Veteran Long-Term Care Analysis Report

Arkansas Department of Veterans Affairs

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EXECUTIVE SUMMARY

As the third component of the Arkansas Department of Veterans Affairs (ADVA) 2015-2020 Strategic Plan, this report explores options for addressing the long-term care needs of Arkansas veterans. ADVA currently offers a 108-bed veterans' home in Fayetteville with 87 operational beds, and the department recently opened a new 96-bed facility in North Little Rock. The number of Arkansas veterans who will need long-term care is projected to peak in the year 2034, and with approximately 3,276 veterans of retirement age who require long-term care, ADVA is proactively planning for viable and financially feasible solutions to address future care needs of Arkansas veterans.

Three proposed considerations are provided to guide agency decision-making about veterans' long-term care needs:

1. As an alternative to nursing homes, facilitate greater access to home- and community-based services through partnerships with local home- and community-based service providers and the U.S. Department of Veterans Affairs (VA).

2. Partner with the nursing home industry to encourage certification of homes in target areas so these facilities qualify for VA reimbursement.

3. Partner with hospitals to acquire VA certification, especially those hospitals in high-need areas with existing nursing home facilities.

Creating sustainable, cost-effective recommendations, while ensuring highest quality of care to veterans, is the primary objective of this report.

PROPOSED CONSIDERATIONS

After examining the population estimates and analyzing the current long-term care (LTC) environment in Arkansas and nationally, the study team determined that the LTC needs of Arkansas veterans can be met through existing state and federal programs and infrastructure at a lower cost than building new veterans' homes. Based on these findings, the following considerations are offered for review:

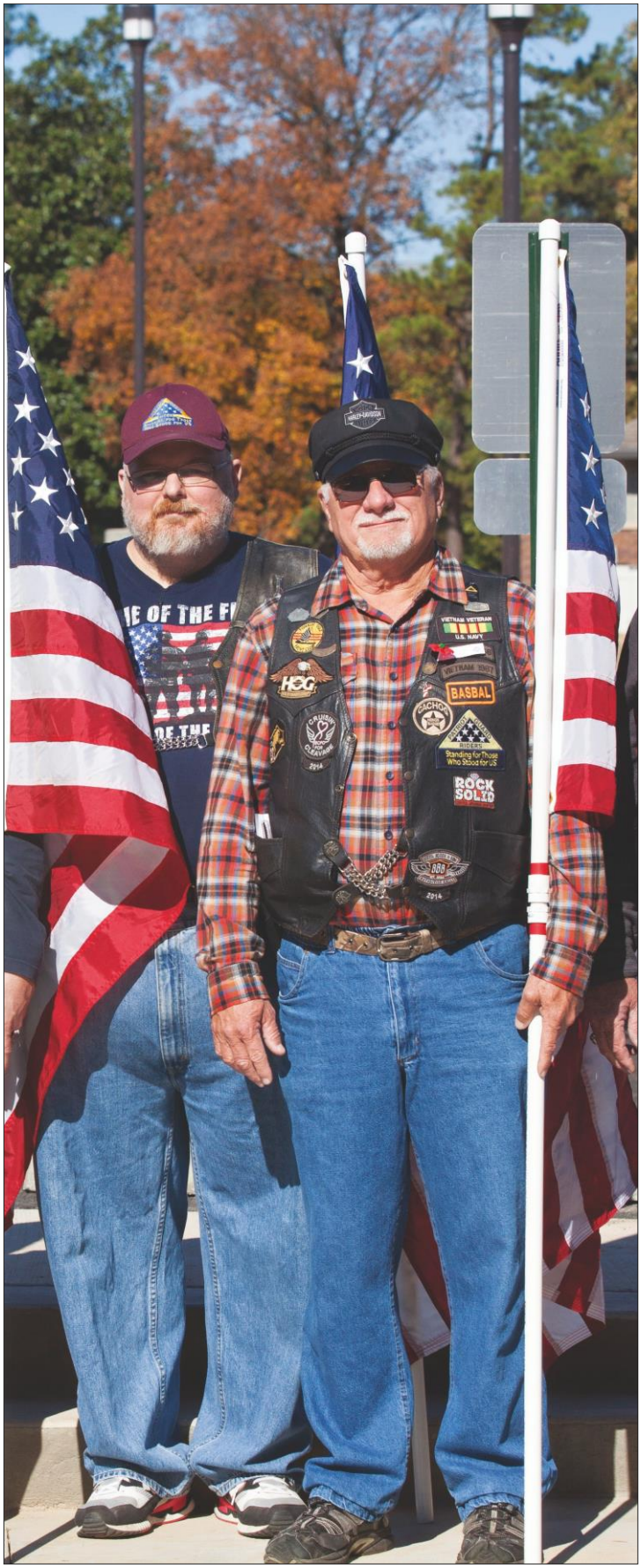
1. As an alternative to nursing homes, facilitate greater access to home- and community-based services (HCBS) through partnerships with local home- and community-based service providers and the U.S. Department of Veterans Affairs (VA).

2. Partner with the nursing home[1] industry to encourage certification of homes in target areas so these facilities qualify for VA reimbursement.

3. Partner with hospitals to acquire VA certification, especially those hospitals in high-need areas with existing nursing home facilities.

No one recommendation fully addresses the long-term care needs of aging veterans; more than one approach is needed based on the demographics of, and available resources in, particular areas.

[1]Nursing home and long-term care facility are used interchangeably throughout this report.



INTRODUCTION

The Arkansas Department of Veterans Affairs (ADVA) commissioned this study to assess the LTC needs of veterans, especially Vietnam-era veterans, for the next 25 years. To determine future needs and formulate recommendations for ADVA, this research is guided by five central research directives:

- Estimate the projected number of veterans needing LTC over the next 25 years, or through 2041;
- Understand the geographic distribution of veterans throughout Arkansas;
- Examine existing and available public and private resources that can meet veterans' LTC needs;
- Explore potential public-private partnerships to assist in meeting veterans' LTC needs; and
- Evaluate current resources by determining programmatic approaches to identify savings and avoid new capital projects.

