Controlling the Supply of Long-Term Care Providers at the State Level

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs and their effects. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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Assessing the New Federalism

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Controlling the Supply of Long-Term Care Providers at the State Level

Introduction

Long-term care for the elderly and younger people with disabilities is an important component of state spending on health care, accounting for 36 percent of Medicaid service expenditures and 14 percent of state spending for health care in 1996.[1] Many states have responded to growing Medicaid long-term care expenditures by limiting the number of nursing home, home health, and nonmedical residential facilities through certificate-of-need (CON) programs and moratoria on new construction or certification for participation in the Medicaid program. CON programs require state regulatory approval for the establishment or expansion of health facilities or services.

The premise of supply constraints as a cost-control strategy is based on Roemer's Law, which holds that utilization increases when supply rises, independent of need.[2] For example, a new nursing home bed has a high probability of being occupied, most likely by a Medicaid beneficiary. The availability of open-ended, third-party reimbursement gives providers substantial control over demand, resulting in a high correlation between bed supply and occupancy. Moreover, given the high cost of long-term care and the low level of insurance coverage for these services, the majority of nursing home residents—nearly 70 percent—rely on Medicaid to help finance their care. As a result, expansion of the long-term care supply guarantees an increase in Medicaid expenditures. In addition, new nursing homes require millions of dollars in

capital financing, and a new facility could last 40 years or more. Large capital expenditures imply a long-term commitment to the provision of a service by a particular provider. Thus, it is especially important that new facilities meet a community need. Opponents of supply controls contend that they result in reduced access, higher prices, and perhaps worse quality of care, and serve primarily to protect existing providers.

This report focuses on the use of CON programs and moratoria as a long-term care cost-control strategy across the 13 states that are the focus of the *Assessing the New Federalism (ANF)* study: Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. The *ANF* project analyzes state health, income support, and social service programs for the low-income population, primarily in the 13 states mentioned above, which account for more than half of total Medicaid spending for long-term care for the elderly.[3] The information included in this paper is drawn largely from telephone interviews and documents collected in June and July of 1998. Qualitative data collected from representatives of state health planning agencies and nursing home associations provide the basis for the state-specific information. Additional information was obtained during site visits to the states in late 1996 and the first half of 1997.

In brief, most of the 13 focal states control the supply of nursing home beds either through CON programs or moratoria, but the use of supply controls is less prevalent for home health and residential care. States use various methodologies to determine nursing home bed need, most of which are based on the current bed-to-population ratio adjusted for population growth. These supply policies are primarily motivated by the hope of cost containment, although ensuring a balanced long-term care delivery system is also mentioned as a goal. Finally, as home and community-based services expand, states are struggling to adapt the role of supply policy—which has typically focused on nursing home beds—to the expansion of nursing home alternatives.

Background

States have used CON to shape the health care market (acute and long-term care) for almost 30 years. A handful of states had programs before 1970, and almost all states had enacted such programs by 1979.[4] The growth of these CON programs was spurred in part by the National Health Planning and Resources Development Act (PL 93-641) of 1974, which required that states operate CON programs to be eligible for some federal funds available through the U.S. Public Health Service. Guiding the development of such programs was the hope of ensuring rational allocation of health care resources and controlling total health care spending.

CON programs for acute care fell out of favor as anticompetitive and unduly regulatory in the 1980s. Following the lead of the Reagan administration, Con-

gress let PL 93-641 expire in 1986. At the same time, other cost-control mechanisms, such as prospective payment and especially managed care, seemingly lessened the need for supply controls.

Many states, however, have continued to use CON for long-term care services, focusing largely on nursing home beds. As of 1996, 39 states had a CON program for construction of new nursing home beds.[5] However, CON programs often do not have the technical rationale to find a lack of "need" for more nursing home beds, especially given a rapidly aging population and the lack of control over the funding for home and community-based services (arguably a substitute for nursing home care). Moreover, CON programs are usually required to judge only need and to ignore state budgetary concerns. A more blunt strategy used by many states is to inhibit construction of new nursing home beds by establishing a moratorium on certification of additional beds for participation in Medicaid. As of 1996, 20 states had moratoria on additional nursing home beds (14 of these states also maintained CON). These policies seemed to have an effect. A study of the change in the nursing home bed supply between 1981 and 1993 found that CON programs and moratoria on new construction significantly reduced the rate of increase in the number of nursing home beds.[6]

States also seek to control the supply of other long-term care providers. In addition to limiting freestanding nursing home beds, most states limit conversions of hospital beds to nursing facility beds. Nationally, 42 states control the conversion of hospital beds to skilled nursing beds through either a CON or a moratorium or both (25 with only a CON, five with only a moratorium, and 12 with a CON and a moratorium). In addition, some states have sought to control the supply of home and community-based services. Nationally, 16 states control home health supply through a CON only, two states use both a CON and a moratorium for home health providers, and one state has a moratorium only. Coverage by CON is almost always limited to more medicalized "home health" agencies; agencies providing only social home care (e.g., homemaker services and personal care) are usually excluded. Finally, 11 states regulate the supply of nonmedical residential long-term care facilities (such as assisted living facilities) with either a CON or moratorium or both (seven with only a CON, two with only a moratorium, and two with a CON and a moratorium).

