

# Regulating the Bed Supply in Nursing Homes

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**W**HEN CONGRESS ENACTED MEDICARE AND MEDICAID legislation in 1965, nursing home coverage was perceived as a minor adjunct to government insurance for medical care in acute illness. Today, nursing homes have become perhaps the major issue in public financing of health care for the elderly. In 1975, expenditures on such nursing home care were five times their 1966 level, an increase exceeding that for any other medical service in that period. As a result, nursing homes have come to absorb more than 25 percent of total health expenditures on the elderly, as compared with roughly 15 percent in 1966. Except for a brief period at its beginning, the Medicare program has contributed very little to nursing home financing. By default, as much as design, the federal-state Medicaid program has assumed responsibility for nursing home coverage (Chulis, 1977), and today pays for about half of all nursing home care; most of the other half is paid directly by the elderly themselves.

Expenditures for nursing home care loom large in the Medicaid budget—39 percent in 1977. Faced with fiscal pressures in the 1970s, many states have found themselves unwilling or unable to support these obligations and have taken measures to limit their liabilities. This paper analyzes the states' use of one such measure: restriction of the bed supply in nursing homes through "certificate-of-need" regula-

tion. From an analysis of several states' experience, we will argue that direct regulation of this bed supply exacerbates rather than eliminates inefficiencies in the market for long-term care. We conclude that, if expenditure control is to be compatible with efficient and equitable allocation of resources, the states must use their payment policies to ensure that care is available to the persons who need it most.

## Certificate-of-Need Laws and Nursing Homes

Before 1970, several states had enacted certificate-of-need (CON) laws, laws requiring state approval of the establishment or expansion of health facilities. By 1979, almost all the states had enacted such laws, which typically covered nursing homes (see Table 1). State

TABLE 1  
States with CON Legislation

| Year Enacted    | States  |
|-----------------|---|
| Never           | Idaho, Indiana, Louisiana   |
| 1970 and before | California, Connecticut, Maryland, New York, Rhode Island   |
| 1971            | Arizona, Massachusetts, Minnesota, Nevada, New Jersey, North Dakota, Oklahoma, Oregon, South Carolina, Washington |
| 1972            | Florida, Kansas, Kentucky, Michigan, South Dakota   |
| 1973            | Colorado, Tennessee, Virginia   |
| 1974            | Georgia, Hawaii, Illinois   |
| 1975            | Arkansas, Montana, Ohio, Texas  |
| 1976            | Alaska*   |
| 1977            | Alabama, District of Columbia, Iowa,* West Virginia, Wisconsin, Wyoming   |
| 1978            | Delaware,* Maine, New Mexico, North Carolina  |
| 1979            | Mississippi, Nebraska, New Hampshire, Pennsylvania, Utah, Vermont, Missouri                                       |

Source: DHEW, Health Resources Administration, Bureau of Health Planning, Division of Regulatory Activity, Certification Programs Branch, July 12, 1979.

\*CON legislation went into effect the year after enactment.

action was undoubtedly influenced by passage of the National Health Planning and Resources Development Act in 1974, by which grants from the Public Health Service are contingent upon a state's enactment of CON legislation. For nursing homes, as for other health facilities, the regulation of capital expenditures has been justified as a means both to ensure a rational allocation of health care resources and to control total expenditures on medical care. But assumptions that typically justify the use of CON legislation may not apply in the nursing home market. Control of capital expenditures is intended to compensate for perceived inadequacies in the health care market—notably, the providers' ability to influence and stimulate demand. Providers' influence stems from widespread third-party insurance, which reduces or eliminates the consumers' concern with the cost of the service, and from consumers' inability to evaluate their need for medical services and the kind of services they require. In these circumstances, providers, who benefit financially from delivering more services, can increase the quantity and sophistication of the services they offer. Even if providers deliver only the services they believe to be of positive value, this value is likely to be less than the costs entailed in delivering care. If suppliers determine the nature and quantity of services, and deliver services for which the costs exceed the benefits, regulation of the supply of services becomes an appropriate mechanism to limit expenditures for medical care.<sup>1</sup>

Recent evidence suggests that there are limits to the creation of demand.<sup>2</sup> Assumptions about the creation of demand are particularly inappropriate to the nursing home market, where demand appears to be largely independent of supply. Nursing homes provide a limited quantity of medically related services, along with a larger array of services to satisfy the residents' basic wants for housing, food, and recreational services. Potential residents or their families can evaluate

<sup>1</sup> This argument assumes that providers will allocate their services in accord with a societal view of need. Such behavior might be motivated by a sense of professionalism. An efficient allocation of the regulated supply might not occur if providers acted on other motives, such as profit maximization, and continued to create demand among potential recipients.

<sup>2</sup> On limits to physicians' ability to create demand, see Hadley, Holahan, and Scanlon (1979). Limits on the hospitals' ability to create demand are suggested by steadily declining occupancy rates.

nursing home care relative to alternative living arrangements, according to their own preferences. The need to defer to providers' judgments about what constitutes appropriate use is absent because of the largely nontechnical nature of the product.

Consumers must make real choices with respect to nursing home care because virtually all users face substantial out-of-pocket costs. Private patients must pay the full cost of their care, and Medicaid patients must sacrifice their entire income, less a small personal-needs allowance, in order to enter a nursing home. Even those with no private income must sacrifice resources on entering a nursing home. These people normally would be eligible for cash-assistance payments and could purchase whatever those payments allowed. Entering a nursing home reduces the payment level to the needs allowance.

Public subsidies, primarily from Medicaid, have drastically lowered the price of nursing home care for many elderly persons, while leaving the prices of alternative systems of care unaffected. Naturally this subsidy influences the choices that people make; many persons undoubtedly can obtain more desirable housing, food, and necessary care in a nursing home than their financial resources would allow outside. Under these circumstances, more people may be seeking nursing home care than objective standards of need would justify, or than the Medicaid program is willing to finance.