BACKGROUND

Determining how to best meet the LTC needs of Arkansas veterans, while delivering the highest quality care at the lowest cost, mirror issues confronting the larger state effort to reform Medicaid. As the state agency charged with serving Arkansas veterans through advocacy, education, and providing high-quality, long-term nursing care, ADVA must ensure there is a sustainable system in place to meet the needs of aging and disabled veterans.

In focusing on traditional populations served by ADVA's veterans' homes, this research examines dynamics surrounding LTC needs and issues of retirement-eligible veterans (ages 65 and over).[2] ADVA currently operates a 108-bed veteran home in Fayetteville with 87 operational beds, and plans to renovate and reopen the remaining 21 beds in the near future (M. Snead, personal communication, Sept. 1, 2016). ADVA opened a new, 96-bed facility in North Little Rock in November 2016, which is expected to reach capacity in 2018 (M. Snead, personal communication, Sept. 1, 2016; K. Watkins, personal communication, Oct. 18, 2016). Preliminary estimates by the ADVA show a need for an additional facility with 400 long-term nursing home beds for veterans in the next 25 years (M. Snead, personal communication, Sept. 1, 2016).

ADVA's recently completed five-year strategic plan outlines three major goals of the organization:

1. Increase overall effectiveness of the Veterans Service Officer (VSO) program;
2. Connect veterans with certified services, and connect businesses and communities with veterans; and,
3. Develop a plan to meet the long-term care needs of Arkansas veterans (Arkansas Department of Veterans Affairs, n.d.).

This research addresses the third goal of the strategic plan.

[2]These populations do not include veterans under 65, veterans' spouses, or their dependents.

STATE COMPARISONS

In examining the issues surrounding the LTC needs of veterans, the study team reviewed strategic plans from six states: Alabama, Florida, Texas, Delaware, Massachusetts, and Oregon. Items evaluated from the reports included population projections, the number of veterans homes and total capacity, and recommendations for addressing future needs. As Table 1 illustrates, where population projections are available, Arkansas' projected need is less than all but one state; Arkansas also has the fewest number of veteran home beds. The three proposed considerations outlined in this report are also recommended for Alabama, Texas, and Oregon; two of the three are recommended for Massachusetts, which indicates these proposed considerations are in line with efforts in other states.

Table 1. State Comparison of LTC Needs, Current Veteran Homes and Recommendations

	Arkansas	AL	FL	TX	DE	MA	OR
Projected LTC Need	657	950	-na-	-na-	202-255	900	907
Number of Existing Veterans Homes (Capacity)	2 (204)	4 (704)	6 (750)	8 (1180)	1 (150)	2 (830)	1 (151)
Build New Veterans Homes			√		√	√	
Expand CNHP	√	√		√		√	√
Expand VA HCBS	√	√		√		√	√
Partner with Hospitals	√	√		√			√

LONG-TERM CARE NEEDS PROJECTIONS

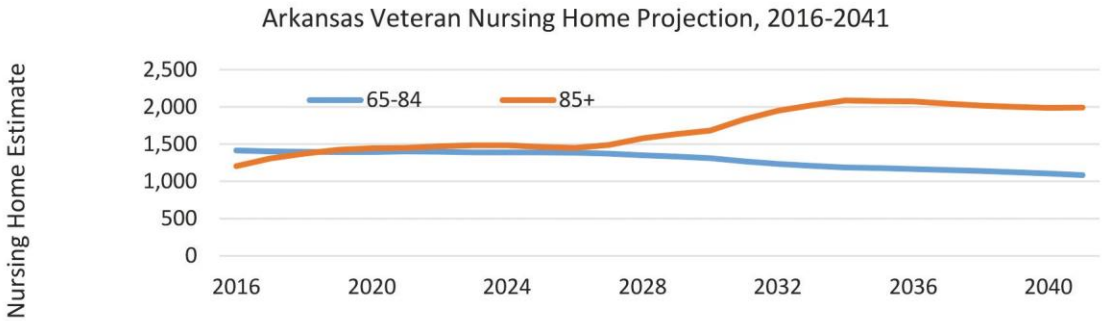
Using the best available data sources, there are 207 Arkansas veterans housed in state veterans' homes or enrolled in the VA's Community Nursing Home program (CNHP) as of September 2016; the remaining veterans in skilled nursing facilities are covered by Medicare, Medicaid, or private pay (M. Snead, personal communication, Sept. 1, 2016; V. Pighee, personal communication, Oct. 20, 2016). Below is an estimate of the actual veteran nursing home population in Arkansas (see Table 2 and Figure 1).

Table 2. Arkansas Veterans in Nursing Homes, 25-Year Estimate

Year	65-84	85+	Total
2016	1,416	1,203	2,619
2020	1,395	1,445	2,841
2025	1,388	1,462	2,850
2030	1,311	1,684	2,995
2034*	1,188	2,088	3,276
2035	1,178	2,079	3,257
2040	1,104	1,991	3,095
2041	1,085	1,995	3,079
***Peak year, 657 more beds than 2016**			

Source: VetPop Age and Gender, Census Bureau, 2015 Nursing Home Data Compendium.

Figure 1. Estimated Number of Arkansas Veterans in Nursing Homes by Age, 2016-2041

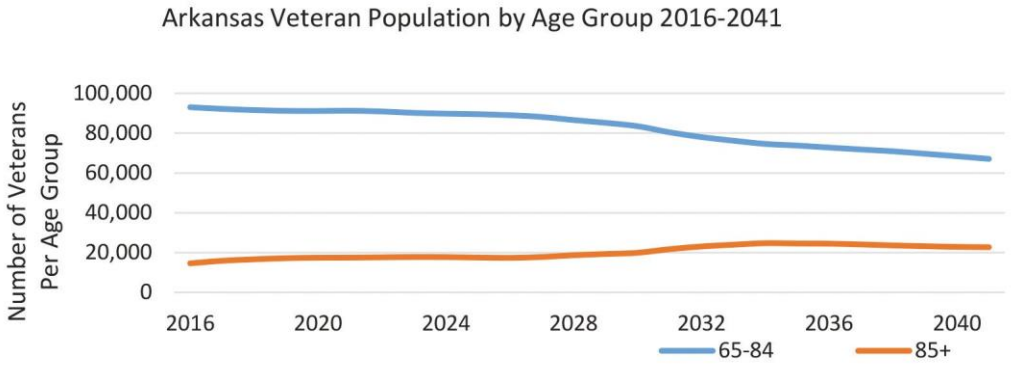


Source: VetPop Age and Gender, Census Bureau, 2015 Nursing Home Data Compendium.