Use of CONs and Moratoria Across the 13 Focal States

As table 1 summarizes, the supply of nursing home beds, home health agencies, and residential care beds varies greatly across the 13 states. Despite these differences in supply, almost all of the 13 states have policies that control the growth in the number of long-term care providers (table 2). Even some states that are otherwise resistant to government regulation of the market—for example, Colorado, Texas, Mississippi, and (until 1996) Alabama—exercise considerable state power to control the Medicaid budget through moratoria on new construction or certification for Medicaid. The principal focus of these programs and

Table 1 *Long-Term Care Bed Supply and Home Health Agencies in the Focal States, 1998*[a]

	Licensed Nursing Facilities		Licensed Residential Care		Licensed Home Health Care		
	Total Beds	Beds/ 1000 75+[b]	Total Beds	Beds/ 1000 75+[b]	Total Agencies	Agencies/ 1000 75+[b]	
Alabama[c]	24,532	101.9	4,000	16.6	281	1.17	240.77
California	119,577	80.9	222,453	150.5	793	0.54	1,478.13
Colorado[c]	20,386	154.7	9,671	73.4	206	1.56	131.76
Florida	82,881	72.8	67,434	59.3	1,382	1.21	1,138.10
Massachusetts	58,612	194.6	5,483[e]	18.2	217	0.72	301.22
Michigan	51,848	95.6	34,330	63.3	200	0.37	542.32
Minnesota	44,602	208.2	46,000	214.7	715	3.34	214.25
Mississippi[d]	17,208	168.5	2,856	28.0	81	0.79	102.14
New Jersey[c]	50,000	113.2	13,100	29.7	61	0.14	441.59
New York	116,660	116.1	35,000	34.8	184	0.18	1,004.50
Texas	126,899	190.1	27,321	40.9	4,159	6.23	667.56
Washington[c]	29,492	130.9	18,074	80.2	164	0.73	225.38
Wisconsin	48,184	174.9	20,820[d]	75.6	193[d]	0.70	275.57
United States[f]	**1,819,901**	**131.3**	**759,207**	**54.8**	**14,262**	**1.03**	**13,862.15**

Source: Focal state data collected from interviews conducted with state officials, June/July 1998.
a. All data is for 1998, except where noted.
b. Beds per 1,000 people ages 75 and over.
c. 1997 data.
d. 1996 data.
e. Rest-home beds only.
f. U.S. total data collected from C. Harrington, et al. *1996 State Data Book on Long-Term Care Program and Market Characteristics.* San Francisco: University of California, San Francisco, 1998.

policies is nursing home beds, especially because institutional expenditures historically have accounted for the vast majority of Medicaid long-term care spending, but many states also regulate the supply of home health agencies and nonmedical residential care facilities.

Nursing Homes

All but one of the 13 focal states control their nursing home bed supply through a CON program or a moratorium policy. Five states (Alabama, Florida, New Jersey, New York, and Washington) use a CON program; three (Colorado, Minnesota, and Texas) use a moratorium alone; four (Massachusetts, Michigan, Mississippi, and Wisconsin) have both a CON and a moratorium in place; and only one state (California) has neither CON nor moratorium (table 2). Although New Jersey and New York officially have only a CON program for nursing home beds, both states have a moratorium for all practical purposes. New Jersey has not issued a call for new nursing home beds in six years, and New York decided in mid-1997 not to consider the approval of any new beds until recommendations were received from a facility planning task force (expected in fall 1998). In addition, a moratorium on the construction of new beds in Wisconsin has been in place for so long—since 1981—that CON is not perceived to have any policy relevance. Moreover, the state is considering a redesign of its

Table 2 *Certificate of Need (CON) and Moratoria in the Focal States, by Provider Type, 1998*

	Nursing Facilities		Home Health		Residential Facilities		Hospital Bed Conversion	
State	CON	Moratorium	CON	Moratorium	CON	Moratorium	CON	Moratorium
Alabama	X		X				X	
California								
Colorado		X						X
Florida	X		X				X	
Massachusetts	X	X			X[a]		X	X
Michigan	X	X[b]					X	
Minnesota		X						X
Mississippi	X	X	X	X			X	X
New Jersey	X		X		X		X	
New York	X		X	X	X		X	
Texas		X						X
Washington	X		X				X	
Wisconsin	X	X					X	X
U.S. (total)[c]	**39**	**20**	**18**	**3**	**9**	**2**	**35**	**14**

Source: U.S. total data collected from C. Harrington, et al. *1996 State Data Book on Long-Term Care Program and Market Characteristics.* San Francisco: University of California, San Francisco, 1998. Focal state data collected from interviews conducted with state officials and nursing home representatives, June/July 1998.

a. Rest homes are subject to the state's CON process, but assisted living facilities are not included.

b. While Michigan does not have a moratorium on the construction of new nursing home beds, it does cap the number of Medicaid-certified beds.

c. Includes the District of Columbia.

long-term care system that could make supply controls largely unnecessary because payment to providers would be capitated.

Finally, CON for nursing homes was eliminated in California in 1987, and no moratorium is in place. While the number of nursing home beds increased from 115,803 in 1986 to 133,127 in 1996, the number of nursing home beds per 1,000 individuals ages 85 and older actually decreased faster than the national average, even as nursing home occupancy rates have declined.[7] Whatever the reason, nursing home bed supply has not exploded in California despite the lack of explicit supply controls.

The methodology for determining nursing home bed need under CON is typically based on a state's bed-to-population ratio at some point, often taking into account age-specific utilization rates, a desired occupancy rate, and future population growth. For example, Florida's CON program divides the state into 36 planning areas and establishes separate bed-to-population projections for people ages 65 to 74 and ages 75 and over. These ratios are then adjusted for a targeted occupancy rate of 91 percent and projected forward over a three-year planning horizon.