Research indicates that the number of persons who demand nursing home care is indeed larger than the number who receive it (Scanlon, 1980). This imbalance is the result of separate policies of state government, designed to achieve conflicting objectives. Eligibility policies, which determine demand, are established with objectives much broader than mere control of the number of persons demanding nursing home care, and may make many more persons eligible than the state is willing to support. The state reveals its financial preferences in other policies—notably reimbursement and CON regulation—that determine the supply of beds in nursing homes. If the objective behind these policies is to control costs, the resulting bed supply is likely to be insufficient to serve the demand encouraged by eligibility policies.

Regulation of the bed supply will not make demand disappear, as it might if suppliers simply created the demand. As long as the current

subsidy structure persists, limitations on supply will pose a rationing problem. Only some of the individuals who want nursing home care will receive it, and the decision as to who receives it will be left in the hands of those who operate the nursing homes. For several reasons, operators are likely to discriminate against the persons most in need of care. Unlike hospital care, nursing home care is not a last resort. Hospitals can and do treat patients unable to find nursing home beds. Nursing home operators can readily refuse to admit patients whom they prefer not to serve. To maximize their profits or net revenues, these operators would prefer patients who pay more (private patients) to those who pay less (Medicaid patients), and patients who require a little care to those who need considerable and costly attention. When nursing home beds are insufficient to satisfy demand, the people most in need of the service have the greatest difficulty finding it.

Concern about this problem led us to question the desirability of applying CON rules to nursing homes. To determine whether this assessment of the nursing home market was correct and, if so, how and why states used CON regulations, in the period August through October, 1978, we conducted interviews in eight states: California, Colorado, Georgia, Massachusetts, New Jersey, New York, Tennessee, and Washington.<sup>3</sup> The eight states studied accounted for about 40 percent of Medicaid expenditures on nursing homes in 1977, and were chosen because they represent various levels and rates of increase in nursing home use, and different levels of total Medicaid spending per capita. Table 2 compares nursing home use and expenditures in the eight states with those in the rest of the nation. New York and California enacted CON legislation in the 1960s; the other six states enacted it in the early 1970s. Georgia is the only state in the nation whose CON program applies only to nursing homes, not to hospitals.

Based on interviews with government officials and industry representatives, and on documentary materials from each of those eight states, this paper analyzes the methods and objectives of the states in applying CON policies to nursing homes, the problems faced in achieving the objectives, and the consequences of actions taken, both

<sup>3</sup> Case studies of four—California, Georgia, New York, and Washington—are available (Lennox, 1979).

TABLE 2  
Nursing Home Use and Expenditures in Eight States

| State           | Beds per 1000<br>Population Aged<br>65 and over*<br>1976 |                  | Average Annual<br>Growth Rate in<br>Beds per 1000<br>Population Aged<br>65 and over*<br>1969-1976 |                  | Average Nursing<br>Home Occu-<br>pancy Rate*<br>1976 |                  | Total Medicaid<br>Expenditures per<br>Capita†<br>1976 |                  | Medicaid Nurs-<br>ing Home Ex-<br>penditures per<br>Capita†<br>1976 |                  | Medicaid Nurs-<br>ing Home Ex-<br>penditures as a<br>Percent of Total<br>Expenditures§<br>1976 |                  |
|-----------------|--|------------------|---|------------------|--|------------------|---|------------------|---|------------------|--|------------------|
|                 | Number   | National<br>Rank | Percent   | National<br>Rank | Percent  | National<br>Rank | Percent   | National<br>Rank | Percent   | National<br>Rank | Percent  | National<br>Rank |
| California      | 65.2   | 24               | 3.94  | 40               | 90.04  | 41               | \$74.40   | 9                | \$16.64   | 35               | 22.37  | 48               |
| Colorado        | 104.3  | 2                | 8.87  | 12               | 83.90  | 50               | 41.43   | 30               | 19.97   | 28               | 48.20  | 17               |
| Georgia         | 66.5   | 23               | 10.66   | 5                | 95.61  | 3                | 51.31   | 21               | 22.17   | 18               | 43.21  | 24               |
| Massachusetts   | 74.7   | 16               | 3.57  | 42               | 94.44  | 13               | 90.53   | 4                | 41.79   | 4                | 46.16  | 19               |
| New Jersey      | 43.2   | 43               | 4.11  | 39               | 95.04  | 8                | 54.93   | 17               | 16.69   | 34               | 30.38  | 41               |
| New York        | 50.5   | 36               | 5.91  | 28               | 93.09  | 22               | 185.35  | 1                | 69.29   | 1                | 37.38  | 31               |
| Tennessee       | 44.4   | 40               | 8.83  | 13               | 96.02  | 1                | 41.53   | 29               | 18.68   | 31               | 44.97  | 22               |
| Washington      | 81.1   | 11               | 7.68  | 17               | 92.04  | 28               | 49.56   | 22               | 20.57   | 25               | 41.51  | 26               |
| National mean   | 64.0   |                  | 6.49  |                  | 92.06  |                  | 53.79   |                  | 21.64   |                  | 41.96  |                  |
| National median | 63.2   |                  | 6.28  |                  | 92.36  |                  | 43.71   |                  | 20.51   |                  | 41.54  |                  |
| National range  |  |                  |   |                  |  |                  |   |                  |   |                  |  |                  |
| Highest         | 119.1 (Nebr.)  |                  | 20.06 (Alaska)  |                  | 96.02 (Tenn.)  |                  | 185.35 (N. Y.)  |                  | 62.29 (N. Y.)   |                  | 68.06 (Wyo.)   |                  |
| Lowest          | 23.9 (Fla.)  |                  | 1.61 (Okla.)  |                  | 82.57 (Tex.)   |                  | 15.39 (Wyo.)  |                  | 5.39 (W. Va.)   |                  | 16.91 (W. Va.)   |                  |

\* National Center for Health Statistics, *Master Facilities Inventory*, selected years, unpublished data.† Data from DHEW, Health Care Financing Administration, Office of Policy, Planning, and Research, *Medicaid State Tables, Fiscal Year 1976*, Table 5. Population figures for all per capita calculations taken from U.S. Department of Commerce, Bureau of the Census, *1977 Statistical Abstract of the United States*, Table 29.‡ For services in skilled nursing homes and intermediate care facilities in institutions for all, including the mentally retarded. *Medicaid State Tables, Fiscal Year 1976*, Table 5.