In the peak need year of 2034, we estimate an additional 657 beds are required to house veterans eligible for VA LTC programs in Arkansas. The increased need for additional beds is driven primarily by aging Vietnam veterans and the increased number of women who serve in the military. Women are 2.6 percent of the veteran population in 2016, and are projected to increase to 12.9 percent of the veteran population in 2041; twice as many women as men live in nursing home facilities.

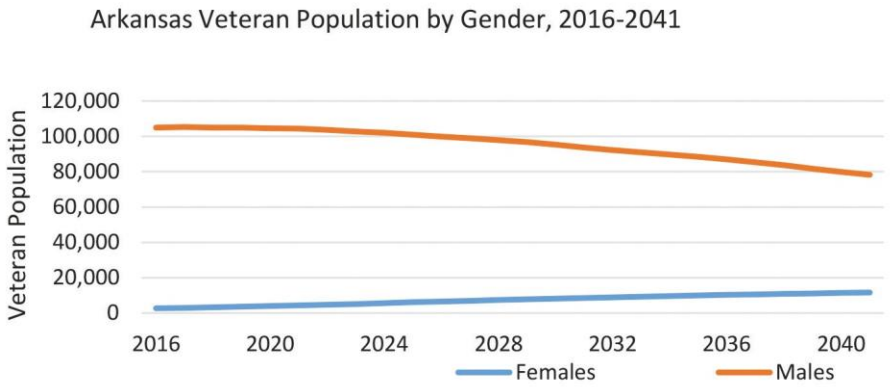
As Figure 2 below shows, the number of Arkansas veterans between the ages of 65 and 84 will decrease over the next 25 years. In contrast, veterans 85 and older maintain steady populations through the next decade before starting to increase in 2027 and peaking in 2034.

Figure 2. Projected Number of Arkansas Veterans by Age, 2016-2041



Source: VetPop Data. Age and Gender http://www.va.gov/vetdata/veteran_population.asp

Figure 3. Estimated Number of Arkansas Veterans by Gender, 2016-2041



Source: VetPop Data. Age and Gender http://www.va.gov/vetdata/veteran_population.asp

DISCUSSION OF PROPOSED CONSIDERATIONS

Home- and Community-Based Care

As an alternative to nursing homes, facilitate greater access to HCBS through building partnerships with local home- and community-based service providers and the VA.

Key Findings

Comparison studies of VA HCBS programs as an alternative to inpatient LTC show significant cost savings with higher levels of patient morale and satisfaction (Cummings, et al, 1990). Most aging patients prefer to receive medical care within a 50-mile radius of where they live; these patients would rather receive care in their home, where they are in familiar surroundings and with some control over routine activities, e.g., meals, temperature, pets, and schedules (Keenan, 2010).

While HCBS may be a preference for older adults, effective care requires a strong, integrated medical component that includes access to regular, ongoing, and coordinated care. Significant issues that must be addressed – particularly in rural areas – are ensuring sufficient numbers of qualified providers and properly trained and organized home-care teams. Initial observations in Arkansas show a disconnect between the VA and community-based organizations, such as the Area Agencies on Aging, that provide or arrange for home care. To be successful, the optimal care of aging veterans requires a major paradigm shift in both public policy and payment methods.

Opportunities for Action

1. ADVA becomes the statewide fiscal agent for the Veteran-Directed Home and Community Based Services (VD-HCBS) program.
   - The nine regional Veterans Services offices can serve as local points of contact for veterans and vendors. Fiscal agents are allowed an administration fee of up to 20 percent, which would cover program costs. ADVA can use its relationships with the VA and the Arkansas Congressional delegation to help ensure timely reimbursements to in-home service providers.

2. Create multiple points of entry for veterans into the VD-HCBS program through education and partnerships.
   - Training veteran service officers about federal HBCS programs available to veterans helps them better serve their client base.
   - By partnering with the Arkansas Department of Human Services, ADVA can ensure veterans who participate in the DHS independent assessment process qualify and receive appropriate long-term care services; DHS can refer veterans eligible for HBCS through VA programs to ADVA for follow-up. Diverting veterans to VA-funded programs helps lower demand for Medicaid-funded services, which represents cost savings for the State of Arkansas.
   - Additional partnerships with community-based, private, and nonprofit organizations (both regional and statewide) must be explored to exploit these care options and reduce LTC costs, e.g., AARP, Area Agencies on Aging, UAMS Donald W. Reynolds Institute on Aging, Program of All-Inclusive Care for the Elderly (PACE) programs, ARVets, local senior centers.

Justifications

Nursing care delivered outside of a nursing home or non-skilled care that assists with the tasks of daily living is a popular choice among veterans and the general population (L. Mattingly, personal communication, Sept. 15, 2016; The Stephen Group, 2015). According to a 2010 AARP survey, 75 percent of respondents express a desire to stay in their current residence for as long as possible, and two-thirds wish to remain in their local community for as long as possible; older adults value HCBS as a way to allow them to age in place (Keenan, 2010).

For older adults who first begin to have difficulty with daily activities, research demonstrates a positive correlation between early in-home social services and improved elder well-being (Shapiro & Taylor, 2002). Shapiro and Taylor (2002) also find a negative correlation between nursing home care and early in-home social services; if home health care is provided early enough, veterans are more pleased, yielding a higher likelihood of delaying the need of nursing home care. Improved elder well-being continues for at least 18 months after the intervention begins; early home intervention is also less expensive than traditional nursing home care (Shapiro & Taylor, 2002).