Although the majority of CON methodologies take the existing bed-population ratio as the appropriate level, a few programs look beyond nursing home use in assessing need for more beds. For example, Washington's CON methodology also includes utilization of home and community-based services

that might be alternatives to nursing homes. The state's three-step CON process begins with an evaluation of statewide and county-by-county need using the current statewide bed-to-population ratio of 45 beds per 1,000, ages 65 and over. The state then examines the use of alternatives such as home health, assisted living, hospice, and board and care facilities, which reduce the need for nursing home beds where the use of home and community-based services is high. Finally, the state examines the use of existing nursing homes in the area, as well as the needs of underserved populations. On the basis of these calculations, no new beds have been approved in Washington in recent years. Determining utilization for alternative providers, particularly for providers who do not receive Medicare and Medicaid funds, is particularly challenging because these data are not readily available.

Even in states with restrictive CON and moratorium policies, exceptions are routinely made, usually to the benefit of existing providers. For example, if a facility in Alabama has a 95 percent occupancy rate and the rate for the county is also 95 percent, the facility can add another 10 beds or 10 percent of its bed supply (whichever is greater). Mississippi, New Jersey, and Texas have similar rules.

Some of the 13 states have devised other strategies to limit and shift nursing home beds among facilities. In Texas, the state may decertify unused Medicaid beds—especially in facilities with poor quality records—and reallocate them to higher quality facilities. The exception is intended to create a pool of 2,000 to 3,000 beds that will be made available to facilities without any major deficiencies or any quality sanctions against them. And in Wisconsin—where nursing facilities are penalized with lower Medicaid reimbursement rates if they fall below the average state occupancy level (currently 91 percent)—a "bed banking" concept allows facilities to set aside or "bank" beds to reduce their total bed complement, so they are not hurt in the rate formulation. Facilities bank beds for a 10 percent depositor's fee (e.g., if a facility banks 10 beds, it loses one bed as payment), lose 10 percent of their banked beds per year to keep beds in the bank, and must keep beds in the bank for a minimum of 18 months. This policy has resulted in a statewide reduction of around 800 beds. Washington also maintains a program that allows facilities to bank beds through two mechanisms—one for facilities that are closing and would like to retain or sell the rights to those beds and one for facilities that would like to bank beds for an alternative use (e.g., to convert nursing home beds into assisted living beds). More than 2,100 nursing home beds (7 percent of the state's total bed complement) are banked in Washington's program, and these beds are counted as available beds in the state's calculation of need.

Conversion of Hospital Beds to Skilled Nursing Beds

Because of declining occupancy rates, many hospitals are seeking to convert empty beds to nursing home units. These conversions are covered in all of the 13 states except California, either as part of the CON program or moratorium. As

might be expected, conversions have become a particularly contentious issue between hospitals and nursing homes. Freestanding nursing facilities in several focal states are concerned that an increase in hospital-based facilities will threaten their market share and divert more profitable Medicare and private-pay residents away from nursing homes. New York has convened a health facility planning task force (mentioned above), partly in response to these conversions. To limit such expansions in New Jersey, the state legislature passed restrictive legislation requiring hospitals to meet long-term care licensure and certification requirements and prohibiting them from serving sub-acute patients for more than eight days (on an aggregate level). In California, which has neither a CON nor a moratorium for nursing home beds, the state is looking at ways to control the proliferation of skilled nursing units within hospitals.

Even though 12 of the 13 focal states place restrictions on the conversion of hospital beds to skilled nursing beds, hospitals often are able to circumvent these regulations by obtaining Medicare certification. For instance, Mississippi limits these conversions on the Medicaid side through a moratorium, but hospitals may still certify skilled beds under Medicare. Financing of post-acute care through Medicare does not affect the state fiscally, but nursing homes are affected by the loss of Medicare revenue, potentially making them more dependent on Medicaid financing. Indeed, Medicare has played a larger role in post-acute care in recent years. Nationwide, the number of hospital-based, Medicare-certified skilled nursing facilities grew substantially between 1990 and 1996—from 1,145 to 2,084, an increase of 82 percent.[8]

It is unclear what impact the passage of post-acute care payment reforms (which were part of the Balanced Budget Act [BBA] of 1997) will have on the expansion of hospitals into post-acute care and on the provision of Medicare home health. The BBA contained provisions that reduced hospital payments for certain individuals who were transferred to skilled nursing facilities and home health agencies. These provisions were intended to address the explosion of Medicare post-acute care expenditures that has occurred in the wake of Medicare coverage changes and Medicare hospital prospective payment reforms in the 1980s.

Reaction of Interest

Nursing home associations in the 13 states generally believe that certificates of need and moratoria are a valid and necessary means to control Medicaid costs. CON programs allow existing nursing homes to maintain their market share and, at the same time, can help them obtain higher occupancy rates, which lowers their per resident costs. On the other hand, resident advocates generally seem more concerned with the potential impact of limiting supply on access to nursing home care.