§ Arizona is not included in the national ranking because it does not have a Medicaid program.

in certificate-of-need programs and in other nursing home policies (notably Medicaid reimbursement and utilization review), for the availability and use of nursing home beds. Because eight states cannot be considered representative of the nation, and because the depth of our investigation varied somewhat among the states, we will use the experience of individual states to illustrate the types of policy choices the states face, rather than to make conclusive judgments on nursing home policy as it operates in all states.

## CON Methods and Objectives

CON legislation provides a mechanism for review and approval of the growth and replacement of nursing homes. As such, it can be neutral, restrictive, or promotive with respect to a state's total bed stock. In addition, it can be used to influence the types of beds built, e.g., those for skilled nursing facilities (SNFs) or those for intermediate care facilities (ICFs), where in the state the beds are constructed, and which proprietors are allowed to build and own beds. The purpose a CON program actually serves varies with its legislative authorization and the objectives of its administrators.

CON statutes have varied with respect to the level of expenditures and types of actions covered. A law like New York's, which covers any capital expenditure and any change in the number of beds regardless of expenditure, allows greater state control over the nursing home industry than does a law like Washington's, which has limited its review to construction whose cost exceeds \$100,000. Exemptions and exceptions for special types of facilities or population groups can also reduce the probable impact of CON legislation, and have varied from state to state.

The importance of statutory variation, however, is declining. Statutes and regulations developed to comply with federal laws now reflect a uniform minimum approach to state regulation of capital expenditures, which allows administrators to influence nursing home growth. Federal influence began in 1972 under Section 1122 of the amendments to the Social Security Act. By this authority, over thirty states established agreements with the Department of Health, Educa-

tion, and Welfare (HEW) to review all capital expenditures that exceeded \$100,000, changed a facility's bed capacity, or involved a "substantial change" in the services provided by health facilities, including nursing homes (Table 3). Any facility acting in spite of a denial under Section 1122 would be refused capital reimbursement under Medicare, Medicaid, and the Maternal and Child Health Program for the expenditures deemed unnecessary. The effectiveness of this sanction has been questioned, because of the facilities' capacity to use private revenues to compensate for reductions in public reimbursement. This argument would seem more relevant to hospital than to nursing home regulation, however, because most nursing homes are more dependent on Medicaid funds. Experience in Georgia suggests

TABLE 3  
States with Section 1122 Agreements

| Year 1122 Enacted | States  |
|-------------------|---|
| Never             | Arizona, California, Connecticut, District of Columbia, Illinois, Kansas, Massachusetts, Rhode Island, South Dakota, Tennessee, Texas                           |
| 1970 and before   | None  |
| 1971              | None  |
| 1972              | None  |
| 1973              | Alabama, Arkansas, Delaware, Indiana, Iowa, Louisiana, Maine, Michigan, Mississippi, Nebraska, New Hampshire, North Carolina, Pennsylvania                      |
| 1974              | Alaska, Colorado, Georgia, Idaho, Kentucky, Minnesota, Montana, Nevada, New Jersey, New York, North Dakota, Oklahoma, South Carolina, Utah, Washington, Wyoming |
| 1975              | Vermont   |
| 1976              | None  |
| 1977              | West Virginia   |
| 1978              | None  |
| 1979              | None  |

Source: DHEW, Health Resources Administration, Bureau of Health Planning, Division of Regulatory Activity, Certification Programs Branch, July 12, 1979.

Note: Oregon terminated its 1122 programs in 1979; Florida, Maryland, Ohio, Virginia, and Wisconsin, in 1978; Hawaii, in 1977; and Missouri in 1976.



that Section 1122 may have allowed states with relatively narrow CON statutes to extend their influence over the nursing home industry. Georgia officials took advantage of a Section 1122 agreement to get around a CON process designed and influenced by the industry.

A more significant impetus for a consistent minimum standard of state regulation is the National Health Planning and Resources Development Act of 1974. That law requires all states to enact CON laws that meet specified conditions (similar to those required by Section 1122, but with broader sanctions), as a requirement for receipt of funds under Public Health Service programs. States did not rush to comply with the requirements of the Health Planning Act and there has been considerable uncertainty that all states would meet its 1980 deadline. As the deadline approaches, however, more states are seeking and acquiring HEW approval of their programs. As of November 1979, HEW had designated thirty-four states as in compliance with the act. The likelihood is that most states will soon share a common set of minimum standards for the regulation of capital expenditures.

Statutory authority, however, is only a precondition for regulation. Far more critical to a state's influence is the willingness of officials to use their authority, as demonstrated by the criteria they apply in ruling on proposed changes in the bed stock. CON statutes (and regulations implementing the Health Planning Act) typically specify the kinds of factors that regulation of the bed supply must "take into account"—variations on the themes of need, financial feasibility, and the quality or character of nursing home owners. In defining and using these criteria, CON administrators reveal their objectives for the size and composition of the nursing home bed supply. Some states have ignored their CON authority for nursing homes, leaving the determination of the bed supply either to local planning agencies or to the marketplace. In contrast, the states that use CON legislation to control costs tend to impose their review criteria even upon resistant local agencies. The states have employed various criteria to determine bed supply in nursing homes.

### *Determination of Need*

The "certificate-of-need" label implies that need is the primary determinant of decisions on the bed supply in nursing homes. Need,

however, is an imprecise term. Used to refer to individuals' need for services, a state's "need" for beds could be interpreted as the number of beds required to accommodate persons in the state who have conditions that experts believe require institutional care. For nursing homes, as with many other health services, there is no consensus on the health status or functional levels that require institutional care. Even if there were consensus, another problem would remain—the relation between objectively defined need and consumer-defined demand. Need for service may have little to do with the number of persons who actually seek nursing home care. Although objectively defined need may influence a person to seek care, the individual's demand will depend on a variety of other factors—personal taste, financial resources, and the price of nursing home care relative to that for other goods and services. Given the generous public subsidy for nursing home care, and the dearth of underwriting of housing and in-home services, limits on bed supply may well mean that more persons will be seeking care than there will be beds available. The result will mean not only a perceived shortage of beds, but also that persons with an objectively determined need for care may not receive it.