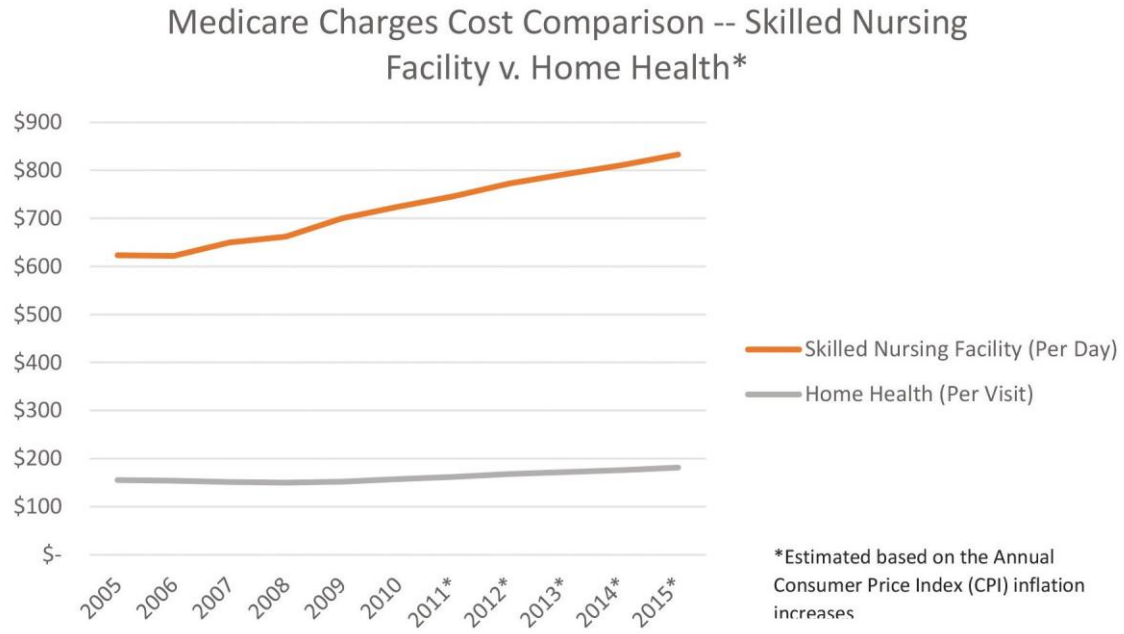
An additional advantage of HCBS is the cost savings provided through delaying the need for more expensive care in long-term facilities. As Figure 3 shows, the costs associated with HCBS, assuming a higher rate of three visits a day, are lower than skilled nursing home care.

The VA funds several HCBS programs for veterans who prefer not to enter a long-term nursing facility; these services include short-term services, such as skilled home health care and home- based primary care, as well as longer-term care, such as homemaker and home health aide care and medical foster homes. Home health care provides skilled medical services or assistance with daily living activities, depending on the level of care needed. In addition, homebound veterans who need care and are eligible for a VA pension may also qualify for Aid and Attendance program funds.

In Arkansas, there is an underutilized VA HCBS program – the VD-HCBS program. In heeding the demand for more patient-centered approaches, the VD-HCBS program empowers veterans to actively participate in making informed decisions about their health care (U.S. Department of Health and Human Services, n.d.). The VD-HCBS program provides veterans a stipend for hiring personal care aides, making purchases, or paying for services that allow them to stay in their home and community.

There are two programs in Arkansas that administered veteran-directed home health care: CareLink (Central Arkansas Area Agency on Aging), and the

Figure 3. Medicare Cost Comparison – Skilled Nursing Facility and Home Health



Source: The National Association for Home Care and Hospice. (2010). *Basic Statistics About Home Care*. Washington, D.C.: Author.

Northwest Arkansas Area Agency on Aging (AAA). CareLink no longer participates in the program, which at one time had 100 veterans participating. CareLink discontinued their participation in the program due to service reimbursement issues with the VA; these habitual delays in payment created a situation in which they could no longer cover the costs associated with maintaining this service for veterans (L. Mattingly, personal communication, Sept. 15, 2016). The Northwest AAA has only four veterans in the program, but no longer receives referrals from the VA for new veterans; Rita Nunn Jones, the local VA HCBS coordinator, did not elaborate on how referrals are made to VD-HCBS providers (R. Nunn Jones, personal communication, Nov. 4, 2016).

Encouraging greater use of HCBS aligns with national and federal initiatives aimed at the general population. On the national level, there are efforts to move the focus from institutionalized care to more community-based methods (Ryan & Edwards, 2015). Between 1995 and 2013, HCBS expenditures in state Medicaid programs increased from 18 percent of total Medicaid long-term services and supports (LTSS) spending to 51.3 percent (Ryan & Edwards, 2015). Passing the 50 percent mark for HCBS expenditures in Medicaid LTSS represents success in "rebalancing," or shifting expenditures to a more community-centered focus (Ryan & Edwards, 2015).

In Arkansas, the General Assembly convened a legislative task force in 2015 to reform the state Medicaid system. The Stephen Group, a consulting group hired by the task force, estimates that if the state shifts LTSS spending to where HCBS represents 50 percent of the overall expenditures, the Arkansas Medicaid program could realize a nearly $200 million annual, all- funds savings by 2021 (The Stephen Group, 2015). Conversely, without this shift, Arkansas may assume a 3 percent annual census growth in both nursing facilities and community-based care, and a 2 percent annual per capita cost growth in both settings, which, based on percentage difference, averages to increased costs of approximately $72 million annually through 2021 (The Stephen Group, 2015).

A May 2016 memorandum of understanding executed by the Arkansas Health Care Association, Gov. Asa Hutchinson, the Arkansas Department of Human Services (DHS), and the DHS Division of Aging and Adult Services, provides two of the agreed-upon goals for reforming Medicaid LTSS in Arkansas:

1. Smart rebalancing of LTSS to "ensure that supports and services in the community are cost effective," and

2. "Strengthen and modernize the independent assessment process" for HCBS (Hutchinson, 2016, para. 6-7).