While the for-profit nursing home associations have been mainly supportive of supply constraints, not all facilities in each state agree with the state's CON or moratorium policy. For example, nursing homes in Washington have

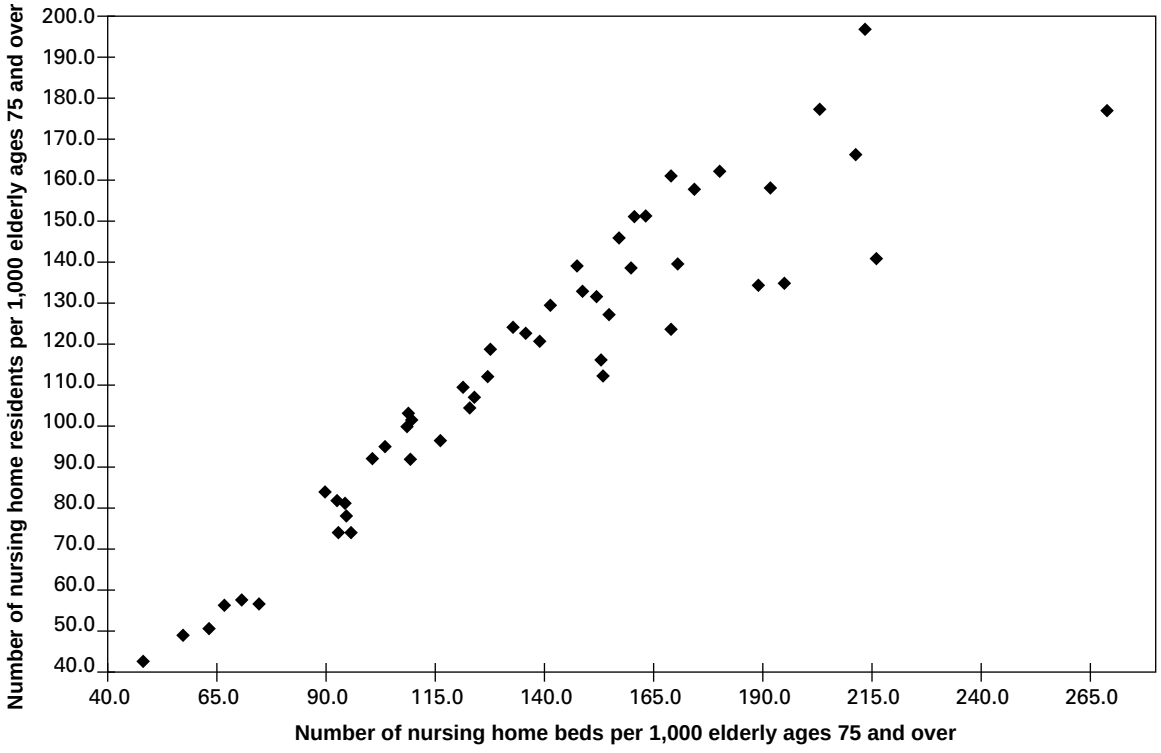
expressed mixed feelings about the CON program: Larger chains interested in expanding in the state find CON too restrictive, while single facility providers value the market protection and support its continued application.

Effect on Expenditures

The primary reason given by states for enacting a CON or moratorium is an interest in controlling Medicaid costs. As mentioned above, the original premise of supply constraints as a cost-control strategy is based on Roemer's Law, which holds that the availability of open-ended, third-party reimbursement allows demand for health care services to expand to meet whatever supply is available.[9] Support for this position can be found nationally in the extraordinarily strong relationship between the number of nursing home beds per 1,000 elderly ages 75 and over in each state and the number of nursing home residents per 1,000 elderly ages 75 and over in each state (figure 1). This strong relationship holds for the 13 focal states as well (figure 2).

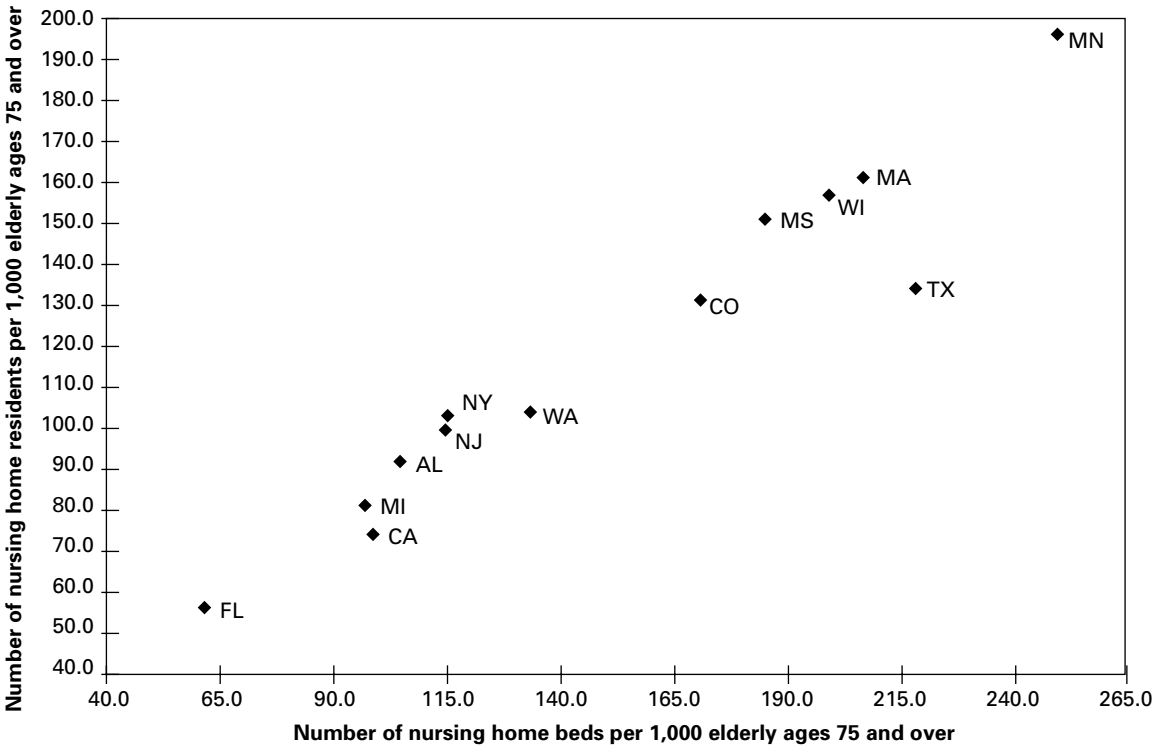
An alternative view, which has the same cost implications but shifts the reason for increased utilization away from providers, is that the nursing home market is characterized by "excess demand." Excess demand essentially exists when too few beds are available for patients demanding care at a given market

