respite). The Arkansas average is rounded to 6%. The mean of 6% and 20% is 13%. This mean (13%) is multiplied times the number of projected hospice patients in the county to determine the county need for hospice beds.

Applicants can apply for a minimum of 4 beds and a maximum of 36 beds.

Applicants who have a facility and who propose to expand: (1) can not expand to greater than the maximum number of beds per county (See Bed Need Book Appendix A) and (2) can not exceed 36 beds.

Hospice need is projected five years in the future as of July 1st of each calendar year. The number of projected hospice patient deaths will be computed from the most recent Crude Death available from the Center for Health Statistics, Arkansas Dept. of Health and the most recent available population estimates obtainable from the US Census Bureau.

* The service area is the county

C. REQUIREMENTS:

Applicants are required to provide **a business plan including** the following:

1. Documentation of financial support to provide cost efficient hospice care as measured by industry standards The National Hospice and Palliative Care Organization or The Hospice Association of America.
2. A street address and city for the proposed facility in the county in which the applicant is applying for a Permit.
3. Agreement to provide timely and accurate reporting data to the Health Services Permit Agency as requested.

HSC Regulation 100M Nursing Home Bed Methodology (05/03)

All dates contained herein, (with one exception see below), will move forward one year each July 1st, e.g. on July 1, 1998, the date 2002 which is listed under “I. Population Based Methodology” will move forward to 2003.

The term licensed beds means the bed count as reflected on the current license issued by the Department of Human Services, Office of Long-Term Care.

I. POPULATION BASED METHODOLOGY (PROJECTED TO 2002)

In order to qualify for additional beds, counties showing a “need” under this section must have had an overall occupancy of at least 70% for the most recently available occupancy as reported by DHS. If a “need” is projected for additional nursing home beds in a county (based on the Commission’s adopted formula) then the following would apply:

A. Applicants will be favored in the following ranked order:

1. Applicants whose facility had a 96.0% average occupancy rate or greater for the most recently available occupancy as reported by DHS. These applicants would be eligible for 10% increase in their licensed capacity or 10 beds, whichever is greater. Qualifying applicants will have a preference (for a total of up to 35 additional beds) over applicants proposing a new facility.
2. Applicants who proposed to replace facilities would be eligible for a 20% increase in their licensed capacity.
3. Applicants who have a facility proposing to expand to 70 beds would be eligible to expand to 70 beds. Applicant facilities with less than 70 beds and more than 60 licensed beds would be eligible for a 10 bed increase.
 - (1) The Commission may exceed “need” when “need” is less than 10 beds in order to approve one applicant for a 10 bed increase (i.e., the 10 beds would not be spread over two (2) or more applicants).
 - (2) The Commission may disregard the overall county occupancy one time in order to approve a 70 bed facility in a county where the projected need for the county exceeds the “existing” (i.e., licensed and approved) beds by 250 or more beds.

II. UTILIZATION BASED

- A. Nursing homes may acquire additional beds from another facility either located in the same county or outside the county, if the applicant is acquiring fewer beds than the net need of the county and
- B. the applicant:
 - 1. averaged 90.0% or greater occupancy according to the most recently available occupancy as reported by DHS.
 - 2. currently has no approved but unlicensed beds and had no approved but unlicensed beds during the previous State fiscal year,
 - 3. acquires beds from a facility that averaged 70% or less occupancy for the past two State fiscal years,
 - 4. is located in a county without a Population-Based need; and
 - 5. is not located in a county where the number of approved but unlicensed beds equals 10% or more of the county's licensed beds in the previous state fiscal year

Beds may not be transferred back or returned to the original facility unless all the requirements of this section Part II. A. are satisfied.

- C. Nursing homes with less than 60 licensed beds could be approved to expand to 70 beds, if the facility:
 - 1. averaged 90.0% or greater occupancy according to the most recently available occupancy as reported by DHS.
 - 2. currently has no approved but unlicensed beds and had no approved but unlicensed beds during the previous State fiscal year,
 - 3. is located in a county without a Population Based "need"; and
 - 4. is not located in a county where the number of approved but unlicensed beds equals 10% or more of the county's licensed beds in the previous state fiscal year
- D. Nursing Homes that first commenced operations in buildings constructed between August 1, 1996 and August 1, 2002 and which have unused bed capacity may add up to 10% of their licensed capacity or 10 beds, which ever is greater, notwithstanding any other provision of this methodology, if the facility:

1. averaged 90.0% or greater occupancy for the most recently available occupancy as reported by DHS.
2. currently has no approved but unlicensed beds and had no approved but unlicensed beds during the previous State fiscal year;
3. can add such additional beds without incurring additional capital expenditures related to construction;
4. is located in a county without a Population Based need; and
5. Is not located in a county where the number of approved but unlicensed beds equals 10% or more of the county's licensed beds in the previous state fiscal year

Section D shall expire on June 30, 2004.