The state moved toward achieving the second goal in October 2016, when DHS issued a draft request for proposals for an independent assessment vendor responsible for assessing Medicaid beneficiaries to determine appropriate care level services for LTSS and other related services.

Private Nursing Homes

Partner with the nursing home industry to encourage certification of homes in target areas so these facilities qualify for VA reimbursement.

Key Findings

Given an occupancy rate of 72 percent, coupled with a projected decline in bed need, ADVA should seek partnerships with community nursing home facilities and encourage these facilities to engage the VA certification process in order to receive payment through CNHP for eligible veterans. CNHP-eligible veterans are those with at least a 70 percent service-connected disability or who meet other eligibility requirements. CNHP provides certified nursing homes with reimbursements based on Medicare fee-for-service for skilled nursing facilities formulas, which are at a higher rate than Medicaid (U.S. Department of Veterans Affairs, n.d.). Placing eligible veterans in VA-certified nursing homes also shifts payment responsibility from Medicaid to the VA, and unlike Medicaid, CNHP payments require no state matching funds.

Nursing homes seeking VA certification face barriers surrounding duplicate reporting requirements and enhanced regulatory requirements. The passage and implementation of the Veterans Choice Improvement Act of 2016 (VCIA) would align VA requirements with the Centers for Medicare & Medicaid Services (CMS); this alignment of certification requirements would then mitigates issues surrounding reporting and regulatory duplication, because these redundant requirements are major deterrents to private nursing homes accepting CNHP veterans at their facilities. Should the VCIA pass, the number of VA providers will likely increase, thus giving veterans more choices and access to more efficient and attainable LTC.

Opportunities for Action

1. Support the VCIA along with the Governor and the state's Congressional delegation and work for its passage.
2. To help offset costs of compliance with Office of Federal Contract Compliance Programs (OFCCP) regulations, explore workforce incentives (or other types of incentives) available to LTC or nursing home facilities to support VA certification in target areas.
3. Train veterans' service officers on CNHP and have them provide eligible veterans with a list of VA-certified nursing homes in their area.
4. Partner with DHS to ensure that veteran and disability status is captured during the assessment process, so eligible veterans can be referred to VA-certified homes (if available); this must be done as the independent assessment process for LTSS is developed.

Justifications

The State of Arkansas regulates the allocation of nursing home beds. There are a finite number of permitted beds available; to date all permitted beds available have been allocated to facilities across the state. The most common means of increasing the number of available beds for long- term care are: 1) a nursing home owner generally must demonstrate a population-based need to open a new facility, or 2) an existing facility owner must be willing to relinquish a number of permitted beds (Arkansas Health Services Permit Agency, 2016).

The current average state occupancy rate for nursing homes is 72 percent, which is much lower than surrounding states, and, as the demand for nursing homes continues to decrease, there is a lower likelihood of gaining new beds through the population-based allocation method (R. Davis, personal communication, Oct. 14, 2016). The most current bed-need report by the Arkansas Health Services Permit Agency (2016), the agency responsible for determining the appropriate number of beds throughout the state, indicates there is an expected surplus of more than 5,379 nursing home beds statewide in 2021, which is exclusive of the existing veterans' homes. In addition to low average occupancy rates,

Gov. Hutchinson announced in May 2016 that his administration would not contribute to an oversupply of nursing home beds in the state through the permitting of more beds (Associated Press, 2016). These combined practical and political realities suggest that the ADVA, rather than building new homes or pursuing partnerships with health care facilities without state-approved licensed beds, should look to partner with community nursing homes to meet veterans' needs for long-term skilled nursing facility care.

While most veterans who enter nursing homes are eligible for Medicare and Medicaid benefits, veterans with at least a 70 percent service-connected disability, or who meet other eligibility requirements, can receive federal CNHP benefits. These CNHP benefits reimburse nursing homes certified by the VA at a higher daily rate than Medicaid. Placing eligible veterans in VA-certified nursing homes also shifts payment responsibility from Medicaid to the VA, which represents cost savings to the state.

There are currently 21 VA-certified nursing homes in the state, and two nursing homes – one in White County and one in Forrest City – are currently completing the application process (V. Pighee, personal communication, Oct. 20, 2016). As of October 2016, 114 veterans are part of the CNHP in Arkansas. Veronica Pighee, CNHP coordinator for Arkansas, indicates that the only area in the state that does not currently have sufficient availability is Central Arkansas, which only has one VA-certified home each in North Little Rock, Benton, and Conway; this demand, however, may be mitigated somewhat when the North Little Rock home is fully operational (V. Pighee, personal communication, Oct. 20, 2016).

As a result, partnering with community nursing homes to receive VA certification, especially in areas with higher concentrations of older veterans, addresses the needs of veterans needing round-the-clock nursing care. There are, however, several challenges nursing homes face when seeking VA certification.

The VA certification process for long-term care is involved and lengthy. The certification process begins with the regional VA health care facility to determine whether there is a need for additional nursing home care unable to be met by the VA at the time. Once this need is confirmed, the nursing home ownership must seek approval from the VA (using a VA form that acts as a proposed contract between the nursing home and the VA); once this application is made, the nursing home is able to begin the certification process with the VA.

The steps in the certification process require the nursing home to provide proof of state licensure and medical liability insurance and proof of Medicare or Medicaid certification. Upon satisfying these requirements, the process moves to the VA, where the agency reviews the information and examines previous facility surveys and CMS reports.

Assuming the home is in compliance and any or all deficiencies are corrected, the facility is eligible for an on-site visit conducted by the VA. Upon meeting on-site visit standards, the nursing home is eligible for certification. The VA is quite strict with regard to tolerating deficiencies, as one deficiency during the certification process – during the initial review, or during the on-site visit – can jeopardize certification and a successful contract award. The process leaves no room for error; thus navigating the process without opportunity to address, correct, or remedy a deficiency imposes a tremendous challenge to nursing home ownership.

In addition to this stringent certification process and facility survey, VA-certified nursing homes are also subject to regulations of the OFCCP. When a nursing home or long-term care facility provides services for a veteran, the facility is presumed to have entered into a government contract; this contract triggers OFCCP regulatory oversight for the facility.