Figure 1 *Relationship between Nursing Home Beds and Residents in the U.S., 1997*



Source: HCFA-OSCAR Form 672: F78–F93, 1/31/97, and Form 1538: L13, L37–39, 1/31/97. Includes the District of Columbia.

Figure 2 *Relationship between Nursing Home Beds and Residents in the Focal States, 1997*



Source: HCFA-OSCAR Form 672: F78–F93, 1/31/97, and Form 1538: L13, L37–39, 1/31/97.

price. Scanlon was the first to demonstrate the existence of "excess demand" in the nursing home market and to postulate that this could be a position of economic equilibrium that is optimal for both states and nursing homes (although not necessarily for people seeking admission to nursing homes).[10] Such a market state is optimal for nursing homes because it allows them to maintain full occupancy and to pick and choose whom they admit (e.g., nursing homes prefer more profitable, private-pay individuals). If excess demand exists, profit-maximizing nursing homes would admit private-pay patients first, filling whatever beds remained with Medicaid-paying patients. Consequently, if excess demand exists for nursing home beds, it is excess Medicaid demand; and if more nursing home beds were built to alleviate excess demand, Medicaid beneficiaries would likely fill these newly built beds. Thus, excess demand is financially advantageous for the state because it limits access to nursing home care for the Medicaid-reliant population and thus minimizes Medicaid expenditures.

Excess demand for nursing home care, however, seems to have diminished in recent years, at least somewhat. Even though nursing home bed/elderly population ratios have fallen substantially in many states—the number of nursing home beds per 1,000 elderly ages 85 and over in the United States fell by 18 percent between 1978 and 1994[11]—few states believe that a shortage of nursing home beds exists. Instead, most state and nursing home officials point to falling nursing home occupancy rates as they make the case for continued limitation of

the nursing home bed supply. Nationally, nursing home occupancy rates have fallen from an average of 92 percent in 1985 to 87 percent in 1995.[12] This decline has taken place in all regions of the country.[13] Several factors have contributed to this relative drop in demand, including declining disability rates, increased use of home and community-based services (including Medicare home health), the greater use of short-term post-hospital nursing home care under the Medicare program, and the growing number of married elderly couples (which increases the availability of informal care).[14]

With the recent decline in nursing home occupancy rates, a different rationale has been put forward for continued use of supply controls in long-term care. Some state observers argue that more nursing home beds will result in lower occupancy rates, a situation that is inefficient and may result in unnecessarily high Medicaid reimbursement rates because fixed costs must be spread over fewer resident days. Of course, there is no legal requirement that states increase payment rates, especially since the repeal of federal standards on Medicaid nursing home reimbursement as part of the BBA of 1997. In fact, some argue that states could control nursing home supply simply by reducing Medicaid reimbursement rates, thereby making it less financially attractive to operate facilities. Downward pressure on Medicaid rates, however, could negatively affect quality of care and would be strongly resisted by the industry.

Regardless, most states feel that supply controls have contributed to cost containment, although none could quantify the effect. The prevailing justification for this belief was that expenditures were reduced because supply controls resulted in fewer nursing home beds being built. However, in some cases, such as Massachusetts, the moratorium is perceived to have had little effect on state Medicaid expenditures, in part because of the large number of beds that were approved but not yet built in the state before the moratorium.

Effect on Access

Although the main effect of CON programs and moratoria is to limit the number of nursing home beds, state observers contend that the programs have not had an adverse effect on access to nursing home care. State and nursing home officials typically cite falling nursing home occupancy rates as evidence of adequate access. Although state and nursing home officials admit that people might not get into the specific nursing homes they choose, access to nursing home care overall is considered good in most of the 13 states. However, nursing home and state officials in several states indicate that access varies somewhat across geographic regions. In the majority of cases, urban areas are described as relatively overbedded, while access is more problematic in rural areas (e.g., in Alabama, Florida, Michigan, and Mississippi).[15]

In Mississippi, state officials have received numerous complaints about access to nursing home care, especially in rural areas. Average occupancy rates exceed 97 percent, and many nursing homes have long waiting lists. The nursing home industry supports the construction of additional beds, provided it is

done in accordance with the state health planning methodology. However, the state's Medicaid director and governor do not agree with this assessment, and the governor recently vetoed legislation revising the state's CON methodology that would have added almost 1,900 beds (about 10 percent of the total nursing home bed supply) over the next five years. It remains to be seen if the state legislature will attempt to override this veto in January 1999.