The gap between medical need for care and demand for care poses a dilemma for a state government. A bed supply that is adequate to satisfy demand will raise the costs to the state; a bed supply intended to satisfy only need may leave many people inadequately served. The state's choice between these extremes represents its demand for nursing home services, and reflects both its goals for serving the elderly and the disabled population, and the price it is willing to pay to achieve these goals.

Broadly speaking, two methods are used to determine a state's demand for beds. One method projects the number of beds needed in the future on the basis of the number in current use, adjusted for expected changes in the size of the elderly population and for an independently determined standard for nursing home occupancy. The other method establishes a norm or target ratio of beds to population that is independent of current use. The current-use approach, derived from the Hill-Burton program, may reflect neither medical need nor consumer demand. In the last fifteen years, numerous investigations

of nursing home use throughout the country have produced estimates of inappropriate placement ranging from 6 to 76 percent (Congressional Budget Office, 1977). Given this range, it is hard to believe that current use of nursing homes reflects any standard of medical need.

There is also reason to question whether the Hill-Burton approach satisfies the demand for care. If other factors affecting nursing home use (in particular, Medicaid policies, the availability of alternative housing and services, and income levels) remain constant, adoption of the Hill-Burton method is a decision to satisfy in future years the same proportion of demand that is satisfied at present. If the bed supply is insufficient to meet demand now, it will continue to be insufficient five years from now.

A state's reliance on the Hill-Burton method suggests indifference, more than a positive decision with respect to need and demand. Unless a state is dissatisfied with the status of its nursing home industry, use of CON legislation to perpetuate existing practices would seem the simplest path to take. Among the states we visited, the Hill-Burton method was commonly used at the outset of a CON program, when hospitals tended to be the primary concern of legislators and administrators and fiscal pressures were not severe. As long as the elderly population is growing, the Hill-Burton method implies little interference with the nursing home industry's ongoing pattern of growth.

The Hill-Burton method, however, can be manipulated to influence and alter growth patterns. Both Georgia and Massachusetts sought to equalize bed distribution within the state by using the state-wide ratio of beds to elderly (instead of locally determined ratios) as a target for beds in all parts of the state. This ratio became a ceiling in high-growth areas, and a goal in relatively underserved areas. Depending upon the existing distribution of beds and the size of the geographic area to which the ratio is applied, this method may allow significant growth. Growth will occur if the geographic area is small (e.g., a county), if bed supply varies considerably across areas, and if beds are not closed in areas with relatively high ratios of beds to population. Growth, as well as redistribution, is encouraged by New Jersey's effort to tie bed projections to the patients' home county, rather than to the county in which they currently receive care. New Jersey compares the number

of nursing home users from a county with the number of persons over sixty-five in the county to arrive at a target for beds needed. The objective is to encourage a supply of beds close to home.

In their acceptance of current-use rates, state-wide-ratio and county-of-residence methods resemble the standard Hill-Burton approach. But in their efforts to alter the location of beds to achieve independently determined goals, these methods resemble the normative approach to planning. Some states have departed entirely from current-use rates in establishing targets. Tennessee, for example, projects bed supply to satisfy expected users—the number of the unmarried elderly unable to carry on their major functions. With this approach, Tennessee encourages increases in the bed supply to better accommodate the estimated need for formal care. New York and Massachusetts have attempted to develop more precise estimates of need by surveying samples of the elderly population. Targets for different types of beds (skilled nursing, intermediate care, and domiciliary care facilities) are derived from the survey's identification of the proportion of the elderly who need each level of care. Until recently, New York's assessments of needs justified a considerable expansion of the number of beds in nursing homes. In contrast, Massachusetts' survey projected only a slight increase in beds but a massive change in the types of services available. The surveys and the related methodologies in both states have been criticized—the New York estimate as too heavily weighted toward meeting demand, thereby projecting beds in excess of medical need; the Massachusetts estimate as too heavily weighted toward medical need, and insufficiently sensitive to demand.

Obviously, no method is above criticism; all methods are subject to manipulation to arrive at preconceived objectives. A brief description of experiences in Georgia, Washington, Massachusetts, and New York illustrates the way in which states adapt their methodologies to fiscal concerns.

Georgia began its certificate-of-need program by adopting the state's average ratio of number of beds to number of the elderly (70 beds per 1,000 elderly) as a ceiling on bed increases in individual counties. State officials perceived this method as suitable to a desired redistribution of beds, but as supportive of an overall level higher than

was desirable for the state. Although Georgia officials regarded the projection of current-use rates as consistent with the demand for care (90 percent of which was financed by the Medicaid program), they saw it as working at cross-purposes not only with the need to encourage alternatives to institutionalized care, but also with the state's potential future ability to pay. Despite the fact that Georgia's commitment to so-called alternatives was then limited to a demonstration program involving only 400 Georgia residents, the state reduced its target to 55 beds per 1,000 elderly. The target was selected almost arbitrarily, said officials, to accommodate state budgetary objectives.

These officials were under no illusion that their method would ensure service to all persons in need of care. They readily admitted that, at the reimbursement rate they believed necessary to ensure high-quality care, more beds would be supplied and filled with those needing service than the state would be willing or able to finance. Officials justified the reduction in bed projections as perhaps necessary to create a scarcity of long-term inpatient-care service, in order to increase the incentive to find other solutions for those patients who do not need full-time institutionalization. The state's willingness to incur the additional costs of alternative solutions, however, was an open question.