The OFCCP is charged with enforcement of various equal employment opportunity laws that require specific federal procedures to be observed and thus encompasses greater compliance obligations. Such compliance includes additional and more extensive equal employment reporting and other related com-

pliance reports (Lane Powell, 2010). Duplicative reporting and more extensive compliance requirements are reasons cited by LTC operators that preclude more facilities from pursuing certification and qualification to provide services to veterans. The state of North Dakota specifically cites this as the reason that only 15 of its 80 (19 percent) nursing homes contract with the VA (Hoeven, 2016). These enhanced reporting and personnel requirements, along with the attendant risk, make it challenging for Arkansas nursing homes to participate in the CNHP, especially if a facility has few or no veterans in residence eligible for the enhanced reimbursement rate (R. Davis, personal communication, Oct. 20, 2016).

To address these challenges facing nursing homes in participating in the CNHP, the Veterans Choice Improvement Act of 2016 (VCIA) was introduced in the U.S. Senate (Veterans Choice Improvement Act, S. 2646, 114th Cong., 2016). VCIA would codify the Veterans Choice Program of the VA, which gives veterans the choice of selecting among eligible providers (Veterans Choice Improvement Act, S. 2646, 114th Cong., 2016). The VCIA would also lead to the expansion of the list of providers by making it easier for the Secretary to enter into service agreements with non-VA facilities (Veterans Choice Improvement Act, S. 2646, 114th Cong., 2016).

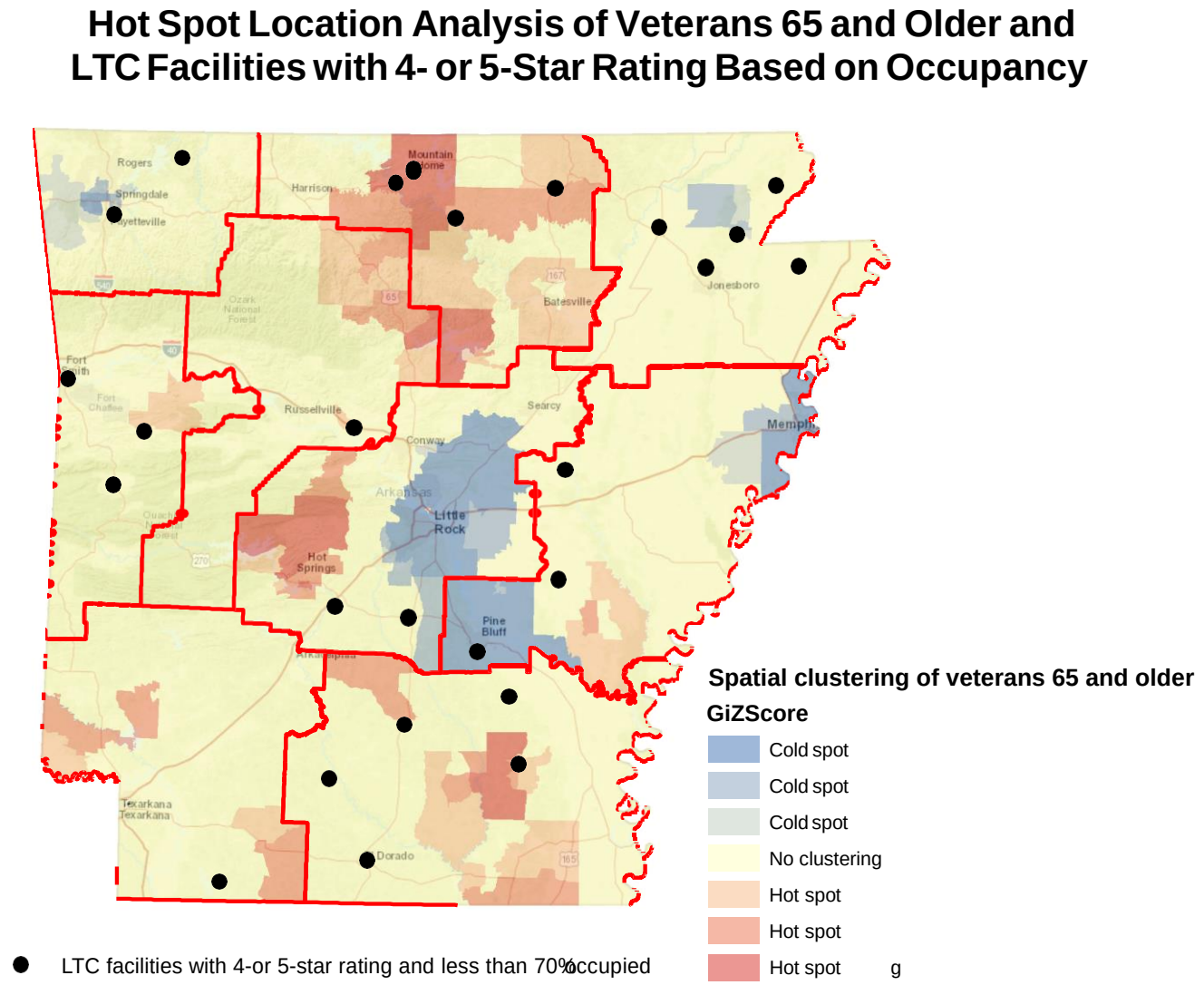
For purposes of this project, the key provision of the legislation would grant the VA legislative authority necessary to enter into provider agreements for extended care services when it is not feasible to provide those services through VA facilities. Presently, and without this proposed authority, private LTC providers must comply with reporting requirements and regulations deemed additional burdens. Yet, when these same providers contract with CMS, they are not subject to the OFCCP regulations (Porter, 2016). Thus, those items deemed burdensome by LTC providers often dissuade them from admitting VA patients (Porter, 2016).

The VCIA legislation would make these requirements similar to those of the CMS, thus making it less burdensome for providers to enter into provider agreements (Porter, 2016). With a less onerous process, the number of providers willing to accept veterans into their facilities will likely increase, making access to health care for them much easier (Porter, 2016).