Effect on Quality of Care

Although none of the individuals interviewed saw any direct link between quality and supply policy, some researchers have contended that restricting the supply of nursing home beds can exacerbate excess demand and adversely affect quality of care by restricting competition for patients on the basis of quality. The theory is that, under excess demand, an increase in quality of care is necessary only to attract more private-pay patients (i.e., nursing homes can attract as many Medicaid patients as they want, regardless of quality).[16] In a market with a surplus of nursing home beds, however, residents can exercise their preferences in choosing a nursing home, and nursing homes must increase quality in an attempt to attract patients. Some research, in fact, has shown that diminished competition as a result of excess demand has a negative impact on quality of care.[17] Moreover, in a nursing home market with a very tight bed supply, elimination of poor-quality beds could compromise access to nursing home care. In some states, quality regulators have historically pushed for more nursing home beds so there would be empty beds to receive patients when poor facilities were closed.[18] However, the extent to which excess demand still exists in the long-term care market is unclear.

Because some supply policies restrict facility renovation and remodeling, controls also can create a barrier for existing facilities' quality improvement efforts. By not allowing extensive new capital investment, the controls lock facilities into existing physical plants. For example, according to Minnesota's for-profit nursing home association, the average facility in Minnesota is more than 30 years old and is unable to modernize. Existing facilities have a limited supply of single rooms, levels of care (e.g., no assisted living beds), and space for rehabilitation therapy.

But supply controls can also be used as a tool to ensure quality of care. Some states, such as Florida, have used quality of care records to deny facilities CON approval, preventing providers with a poor history from being granted a CON.

Effect on Balance of Long-Term Care Delivery System

Although controlling rising state Medicaid spending was the foremost rationale for implementing CON and moratoria, other factors motivated state supply policies as well, including an interest in encouraging the expansion of alternatives to nursing home care. For example, Minnesota felt that restrictions on institutional care would provide counties with an incentive to promote alternative settings. Massachusetts imposed a moratorium not only to control

its surplus of beds but also to adjust its long-term care planning efforts to current changes in the long-term care system, including the increase in assisted living and proposals to tighten Medicaid eligibility criteria.

By definition, CON programs do not fund or create home and community-based services; they are almost entirely reactive to applications that they receive. In some focal states (e.g., Massachusetts, Minnesota, New Jersey, New York, Washington, and Wisconsin), though, constraints on the nursing home supply are linked, at least at the rhetorical policy level, to diverting resources to home and community-based services. Washington is the only focal state with a direct and explicit trade-off between the expansion of nursing home beds and home and community-based services under CON. And in Wisconsin—where the expansion of home and community-based services was a major reason behind the development of the moratorium—the growth of these services has been linked in part to nursing home bed closings. When nursing home beds in Wisconsin are eliminated or delicensed (as opposed to being put in the bed bank), a small portion of these beds are held in a nursing home bed pool, but a larger percentage are turned into community placement slots as part of the state's Medicaid home and community-based services (HCBS) waiver program. In lieu of adding new nursing home beds, New Jersey has made a concerted effort to increase assisted living options by allowing these facilities to participate in an expedited CON review process. Although nursing homes have raised some concerns about this expansion, many nursing homes have adapted to these market changes by developing their own assisted living facilities.

Home and Community-Based Services

When CON policies were first used by states to control long-term care expenditures, the health care market was far different than it is today. Changes in both the acute and long-term care sectors over the past 25 years have altered the role that supply controls can play in shaping the health care market and controlling expenditures. One substantial change is the increased availability of home and community-based services. Although home and community-based care spending accounted for only three percent of Medicaid long-term care expenditures in 1984, these expenditures increased to 21 percent of Medicaid long-term care in 1996, mostly for younger people with disabilities.[19] In addition, Medicare home health expenditures increased an average of 29 percent annually between 1990 and 1996.[20] Finally, many states are exploring the option of expanding financial support of residential alternatives to nursing home care.

Although the overwhelming majority of Medicaid expenditures for long-term care for the elderly are for institutional care, the expansion of these home and community-based options (including Medicare home health) has decreased the absolute reliance of some states on nursing home care.[21] In the past, CON policy could focus only on nursing home beds, which covered virtually all long-term care spending. With the growth of nursing home alternatives, how-

ever, this is no longer the case. Still, only about half of the 13 states regulate the supply of home health agencies and even fewer restrict the supply of nonmedical residential facilities.

Given that a secondary objective of CON and moratorium policy for states (in addition to cost control) is to shift the balance of the long-term care delivery system from institutional care to home and community-based care, it is unclear what the goal of supply policy should be for home and community-based services. Indeed, policymakers in every focal state endorse creating a more balanced delivery system through the expansion of home and community-based services (although the extent to which the states have accomplished this varies considerably).[22]

Home Health

Six focal states control the supply of home health agencies, and two of these states (Mississippi and New York) do so with both a CON and a moratorium (table 2). Although these supply controls regulate the number of agencies, they do not regulate the amount of home health services provided by any agency. Thus, as a practical matter, any agency that wishes to greatly expand services may do so. Existing agencies may or may not maintain their existing service levels, but nothing in the CON requirements prohibits them from expanding. Also, by definition, home health care does not require substantial capital expenditures (i.e., there are no "bricks and mortar" or mortgages that must be maintained). Thus, there is no implicit commitment to maintain services over a very long period. In principle, home health agencies can expand and contract (and go out of business) very quickly. Thus, CON in these instances protects existing providers but is a particularly weak expenditure control.