Washington's experience is markedly similar. From 1971 to 1975, the state used the Hill-Burton method to project the need for nursing home beds on a county-by-county basis. By 1975, concern with rising Medicaid costs led to reconsideration of this method. As in Georgia, Washington officials recognized that current use was not determined simply by the availability of beds, but was also a function of the existing pattern of subsidies for institutional care. The task force evaluating the bed-need methodology therefore advised that if the state were prepared to finance noninstitutional alternatives to nursing home care, bed-need projections should assume a 10 percent reduction in the current-use rate and should employ a nursing home occupancy rate of 95 rather than 90 percent. The 10 percent figure was chosen as an estimate (derived from experience outside of Washington) of the number of people placed in nursing homes who had no objectively determined need to be there and could instead be cared for at home. The 95 percent occupancy rate was justified in terms of

the relative stability of a nursing home's patient population. The resulting formula would mean a substantial reduction in the state's projected need for beds.

Washington adopted the recommended change in the formula but rejected the condition that had been used to justify it: expanded financing for noninstitutional services. Concern with the cost per service, and the possibility that noninstitutional services would be used by persons not previously served, as well as by those inappropriately placed in nursing homes, led the state to reject a commitment to support noninstitutional services. Washington, then, reduced its bed-supply objectives with the understanding that services were not available to encourage more appropriate use of nursing homes.

Massachusetts demonstrates a similar phenomenon. From 1974 through 1976, the state, like Georgia, used a state-wide-ratio approach to determine bed need. Reconsideration of this approach was initiated not only by concern with the costs of financing the demand for nursing home care, but also by recognition that the formula allowed expansion that exceeded demand. Use of the state-wide ratio of beds to population allowed expansion of the bed supply in areas that already had low occupancy rates. When the formula led the state to reverse a local planning agency's recommendation for denial on these grounds, policy makers demanded a reevaluation of the bed formula. While that reevaluation was in progress, the state declared a moratorium on all nursing home construction.

In Massachusetts, unlike Georgia and Washington, reevaluation involved the use of specified criteria to determine the need for medical care in the elderly population, independent of their current place of residence. After surveys in all types of institutions, and a sampling of high-risk elderly at home, the state arrived at a set of targets that mandated a slight increase in the total number of beds but massive changes in the types of beds then supplied—specifically, a substantial decrease in the number of beds in chronic disease hospitals, ICFs, and rest homes, and an increase in the number in SNFs. When applied to regions, these state-wide targets were to be adjusted for the percent of the elderly who were seventy-five and older, and the percent living alone. The resulting projections were intended, then, to accommodate variations in the need for nursing home care among the elderly popu-

lation. As in other states, the new method's departure from the projection based on current use was presumably contingent upon a significant commitment of funds for noninstitutional services that no one was certain would be forthcoming. Despite uncertainty about this and other changes in state policy on long-term care, the state adopted the new method, slightly modified. In contrast to Georgia and Washington, however, Massachusetts explicitly declared its method to be an interim approach, and policy makers continued to debate and deliberate an appropriate policy.

Although, until now, New York has explicitly acknowledged a willingness to ignore need estimates when waiting lists or other factors demonstrate a demand for beds, here, too, restrictive pressure is rising. Reacting both to financial concerns and to scandals related to the quality of care, planners have gradually tightened their estimates of need and employed other criteria to restrict nursing home growth. The New York Department of the Budget approves all CON recommendations before final action, and reportedly objects to any departure from the need estimates. Furthermore, official pronouncements increasingly criticize the state's excessive reliance on institutional as opposed to noninstitutional services. Here, as elsewhere, the state is becoming willing to restrict bed-supply growth to levels below the projected demand. Although states may use medical need to justify these restrictions, to date they have been reluctant to establish the noninstitutional services they believe necessary to compensate for unbuilt beds. The actual justification for restriction, then, apparently has less to do with medical need than with limited financial resources and competing demands for funds.

### *Review of Financial Feasibility*

Bed-need restrictions are not the only way the states have used CON statutes to contain costs. CON programs have often been used to enforce restrictions on Medicaid payments or to close loopholes in capital reimbursement policies that lead to higher payments than the state wishes to make. Overall enforcement of Medicaid rates occurs in the CON review of the "financial feasibility" of a proposed project. In this process, analysts assess the applicant's assumptions with respect to

the volume and level of payment from Medicaid and from private patients. If the assumptions are inconsistent with Medicaid payment policy, or, in some instances, entail unrealistic projections of the number of private patients, reviewers will find the project infeasible and the certificate of need will be denied.

States differ in the importance they attach to this process. One indication of commitment is reliance on the Medicaid rate-setting agency to perform the CON financial review. This occurs in New Jersey, New York, Washington, and, for some transactions, Georgia. Process alone, however, is not sufficient to ensure consistency between the rates used for CON approval and the rates actually paid. Washington's payment rates have been criticized as different from CON-approved estimates, a result attributed to fluctuations in the rate-setting method and in its administration. In contrast, in New York, CON approval of the costs of a capital expenditure justifies inclusion of those costs in the Medicaid rate. New York's review of capital expenditures is very detailed, involving line-by-line approval of a capital expenditure budget. A finding that capital expenditures will drive the costs of a nursing home above its Medicaid ceiling leads to reduction or denial of the expenditure.

States have also used CON review to close specific loopholes in Medicaid reimbursement policies—in particular, to eliminate reimbursement that allows nursing homes to increase Medicaid revenues by selling or leasing homes. CON review may be used here not simply to enforce Medicaid restrictions in advance, but to impose limits beyond those specified in the payment process. Most often this is achieved by disapproving unacceptable levels of (or methods for calculating) lease or sales costs. But Georgia has gone beyond this to prohibit all sales in areas its need-projections identify as having too many beds. Although the industry objects that need should have nothing to do with sales, Georgia's policy serves the state's primary purpose: to restrict real estate transactions that raise Medicaid rates. Prohibition of sales might force nursing homes to close and thereby reduce the bed supply.

Instead of using CON review to close specific loopholes in reimbursement policy or to enforce reimbursement decisions in advance, some rate-setting agencies operate in complete independence of CON



review. This is true in both Massachusetts and California. Massachusetts uses a set of Medicaid-prepared capital-cost estimates to evaluate proposed capital expenditures, and requires a new CON review for expenditures above the approved amount (plus a generous contingency allowance). But those who set Medicaid rates are not bound in any way by the CON approval.