To determine the location of LTC services for veterans relative to where there is a large concentration of veterans in the state, a cluster, or hot-spot, analysis is employed. The hot-spot analysis identifies under- or over-served LTC areas based on veteran population; this kind of analysis also identifies areas where veteran outreach can be used more efficiently.

In Figure 5, the areas in red identify high concentrations of veterans (hot spots) when accounting for the spatial distribution of veterans across the state. Similarly, the blue areas identify lower concentrations of veterans (cold spots); while these blue areas are indicative of a lower number of veterans, these areas are significant because there is spatial clustering of veterans. The dots (•) represent LTC facilities that are rated four- or five-star by CMS in terms of quality and have less than a 70 percent occupancy rate. The listing of facilities provides for their locations relative to high concentrations (in red), or lower concentrations (in blue) of veterans. There are 12 facilities located near concentrations of veterans that, all things equal, are likely to be certified by the VA based on rating and can accommodate new residents.

Figure 5. Hot Spot Location Analysis of Veterans 65 and Older and LTC Facilities with 4- or 5-Star Ratings with Less Than 70% Occupancy



Fac ility Name	Rating	Address	City	Beds	Occupancy
HIRAM SHADDOX GERIATRIC CENTER	4	620 HOSPITAL DRIVE	MOUNTAIN HOME	81	55.57
PINE LANE THERAPY AND LIVING CENTER, INC.	4	1100 PINE TREE LANE	MOUNTAIN HOME	105	58.6
GASSVILLE NURSING AND REHABILITATION CENTER	4	203 COTTER ROAD	GASSVILLE	105	66.78
BROOKRIDGE COVE REHABILITATION AND CARE CENTER	5	1000 BROOKRIDGE LANE	MORRILTON	118	66.45
ST. JOHNS PLACE OF ARKANSAS, LLC	4	1400 HWY 79/167 BYPASS	FORDYCE	126	54.75
THE WOODS OF MONTICELLO HEALTH AND REHABILITATION, LLC	4	1194 N. CHESTER ST.	MONTICELLO	122	65.45
EAGLECREST NURSING AND REHAB CENTER	5	916 HIGHWAY 62/412	ASH FLAT	90	67.7
BELLE MEADE, A REHABILITATION AND GUEST CARE FACILITY	5	1800 LINWOOD DRIVE	PARAGOULD	167	50.12
WHITE RIVER HEALTHCARE	5	601 CALICO STREET	CALICO ROCK	91	62.91
DAVIS EAST	4	6811 SOUTH HAZEL STREET	PINE BLUFF	126	55.35
OAK MANOR NURSING AND REHABILITATION CENTER, INC.	5	150 MORTON AVENUE	BOONEVILLE	120	65.83
BUTTERFIELD TRAIL VILLAGE	5	1923 EAST JOYCE BLVD.	FAYETTEVILLE	70	62

Source: Veteran data from ACS 5 yr Table S2101 at the census tract level. Facility data provided by AGIO and The Arkansas Health Service Permit Agency

Hospitals

Partner with hospitals to gain VA certification, especially hospitals in high-need areas with existing nursing home facilities.

Key Findings

While hospitals want to support the LTC needs of veterans, there are issues that must be considered in determining how these facilities can be utilized most effectively. A few of these obstacles include statewide caps on nursing home beds, issues with timely payments on VA claims, and reduced uncompensated care costs as a result of Medicaid expansion, which has worked to stabilize many hospitals that were once struggling financially.

There are opportunities to engage with rural hospitals to partner with ADVA in providing veterans care. These opportunities include six Arkansas Hospital Association (AHA) member hospitals that already operate nursing homes within their facilities. Additionally, ADVA could seek out partnerships with other community nursing facilities to relinquish bed permits and allow additional hospitals to establish long-term nursing units equipped for veterans.

However, the outcome of the recent presidential election is likely to have significant impacts on many key components of the Affordable Care Act (ACA). President-elect Donald Trump stated throughout his campaign that his administration will work with Congress to repeal and replace many provisions of the ACA, which could include Medicaid expansion. A dismantling of Medicaid expansion would be detrimental for hospitals, where dramatic drops in uncompensated care costs have been dependent upon this provision, which could open greater opportunities for partnership with ADVA.

Opportunities for Action

1. Using the veteran geographic distribution information in this study, identify potential hospitals with which to partner, especially those with existing long-term nursing facilities.

2. Work with the Governor's office and the state Congressional delegation to identify ways to support VCIA and help ensure the Act's passage.

3. Explore workforce or other incentives for nursing homes that pursue VA certification in target areas to help offset the cost of complying with OFCCP regulations until VCIA passes.

Justification

Although partnering with hospitals to develop long-term nursing care units in their facilities face as many, if not more, challenges as partnering with community nursing homes, ADVA may want to consider this recommendation in areas of the state where other methods prove insufficient to meet veterans' needs.

Annually, the AHA releases various statistics on the state's hospitals, including facility types, financial indicators, number of licensed beds, and additional information. According to the most recent AHA report (2016), there are a total of 104 licensed hospitals operating in Arkansas, 95 of which are members of the AHA.