- E. Notwithstanding the foregoing provisions of this section II but subject to section IV E and F herein, and subject to commission approval, an existing facility may relocate beds within the county where the facility is located. In doing so, the facility may either move all or some of its existing beds or the facility may acquire and move beds from another facility located within the same county.
- F. In any county where every nursing home facility in the county has an occupancy rate of at least 90.0%, and there is no population based need, an applicant may add 10% of their licensed capacity or 10 beds, which ever is greater, if the facility:
 1. currently has no approved but unlicensed beds and had no approved but unlicensed beds during the previous State fiscal year, and
 2. is not located in a county where the number of approved but unlicensed beds equals 10% or more of the county's licensed beds in the previous state fiscal year

III. REPLACEMENT OF FACILITIES AND BEDS

- A. Qualified applicants would be applicants who propose to replace existing beds with "new construction." As used in this methodology, "new construction" means the replacement of an entire facility with a newly constructed facility, or the relocation of existing beds into a newly

constructed facility. This section prohibits the relocation of existing beds for purposes of “adding on” to an existing facility, irrespective of whether the “add on” is new construction. Applicants would be approved for up to a 20% increase of their present licensed capacity.

- B. Qualified applicants cannot combine any criteria to increase existing licensure by more than 20% except in the case of facilities expanding up to 70 beds. This does not affect applicants which qualify for approval under I.A.1. of this methodology.
- C. Qualified applicants may move to another county or counties if:
 - 1. the beds are located where “existing” (i.e. licensed and approved) beds exceed the projected county need by 100 or more beds;
 - 2. the county (or counties) to which the beds are being moved has a projected need which exceeds “existing” beds by 150 or more beds, and;
 - 3. the moved beds are used for “new construction.”

IV. UNFAVORABLE REVIEW

No application will be approved for additional beds that:

- A. does not agree to eliminate all three (3) or more bed units in the applicant facility. A facility may have three (3) or more beds units only in order to comply with specific regulations for intensive care, Alzheimer’s disease, and/or sub-acute care units (pertinent regulations to be promulgated by the Department of Human Services, Office of Long-Term Care),
- B. does not include a sprinkler system and generator under regulations promulgated by the Department of Human Services, Office of Long-Term Care. (This applies to new facilities only),
- C. is for an applicant home with current life threatening compliance issues that could not be corrected by the proposed construction, or
- D. is for any nursing home found to have had an H level deficiency or higher by the Office of Long Term Care in the twelve (12) months preceding the date the application is placed under review or from the date the application is placed under review until the final decision of the Commission.
- E. will cause a facility to exceed 140 beds, or create a facility with fewer than 70 beds. Any deviation will require special consideration by the Commission.

- F. would create an under-served area. The Commission will make this determination.
- G. No applicant will be approved for additional beds if it is located in a county where the number of approved but unlicensed beds equals 10% or more of the county's licensed beds in the previous state fiscal year. e.g. if in 1997 County "A" had 140 licensed beds with a 28 bed approval then the facilities in County "A" would not be eligible for additional beds under either the Population Based or Utilization Based methodology. The rationale is that an increase in beds would have affected occupancy.
- H. 1. In any one review cycle, for all applications submitted under sections I and III of this methodology, only one (1) application may be approved per county. For example, if there are two (2) applications submitted under section I and one (1) application submitted under section III, only one of the three applications may be approved in any one review cycle.
- H. 2. With respect to applications submitted under section II, one application per county may be approved per review cycle, in addition to the one (1) application to be approved as described in section IV.H.1.

NOTE: Occupancy data on Medicaid certified facilities will be based on the report supplied by the Department of Human Services, Division of Medical Services to the Health Services Permit Agency. Occupancy data on facilities that did not report to the Department of Human Services, Office of Long-Term Care will be based on the survey conducted by the Health Services Permit Agency. (Non-reporting facilities include facilities without Medicaid beds and those facilities which changed ownership during the previous calendar year.)