Differences among states in their reliance on CON review reflect variations in payment philosophies and political strategies. In New York, Washington, and Georgia, reimbursement has been sufficiently lucrative to attract a larger supply of beds than the state wants to support. The reasons are too complex to analyze here (Spitz and Weeks, 1978–1979), but they include concern that payment be adequate to support high-quality care, to ensure access for Medicaid patients, and to achieve political peace with the nursing home industry. Whatever the reasons, policy makers regard CON review as a valuable and necessary instrument in payment control. To have the mechanism and not use it, said one New York official, would open the state to charges that “it had missed its chance.” Then the state would have to pay the expenses incurred. As long as the state believes this is true, CON review of financial feasibility serves an important function in state policy.

Obviously, other states do not share this belief and need no prior review to enforce their nursing home rates. In Massachusetts, this choice is particularly noteworthy because it differs from the relation between rate setting and CON review that applies to hospitals. For hospitals, rate setters perform and then abide by CON reviews of capital expenditures. A greater willingness to deny nursing home expenditures after the fact may be associated with the lower political risk of disrupting a for-profit as opposed to a nonprofit industry.

### *Review of Quality*

Some states have used CON statutes not only to control the number and cost of beds, but also to control the quality of nursing home care. Like the review of financial feasibility, the review of quality supplements another policy mechanism in the state—licensure. Some states are more willing to prevent the establishment of a new facility, or to deny a facility an opportunity to expand, than they are to revoke the

license of an existing facility. Officials did not try to defend this distinction in terms of quality of patient care, but it makes sense in political terms. Proprietors (and residents) are likely to exercise far more pressure to prevent a loss than to seek a gain. Hence, the state is able to impose different and more restrictive standards by denying a certificate of need than by revoking a license.

Although not unique in its use of the CON program to review quality, New York has carried this review to such an extreme that it has become a significant impediment to nursing home expansion. Like Colorado and Washington, New York reviews an applicant's licensure record, in and out of the state, to determine whether the proprietor has performed acceptably in the past. Unacceptable performance leads to denial of a certificate. In response to scandals about the poor quality of some nursing homes, New York's criteria for acceptability became extraordinarily restrictive. For new facilities, the legislature required the state to review an applicant's licensure record for the preceding ten years, to determine whether the applicant had consistently delivered high-quality care. For chains of nursing homes, the record of each participating home must be reviewed. If an existing facility seeks expansion, the state examines only its current licensure status. In either case, the reviewers make subjective judgments as to the adequacy of performance.

Although New York officials reportedly try to distinguish between "important" (related to patient care) and "unimportant" (paperwork) shortcomings, the state and the industry agree that the criteria are excessively demanding. The fact that cited deficiencies have been rapidly corrected, for example, does not help to clear a record. Furthermore, a state official explained, the documentary evidence of licensure violations makes it easier for reviewers to support a negative than a positive finding. Existing requirements also produce Catch 22 situations. For example, if two partners, one upstanding and the other negligent, own a nursing home, and the negligent partner wishes to leave, the remaining partner would be denied a certificate for change in ownership because of his previous association with an unacceptable operator.

Perhaps even more important than these difficulties is that New York's quality criteria have created a bias in favor of new entrants who

have no previous experience in the nursing home industry. Although the state consults better business bureaus and district attorneys' offices to check on these people, the applicants are far less likely than existing operators to have unacceptable characteristics. State officials are dissatisfied with this bias toward inexperience, believing it to be the source of many of the undesirable practices uncovered in recent investigations of the industry. Despite its shortcomings, quality review has become a significant source of CON denials in New York, and has contributed to what state officials increasingly regard as a necessary restriction of the bed supply.

## The Effects of CON Policies

Certificate-of-need regulation makes assumptions about or tries to affect almost all aspects of nursing home use and performance. To evaluate CON policy, it is therefore necessary to consider its consequences on several fronts—with respect to the total supply of nursing home beds, the distribution of beds by geographic area and level of care, the availability of beds to different types of users, the quality of care provided, and the costs to the state. Obviously, these aspects of the nursing home market are influenced by other factors as well as by the CON policy. The market is also shaped by the socioeconomic characteristics of the state population and by a combination of policies that include Medicaid reimbursement rates, licensure requirements, and utilization review programs. Detailed examination of these policies was beyond the scope of our study. What follows is therefore a qualitative assessment of the effects of CON policies on the nursing home market, based largely on the perceptions of officials and industry spokesmen in several states.

As long as funds are pouring in, a CON program appears to have some effect on industry behavior, but perhaps not the effect that policy makers intend. Enactment of CON legislation frequently induces substantial increases in the bed supply, as nursing homes seek to shut out competition or avoid future restrictions. Georgia officials estimated that plans for 5,000 beds (roughly a 20 percent increase) were initiated between the date of CON's enactment and its starting

date, and Tennessee officials estimate a similar (roughly 25 percent) increase. In California, officials describe the growth spurt associated with its 1969 CON law as so large as to exceed demand for the next several years.

Aside from this initial effect, it is difficult to determine whether CON laws affect the rate of nursing home growth. Application and denial rates have been discredited as indicators, since they are themselves shaped by CON policies. On the one hand, operators may continually submit more applications than they intend to use, to compensate for slow or changing decisions in the state; on the other hand, operators may not bother to submit applications that they feel have little chance of approval. The fact that denial rates for nursing homes appear to have been more common than for hospitals (Lewin and Associates, 1975) may indicate differences in the states' willingness to offend these industries. But it is not possible to use these rates to draw conclusions about the effects of CON policies.

Beyond any impact on the total bed supply in nursing homes, CON programs may serve to encourage bed construction in relatively underserved areas. Tennessee and Georgia officials report that operators respond to bed-need projections by applying to build in areas of identified need. This does not mean, however, that operators do not apply in other areas, or that applications in other areas are disapproved. In states with restrictive policies, state officials, local planning-agency staff, and industry spokesmen claim that the state does indeed adhere to its bed-supply projections in awarding certificates of need. But in Tennessee, where growth was favored, officials appeared willing to depart from their need projections for a variety of reasons, including differences in population characteristics, high rates of occupancy, and political pressure.