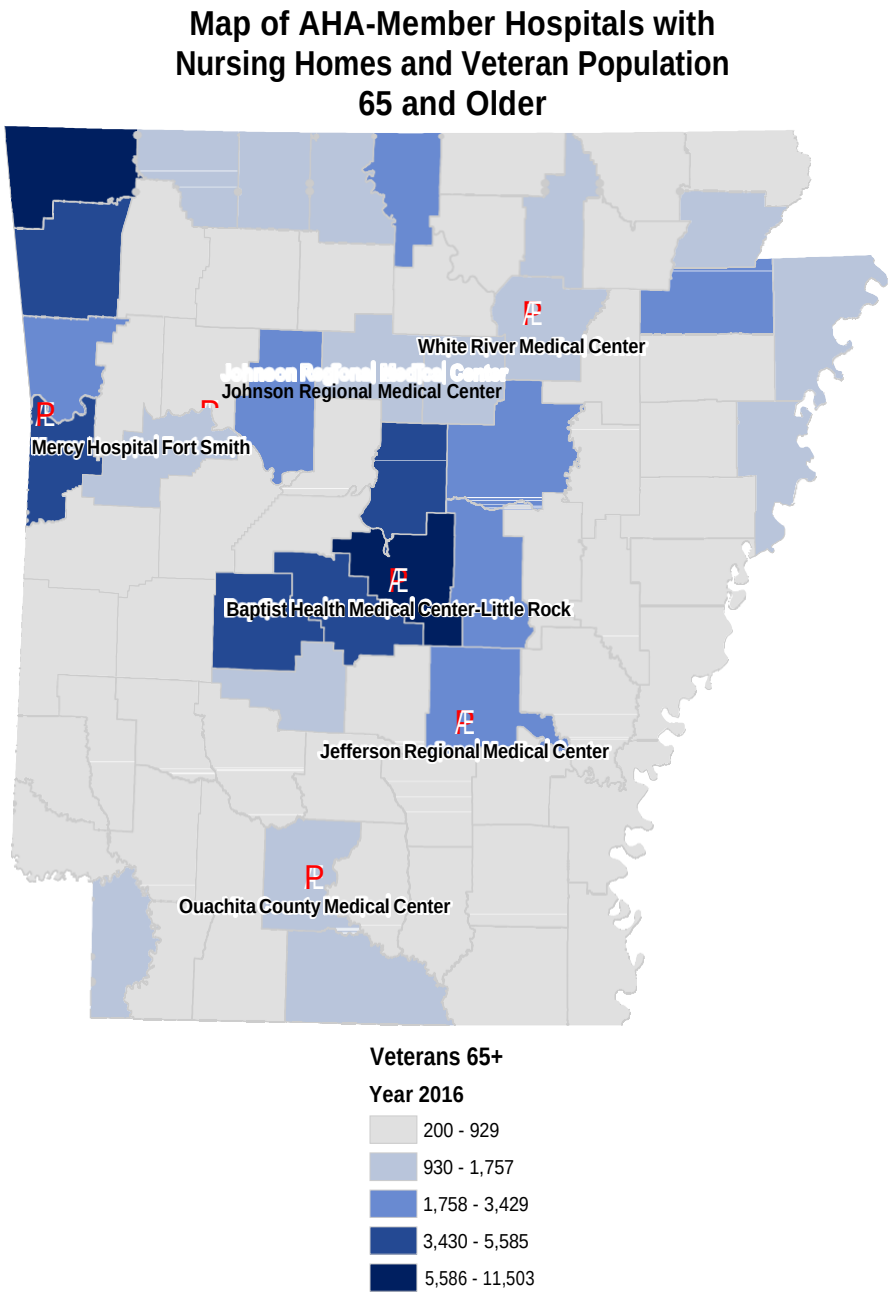
In the same report, the AHA defines categories of hospitals operating in Arkansas by type, size, and control. With respect to hospital type, these include general acute care community hospitals (totaling 72 facilities, including 29 critical access hospitals), 10 psychiatric hospitals, seven rehabilitation hospitals, three specialty hospitals, seven long-term acute care hospitals, and two VA hospitals (AHA, 2016). There are approximately six AHA-member hospitals that operate nursing homes (B. Ryall, personal communication, Oct. 4, 2016):

- White River Medical Center
- Ouachita County Medical Center
- Johnson Regional Medical Center
- Mercy Hospital Fort Smith
- Baptist Health Medical Center-Little Rock
- Jefferson Regional Medical Center

Figure 6 shows the location of each of the six hospitals along with county population information on veterans ages 65 and older. Darker colors on the map indicate a higher population of older veterans.

As discussed in the previous section on nursing homes, there is a finite number of nursing facility beds permitted in the state; currently, there is a low average state occupancy rate and a projected surplus of nursing home beds projected in 2021. With Gov. Hutchison's public opposition to creating new nursing home beds, ADVA either must partner with one or more of the six hospitals with existing nursing homes, or locate a community nursing home willing to surrender some of their bed permits for a hospital to create a new long-term nursing unit.

Figure 6. Map of AHA-Member Hospitals with Nursing Homes and Veteran Populations 65 and Older



Source: StateOfTheStatePop2014 Table 9L county-level veteran population by state, 2013-2043 and Arkansas Hospital Association

While a hospital in danger of closing may be interested in a partnership with ADVA, the financial situation for small, rural hospitals in the state is not as dire as it once believed. Since 2004, five community hospitals have closed (AHA, 2015). With the passage of Arkansas' Health Care Independence Act of 2013 (more commonly known as the "Private Option") however, there is a significant decrease in uncompensated care costs, thus fewer hospital closures. The Private Option is a form of Medicaid expansion that places newly eligible individuals up to 138 percent of the federal poverty line on commercially available qualified health plans.

In June 2014, the AHA worked with the Arkansas Chapter of the Healthcare Financial Management Association on a survey of hospitals to assess the financial effect of the Private Option within its first six months of implementation. The report finds that both the number of people hospitalized without insurance decreased by 46.5 percent and uncompensated care costs were reduced by approximately $69.2 million during that timeframe (Cunningham & Williams, 2014).

Although uncompensated care costs dramatically decreased with the implementation of the Private Option, hospitals still face financial issues resulting from uncompensated care. According to Bo Ryall, director of the AHA, it is estimated that 67,000 of 200,000 individuals between 138 to 400 percent of the federal poverty line are without coverage. The report also noted that, while critical access hospitals have benefitted from reduced uncompensated care costs via the Private Option, the private carrier payments rates are low for these facilities since they have no negotiating power with commercial carriers (B. Ryall, personal communication, Oct. 4, 2016).

Uncompensated care concerns still represent a key concern of smaller, rural health care facilities, but there are additional challenges in leveraging hospitals to help meet LTC needs for Arkansas veterans. For example, the time to receive payment on services for VA claims is often cited as problematic for hospitals; these facilities cannot afford to absorb these costs, even temporarily. Hospitals are also subject to the same OFCCP reporting and personnel regulations as private nursing homes, both of which prove to be tremendous disincentives for achieving certification.