V. Lifecare Nursing Facility (10/02)

The Arkansas Health Services Commission and the Arkansas Health Services Agency amend their rules, policies, and procedures in relation to applications for long-term care facilities as follows:

- A. Continuing care providers, as established by the Arkansas General Assembly and codified in A.C.A.23-93-101 - 23-93-114 and regulated by the Arkansas Insurance Commissioner, shall be governed by the statutory and regulatory provisions relating to applications for long-term care facilities.
- B. Continuing care "life care providers", as established by the Arkansas General Assembly and codified in A.C.A. 23-93-201 et seq., regulated by The Insurance Commissioner of Arkansas and requiring no additional charges for nursing care or personal care services beyond those charged all residents of the facility who are not receiving nursing care of personal care services, shall be governed by statutory and

regulatory provisions relating to applications for long-term care facilities, except:

1. After issuance of a license by the Department of Insurance as a "life care provider", the life care provider may apply for a Permit of Approval for a nursing facility based on one bed per ten constructed, licensed units occupied by bona fide residents upon a signed agreement that no individual will be directly admitted to the nursing facility who has not been a bona fide resident of the life care provider.
2. (i) Additional beds for the life care provider nursing facility may be requested on an annual basis, provided it is in compliance with and has a current license from the Department of Insurance and the Office of Long Term Care, based on one bed per additional ten constructed, licensed units occupied by bona fide residents of the life care provider which have been constructed, licensed, and occupied by bona fide residents and in existence for at least twelve (12) months from the last application under this sub-section, and based on the occupancy of the nursing facility during the previous twelve months, requiring the previous twelve months, until the nursing facility reaches a total of seventy (70) beds, and provided no individual has been admitted to the nursing facility who had not been a bona fide resident of the life care provider. The life care provider shall furnish the Health Services Agency all information requested to substantiate the application. or
(ii) Additional beds for the life care provider nursing facility may be requested on an annual basis, if no new constructed, licensed units have been added to the life care provider, based on the utilization of the nursing facility during the previous twelve months, requiring seventy percent (70%) occupancy over the previous twelve months, and shall entitle the life care provider, provided it is in compliance with and has a current license from the Department of Insurance and the Office of Long Term Care, to an additional ten beds, or ten percent (10%), whichever is greater, until the nursing facility reaches a total of seventy (70) beds, provided no individual has been directly admitted to the nursing facility who has not been a bona fide resident of the life care provider. The life care provider shall furnish the Health Services Agency all

information requested to substantiate the application.

- (iii) Only one of these methods may be used in a calendar year.
- 3. Should the life care provider's license be revoked by the Arkansas Department of Insurance, this Commission shall recommend to the Office of Long Term Care that the nursing facility lose its license to own and operate a nursing facility. Should a life care provider nursing facility directly admit residents who have not been bona fide residents of the life care provider to the nursing facility, the life care provider shall not be allowed to apply for new beds for a total of five (5) years.
- 4. The nursing facility or beds of a life care provider shall not be sold or transferred to any other entity. Any sale or transfer shall automatically forfeit the license of the facility or beds and bar the life care provider from applying for additional beds for ten (10) years.
- 5. Nursing facility beds of a life care provider shall not be counted when computing bed need for a county, as they are not available to the public.

POPULATION BASED FORMULA (04/03)

This methodology projects nursing home bed need using estimated population in four age groups (see below) of a service area (county):

AGE GROUP	BEDS PER 1000 POPULATION
Below 65	.66
65 to 74	10.8
75 to 84	42.97
85 and above	182.5

NOTE: The projection for a county represents the number of patients estimated to need beds. Since all nursing homes cannot be expected to operate at 100% occupancy year round, 5% additional beds are added to the initial projection to allow for patient fluctuation, i.e., the initial projection (using the above mentioned bed figures) represents 95% of the total beds needed.

HSC Regulation 110M. Psychiatric Residential Treatment Facilities (PRTF) Bed Need Methodology

DEFINITION: "A psychiatric residential treatment facility means any non-hospital establishment with permanent facilities which provides a 24 hour program of care by qualified therapists to include, but not be limited to, duly licensed mental health professionals, psychiatrists, psychologists, psychotherapists, and licensed certified social workers, for emotionally disturbed children and adolescents who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of restorative treatment services. An establishment furnishing primarily domiciliary care is not within the definition." (Act 609 of 1985)

I. Population Based Methodology

- A. Projection Time Frame. Each July 1st bed need will be projected five years from the current year, i.e., July 1, 2003 projections will be made for the year 2008.
- B. Service Area is the State of Arkansas.
- C. Bed Need Formula.
 - 1. .385 beds per 1000 persons age 6-17
.300 beds per 1000 persons age 18-21
 - 2. Before additional beds may be approved existing PRTFs must have averaged 80% occupancy for the previous calendar year.
- D. Review Priorities. Applicants will be approved in the following ranked order:
 - 1. Existing PRTFs with an average annual occupancy of 90% or greater.
 - 2. Existing PRTFs wishing to expand and replace an older facility.
 - 3. Applicants for new PRTFs in sections of the State that are more than one and a half hours travel time from existing PRTFs.
 - 4. Applicants for new PRTFs.