Regardless of the state's objectives for total bed supply, reliance on CON regulation to redistribute beds does not always work. If reimbursement policies or private demand make nursing home operation lucrative throughout the state, restrictions on bed supply in some areas may lead to building in other areas. But if nursing homes are not sufficiently lucrative in some areas, building will not occur there, no matter how CON programs are used. Redistribution of beds through use of CON policies is particularly difficult in states where reimburse-

ment does not reflect geographic differences in the costs of care. This is true, for example, in California. But even where reimbursement makes some allowance for geographic differences, payment may be insufficient to attract capital investment in the inner cities, which are high-cost, high-crime areas. California officials reported severe shortages in San Francisco, despite a recognized need for beds. New York reported similar problems in Buffalo, and Massachusetts had a problem in Boston. Without significant alterations in the reimbursement system, building was unlikely to occur in these areas even if they were the only place the state allowed any building at all.

Similar problems arise with respect to CON objectives for redistribution of types of facilities. In Massachusetts, for example, planners proposed to reach bed targets by converting chronic-disease and rehabilitation hospitals to skilled nursing facilities, and by upgrading intermediate care facilities to meet standards for skilled care. Reimbursement policies and certain characteristics of the industry blocked both objectives. Downgrading chronic disease hospitals would have subjected them to nursing-home reimbursement ceilings that did not apply to hospitals. Obviously, institutions prefer the classification that gives them the higher reimbursement, and their interest in downgrading was understandably low. Similarly, operators who made money from ICFs were not inclined to upgrade their institutions to SNF status. The costs of upgrading apparently exceeded the expected returns at SNF rates. An even greater deterrent, the state found, was the fact that 30 percent of existing ICF beds could not meet the standards of SNF Life Safety Code or construction requirements. As a result, the state reported a "disappointing" response to its policies, with only 250-400 beds (of a total 27,000) upgraded in the policy's first year.

Inability to accomplish the objectives behind bed-supply targets has not deterred states from applying restrictive policies. Because states frequently tighten their reimbursement policies for nursing homes at the same time, it is difficult to identify the independent effect of CON restrictions on the bed supply. In some states (e.g., Georgia, Washington, and New York), restrictions on reimbursement were intentionally short-lived. As indicated earlier, these states were unwilling or unable to reduce reimbursement to levels that would sufficiently

restrict the bed supply and Medicaid obligations. They therefore perceived CON regulation as a necessary mechanism for controlling Medicaid expenditures for nursing homes. In other states (e.g., California and Massachusetts), reimbursement restrictions have been the primary instrument of controlling cost and supply. Some states have successfully used CON and reimbursement policies, alone or in some combination, to halt growth in their nursing home industries.

As the states themselves predicted, holding bed supply below demand creates serious inequities and inefficiencies. Because nursing home operators control admissions, their decisions become critical determinants of service use. Operators prefer patients who pay more and cost less. When the bed supply is limited, they can—and reportedly do—exercise this preference in their admission policies. The states we visited consistently reported access problems for Medicaid patients, especially for those who needed considerable care. When they cannot find nursing home beds, these patients reportedly stay in hospitals beyond the appropriate time for discharge. Some officials and industry spokesmen argue that bed shortages have effectively eliminated the freedom of Medicaid patients to choose a provider, for, with few beds available, they must take what they can get. As long as they are in the hospital, however, these patients do continue to receive Medicaid benefits. The attempts in Massachusetts and New Jersey to deny hospital payment for patients awaiting placement in nursing homes were blocked by the courts. The state (with perhaps some help from Medicare) therefore bears the costs of these hospital stays. In California, such patients reportedly accounted for Medicaid expenses of \$2 million per month. New York estimated that 3,000–4,000 persons per day, financed by Medicaid, Medicare, or other sources, were in hospitals awaiting placement in nursing homes. Massachusetts estimated 1,750 in 1974 and 800 in 1976, and New Jersey 1,300.

Just as very sick patients stay too long in hospitals (or, as some observers argue, go without care), persons needing little care stay too long in nursing homes. Although utilization review could theoretically ensure that available beds are allocated more efficiently, its effectiveness appears to be limited. State officials argued that Medicaid reviewers could not legally or practically demand the discharge of patients

whose needs for some form of assistance or housing could not be met in the community. In New York, where an aggressive discharge policy was attempted, it was found unacceptable in court. As the states recognized in advance, failure to provide alternatives to nursing home care in the community makes it difficult to ensure appropriate institutional care.

Restrictions on available beds also interfere with enforcement of quality standards. To paraphrase officials' observations, "You can't close a home when you have nowhere to put its patients." Bed shortages in Massachusetts reportedly led the state to give up on closing a nursing home if it meant finding beds for more than 15 or 20 patients. When hospitals, too, are waiting to place patients, closing a home becomes particularly difficult. "When a new nursing home opened," said one responsible state official, "we had to race the hospital to get hold of the beds."

In sum, the creation of a bed shortage, whether through reimbursement or CON policies, creates what officials in the state of Washington describe as a sellers' market. Not only does a shortage allow operators to pick and choose their patients, reaping the associated financial rewards, but it also improves the operators' negotiating position with respect to quality enforcement and—in some states (e.g., Washington)—reimbursement.

State governments clearly recognize the problems a bed shortage produces, frequently before the problems arise. Once the predicted consequences become fact, the states react in different ways. One response is to expand regulation in order to compensate for undesirable behavior of the industry. Two types of regulation attempt to make existing beds more readily available to Medicaid patients. The first is a requirement that any nursing home licensed or awarded a certificate of need must agree to accept Medicaid patients. This requirement would allow legal recourse in cases of blatant discrimination, and, in Massachusetts, local planners hope to use it to get suburban homes to accept some Medicaid patients from the inner city. But since most homes accept some Medicaid patients, compliance with such laws is possible without major changes in admissions practices. As officials themselves observe, without specification of numbers or percentages, nursing homes are unlikely to substitute Medicaid patients for the more lucrative private patients.