Residential Facilities

The least regulated but most rapidly developing area in long-term care is the supply of nonmedical residential facilities. Known by various names—including personal care homes, residential care facilities, assisted living homes, and community-based residential facilities—these facilities house nearly a million people nationwide.[23] By definition, individuals who receive care in these facilities require some supervision but are not as disabled as the nursing home population. Many states have a substantial number of residential facilities, and the supply of these facilities reportedly is growing rapidly in all of the 13 states—fueled in part by national companies such as Marriott and Hyatt. Although these residential facilities currently are targeting the private market and are not financially important to the Medicaid program (and vice versa), this situation could change in the future as Medicaid expands financing of residential care and as the private market becomes more saturated.

The tremendous growth of nonmedical residential facilities has many of the 13 states concerned, but only Massachusetts, New Jersey, and New York regu-

late the supply of these beds in any way. For the most part, these facilities are simply required to register or apply for licensure to operate in a state. Even in the few states that have supply restrictions for residential facilities, entry into the market is relatively easy. In New Jersey, for example, assisted living facilities are currently under an "expedited" CON review, which is reported to be relatively easy. In New York—where adult homes and assisted living facilities receiving Medicaid funds are regulated by CON and are currently under the temporary moratorium—private-pay assisted living facilities are subject only to local health and business codes and are not subject to state regulations governing entry into the market. Finally, while "rest homes" are subject to CON in Massachusetts, assisted living residences are not.

New Jersey has made a concerted effort to increase assisted living options by allowing these facilities to participate in an expedited CON review process. The state currently has about 50,000 nursing home beds, 9,100 nonmedical residential health care beds, and 4,000 assisted living beds. New Jersey has approved more than 300 certificates of need for almost 30,000 new assisted living beds. About 15,000 of these beds are already either under construction or have completed architectural plans, with another 15,000 soon to come. Obviously, these new beds will dramatically alter the long-term care market in a very short time. The nursing home association in New Jersey—which also represents assisted living facilities and nursing homes that are expanding into assisted living facilities—is not opposed to the expansion of assisted living. However, the association does support a comprehensive approach to health planning (i.e., one that includes nursing home beds and nursing home alternatives). When a law was recently introduced to end CON for these residential facilities and for many other acute and long-term care services, the nursing home association successfully maintained the CON process for these facilities at least until a 15-member commission completes its review of the entire CON process in the state.

One question that arises with this dramatic growth of residential facilities relates to financing. Especially within the context of Medicaid home and community-based services waivers, all of the 13 states are considering an expanded role of residential alternatives to nursing homes in the Medicaid program. Most individuals who reside in these facilities rely on private funds or Supplemental Security Income and state supplements to pay for their care. Although some persons in residential facilities rely on Medicaid financing (typically through HCBS waivers) to pay for the "care" part of residential care (room and board usually must be paid out-of-pocket or with SSI and state subsidies), most of the residential care industry is built on private-pay individuals. For instance, in New Jersey (where 30,000 assisted living beds are soon to be built), the state Medicaid program currently funds residential care only through 1,500 "slots" in its HCBS waiver program.

Even for nursing homes that are not expanding into residential care, the fact that Medicaid currently funds little residential care makes this expansion less threatening. If Medicaid were to expand funding for these residential facili-

ties—possibly at the expense of financing nursing home care—nursing homes might move into more of an opposition role. In fact, such a sequence of events happened in Mississippi when the state recently proposed a Medicaid pilot program that would have included personal care facilities.

Conclusion

Certificate-of-need and moratorium policy for long-term care has typically focused on nursing home beds. Currently, all but one of the 13 states regulate the supply of nursing home beds with either a CON or moratorium. Both nursing home representatives and state officials generally support these measures. For nursing homes, the supply controls help to reduce competition for residents in an era of falling occupancy rates. For states, the supply controls are perceived to help control long-term care spending in an era of cost consciousness.

Although controlling the supply of long-term care providers might serve both states and nursing homes well over the short-to-medium term, it is unclear how well this strategy will work over the long run. The expansion of alternatives to nursing home care—especially the expansion of residential facilities—necessitates that states look beyond nursing homes in their effort to regulate long-term care supply. This need will become especially germane as an increasing portion of Medicaid long-term care spending goes to these nursing home alternatives. In the case of residential facilities, at least, states are struggling with how to regulate an industry that has flourished—in part—because of minimal government regulation.

Finally, long-term care supply controls must consider the needs of an aging population. The care needs of the elderly do not disappear just because no nursing home beds or home health agencies are available. Nursing home alternatives have taken pressure off nursing homes and helped contribute to the drop in nursing home occupancy rates in recent years, even as the supply of nursing home beds has fallen. However, it is unclear how long this trend will continue. Ultimately, long-term care supply policy needs to keep pace with the changing long-term care provider market and the changing demographics of the consumer market if it hopes to ensure access to long-term care and to control Medicaid long-term care expenditures.

Notes

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2. M. Roemer. 1961. "Bed Supply and Hospital Utilization: A Natural Experiment." *Hospitals, The Journal of the American Hospital Association* 35: 36–42.

3. For a more detailed description of the overall project, see A. Kondratas, A.R. Weil, and N. Goldstein. 1998. "Assessing the New Federalism: An Introduction." *Health Affairs* 17(3): 17–24.

4. J. Feder and W.J. Scanlon. 1980. "Regulating the Bed Supply in Nursing Homes." *Milbank Memorial Fund Quarterly* 58(1): 54–87.