I. Utilization Based Methodology.

An existing facility may be approved for up to ten (10) additional beds if the facility had an average occupancy of 90% for the previous calendar year.

HSC Regulation 200M Residential Care Facility (RCF) Methodology (10/05)

I. Residential Care. Definition.

All references to "Residential Care" and "Residential Care facilities" refer to facilities that meet the definition contained in Act 1238 of 1993, which states:

"(14) 'Residential care facility' means a building or structure which is used or maintained to provide, for pay on a twenty-four hour basis, a place of residence and board for three (3) or more individuals whose functional capabilities may have been impaired but do not require hospital or nursing home care on a daily basis
But could require other assistance in activities of daily living."

Residential Care facilities also include:

Any other facility, which meets the statutory definition regardless of licensure category or the existence of a licensure category.

II. Service Area will be the county.

III. Bed need will be determined by a Population Based methodology and a Utilization Based methodology.

A. Population Based

1.a. Numerical Formula. At 90% optimum occupancy the following number of RCF beds are projected by Age group:

Age Group	Beds per 1000
Under 65	.5545
65-74	2.3014
75-84	5.1090
85+	17.4996

Bed need will be projected five years forward each July 1st, e.g., in 2003 bed need will be projected for the year 2008.

1.b. An exception to the population based formula exists when occupied beds in all facilities in a county are 75% occupied by residents who are documented to be under the age of 65 years old. In this instance, beds in those facilities will not be counted in the county bed need.

2. Review Priorities. Applicants will be approved in the following ranked order:

- a. Applicants with high occupancy will have a priority for an increase of 10% or 10 beds whichever is greater. (For definition of "high" see "B. Utilization Based" below.)
- b. Applicants replacing "older" facilities will have a priority for a 20% increase.
- c. Applicants wanting to expand will have a priority for an increase of 5% or five beds whichever is greater.

The above priorities may not be combined i.e., an older facility with "high" occupancy will be eligible for either a 10% or a ten bed increase or a 20% increase but not both.

No additional beds will be approved for a county showing a need under the Population Based Methodology where:

- (1) there is a valid POA for the first RCF in the county which has yet to be licensed; or
- (2) if the county has had its first and only RCF licensed within the last calendar year. After the initial RCF has been licensed for six months, the Commission will review the situation and determine if additional beds will be approved for the county.

3. The Commission may exceed "need", when a need exists and is less than ten (10) beds in order to approve one applicant for up to a ten (10) bed facility.

B. Utilization Based.

This methodology would apply in those service areas where a Population Based Need is not projected. Beds may be approved if:

1. a facility has had a "high" occupancy for the previous calendar year. "High" occupancy shall be at least an average of 85% for facilities of ten beds or less, 90% for facilities of 20 beds or less and 95% for facilities over 20 beds. Proof of occupancy will be based upon

resident occupancy. Proof of occupancy is derived from the DHS, OLTC occupancy reported at the last two (2) site visits and is averaged with the occupancy reported on the site visit conducted by the HSPA. Occupancy is defined as including any individual for whom the facility has agreed to provide room or board, or services or assistance, regardless of whether they are physically present at the time the occupancy is counted.

Eligible applicants may be approved for a ten bed increase.

- C. Unfavorable Review
 - a. No Residential Care Facility will be awarded a permit of approval if the existing facility has had more than two (2) Class A or Class B violations pursuant to ACA § 20-10-205 in any inspection within the last 12 months preceding the date the application is placed under review or from the date the application is placed under review until the final decision of the Health Services Permit Commission.

- IV. Act 1230 of 2001
 - A. Act 1230 of 2001 created the Assisted Living Program and allows Residential Care Facilities that were licensed or holding a Permit of Approval as of the effective date of the Act and subsequent purchasers to be licensed as assisted living facilities subject to the provisions of the Act and without a Permit of Approval.

- V. Moratorium
 - A. Beginning July 1, 2005, applications for construction of new residential care facilities will not be accepted, including applications for replacement facilities, additional beds or to expand existing bed capacity.

 - B. However, applications for replacement of facilities of 16 beds or fewer will be accepted if the number of beds required for replacement is less than or equal to the number of beds for which the residential care facility was licensed before the application for replacement.

ICF/MR MORATORIUM

HSC Regulation 005 Moratorium on Intermediate Care Facilities for the Mentally Retarded, ICF/MR)

As authorized by Act 593 of 1987, as amended, the Commission proposes to retain the moratorium on the acceptance of Permit of Approval applications on proposals to add ICF-MR or any other long term care facility beds for which there is not an adopted review standard of need. (March, 1994)