5. C.A. Harrington, J.H. Swan, C. Giffin, W. Clemena, B. Bedney, H.M. Carrillo, and S. Shostak. 1998. *1996 State Data Book on Long-Term Care Program and Market Characteristics*. San Francisco: University of California, San Francisco.

6. C.A. Harrington, J.H. Swan, J.A. Nyman, and H.M. Carrillo. 1997. "The Effect of Certificate of Need and Moratoria Policy on Change in Nursing Home Beds in the United States." *Medical Care* 35(6): 574–587.

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8. Prospective Payment Assessment Commission. June 1997. *Medicare and the American Health Care System: Report to Congress*. Washington, DC: ProPAC.

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14. C. Bishop. 1998. *Where Are the Missing Elders? The Decline in Nursing Home Utilization, 1985–1995*. Waltham, MA: Brandeis University; and T. Philipson. 1998. *The Rise in Old-Age Longevity and the Market for Long-Term Care.* NBER Working Paper #6547. Cambridge, MA: National Bureau for Economic Research, May 1, 1998.

15. J.M. Wiener and D.G. Stevenson. 1998. "State Policy on Long-Term Care for the Elderly." *Health Affairs* 17(3): 81–100.

16. J.A. Nyman. 1985. "Prospective and 'Cost-Plus' Medicaid Reimbursement, Excess Medicaid Demand, and the Quality of Nursing Home Care." *Journal of Health Economics* 4: 237–259.

17. J.A. Nyman. 1985. "Prospective and 'Cost-Plus' Medicaid Reimbursement, Excess Medicaid Demand, and the Quality of Nursing Home Care." *Journal of Health Economics* 4: 237–259; J.A. Nyman. 1988. "The Effect of Competition on Nursing Home Expenditures under Prospective Reimbursement." *Health Services Research* 23(4): 555–574; J.A. Nyman. 1988. "Excess Demand, the Percentage of Medicaid Patients, and the Quality of Nursing Home Care." *The Journal of Human Resources* 23(1): 76–92; and J.S. Zinn. 1994. "Market Competition and the Quality of Nursing Home Care." *Journal of Health Politics, Policy, and Law* 19(3): 555–582.

18. J.M. Wiener. 1981. *A Sociological Analysis of Government Regulation: The Case of Nursing Homes*. Unpublished doctoral dissertation. Cambridge, MA: Harvard University.

19. Urban Institute estimates based on data from HCFA-64 reports.

20. Prospective Payment Assessment Commission. June 1997. *Medicare and the American Health Care System: Report to Congress*. Washington, DC: ProPAC.

21. It should be pointed out that a substantial bias toward nursing home care still exists for elderly Medicaid beneficiaries. Almost 90 percent of long-term care expenditures for the elderly are for nursing home care.

22. J.M. Wiener and D.G. Stevenson. 1998. "State Policy on Long-Term Care for the Elderly." *Health Affairs* 17(3): 81–100.

23. The Bottom Line on Assisted Living. 1998. *Hospitals and Health Networks*, July 20, 1998. (http://www.hhnmag.com).

APPENDIX

List of People Interviewed

Alabama
Jim Sanders
Alabama State Health Planning and Development Agency

California
Betty Keller and Kondor Chung
California Office of Statewide Planning and Development

Daryl Nixon
California Association of Health Facilities

Colorado
Mary Cole
Colorado Health Care Policy and Financing

Arlene Miles
Colorado Health Care Association

Florida
Elfie Stamm
Florida Agency for Health Care

Gary Crayton
Florida Health Care Association

Massachusetts
Joyce James
Massachusetts Determination of Need Program

Gary Abrahams
Massachusetts Extended Care Federation

Michigan
Aubrey Marron, Jane Reagan, and Robert Alexander
Michigan Department of Community Health

Reginald Carter
Health Care Association of Michigan

Minnesota
Maggie Friend
Minnesota Department of Health

Patti Cullen
Care Providers of Minnesota

Mississippi
Harold Armstrong
Mississippi Division of Health Planning

Martha Carole White
Mississippi Health Care Association

New Jersey

John Calabria
New Jersey Department of Health and Senior Services

William Abrams
New Jersey Association for Health Care

New York

Christopher Delker
New York Division of Health Facility Planning

Scott Sandford
New York State Health Facilities

Texas

Lenny Long
Texas Department of Human Services

Dorothy Crawford and Tom Plowman
Texas Health Care Association

Washington

Janis Sigman
Washington Department of Health

Gerald Reilly
Washington Health Care Association

Wisconsin

Robert Kramer
Wisconsin Department of Health

Thomas Moore
Wisconsin Health Care Association

About the Authors

Joshua M. Wiener is a principal research associate at the Urban Institute's Health Policy Center, where he specializes in research on Medicaid, long-term care, and health policy for the elderly. Before coming to the Urban Institute, he did research and policy analysis for the Brookings Institution, the Health Care Financing Administration, the Commonwealth of Massachusetts, the state of New York, and the city of New York.

David G. Stevenson is a research associate at the Urban Institute's Health Policy Center. His research has centered on aging, disability, and long-term care. Mr. Stevenson's previous research focused on access to health care for people with disabilities, the cost-effectiveness of clinical preventive services, and Medicaid managed care for people with disabilities.

Susan M. Goldenson is a research associate at the Urban Institute's Health Policy Center. Her current research focuses on evaluating managed care in Medicaid and studying access to health care in rural areas. Previously, she served as a policy analyst at the Alzheimer's Association.

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