A second type of regulation, used in a few states, is the application of the state's rate-setting authority to private as well as to public payments for nursing home care. Applying a uniform rate to all patients would reduce the existing financial incentive to accept private before public patients.<sup>4</sup> Preferences might still persist, either because of side-payments or because of factors independent of price, such as race, social class, or health or functional status. But uniform rates should make it easier for Medicaid patients to obtain access to care. In addition, control over private rates could delay the time at which private patients will exhaust their assets and become eligible for Medicaid benefits. New York officials cited this route to Medicaid eligibility as a significant impediment to controlling Medicaid costs. If, indeed, the Medicaid program cannot deny coverage to a financially eligible nursing home resident, regardless of health status, concern about the rate at which private patients become public patients is justified.

Regulation of all nursing home beds would improve access for Medicaid patients. But such interference in the private market for nursing home care imposes a cost on private patients who are denied care, for it reduces their ability to use their resources to satisfy their preferences. Restricting the access of private patients may have other and unintended consequences. Private patients may be currently subsidizing Medicaid patients (Scanlon, 1980). A reduction in the number of private patients would either curtail the number of Medicaid patients a home would accept, or would require an increase in the Medicaid reimbursement rate to keep the number constant. In extending their regulation of beds, states should recognize these potential problems with access and costs as well as the inequity of interference in the private market.

Another type of regulatory action, operative in a few states, relates

<sup>4</sup> It is interesting to note that rate regulation that allows a differential between private and public rates would probably reduce access to care for public patients. Holding private rates at levels below those set by a free market will make nursing home care attractive to a larger number of private patients. Although rate control will limit the operators' revenues from private patients, they will still be more profitable than public patients. With more private patients in the queue, Medicaid patients will have as much, if not more, difficulty in gaining admission as they would have if private rates went unregulated.



to quality enforcement in shortage conditions. If a home is violating safety or other requirements, statutory provisions for receivership would allow the state to take over the home's operation rather than close it down. Massachusetts is considering such a provision, broadening its current authority to take over nursing homes in public emergencies. Current authority is insufficient, officials say, because it is difficult and time-consuming to establish that a "public emergency" exists. These officials recognized that objections to the state's interference in private industry would pose serious obstacles to legislative support for receivership authority. And, even if the legislature enacted broader authority, such objections are likely to affect the state's willingness to take over a nursing home. State officials may also be reluctant to take on the administrative burden of overseeing nursing home management. Receivership could, however, serve as a useful threat to a recalcitrant operator and, in extreme emergency, would allow the state to protect patients who were without alternative sources of care.

Adding new regulations to compensate for the undesirable effects of existing regulation is not uncommon. But it is widely believed that government cannot gain control over industry in a never-ending process of action and reaction that Christopher Hood (1976) has labeled "reciprocal learning." As a large bureaucracy, constrained by a multitude of legal requirements and fixed procedures, the state lacks the freedom to maneuver—and act arbitrarily—that victory may require. It may therefore be far more effective to reduce than to increase regulation when the original goals cannot be met.

Some of the states we visited were in fact taking this course. Pressure to loosen the restrictions on bed supply comes from legislators whose constituents cannot find beds, from nursing home operators who want to expand, from local planning agencies aware of "unmet need," and—within the bureaucracy—from social workers unable to place Medicaid patients, and from budgetary officials concerned about paying for unnecessary days in hospital. Responses to these pressures may be unsystematic, i.e., on a case-by-case basis, or may involve a systematic reassessment of policy. New Jersey appears to be an example of the first; Massachusetts, of the second.

New Jersey reports that it has abandoned its bed-need projections in order to get more beds for Medicaid patients. If they could control

the use of all existing beds, say state officials, the state's current supply would be adequate. But, instead, they find that existing operators limit their admission of Medicaid patients. Although New Jersey has passed a law requiring nursing homes to accept a "reasonable number" of Medicaid patients, regulators believe this law is not sufficiently rigorous to overcome access problems that result from the gap between public and private rates of payment. Instead, they believe it necessary to ignore bed projections (which show too many beds in areas where hospital patients ready for discharge cannot find a nursing home bed), in order to allow entry by investors willing to operate at existing Medicaid rates. Health planners in New Jersey object to this approach so strongly that they have effectively refused to participate in the CON review process. But regulators and rate setters believe that abandonment of CON limits, in combination with some general increases in reimbursement levels and adjustments for existing operators in liberally defined "hardship" cases, will produce more efficient and acceptable nursing home care. A New Jersey official reported that in the past a rate hike ended the problem of placing patients on hospital discharge.

Massachusetts has taken a somewhat different approach. Unlike New Jersey, where rate-setting and CON responsibilities are assigned to the same agency, Massachusetts rate-setting and CON officials have operated independently. At the same time that health planning officials were debating the wisdom of a restrictive CON policy, rate setters altered reimbursement policies in ways that substantially reduced the attractiveness of nursing home investment and, at least temporarily, made it difficult for existing operators to meet outstanding financial obligations. As a result, no matter how the health planners chose to use the CON program, growth in bed supply was significantly slowed. Today, however, rate setters and planners are cooperating in an effort to use payment mechanisms, bed-need criteria, and programs for noninstitutional services to efficiently satisfy the need for all forms of long-term care in Massachusetts.<sup>5</sup>

<sup>5</sup> In addition to the intentional easing of CON restrictions, some nursing homes have obtained legislative exemptions from the Massachusetts CON program. Exemptions will undoubtedly affect the bed supply but, as long as Medicaid rates are restricted, they are likely to affect chiefly the private patients.

To some extent, these adjustments were externally imposed, as CON decisions were appealed and overturned. Appeals resulted from the method the CON program employed to encourage upgrading rather than new construction to meet SNF bed-need projections. In reviewing SNF applications, CON officials did not simply compare the existing number of SNF beds with the target; rather, they summed or "aggregated" the numbers of ICF and SNF beds and compared the sum with the SNF target. They allowed no new construction unless an area showed a net need for beds, counting both types of beds. This aggregation method led to the denial of applications to construct SNF beds. Operators successfully appealed these denials to the Health Facilities Appeals Board, which found the aggregation of ICF and SNF beds inappropriate in the absence of evidence that upgrading did or would occur. The regulators' first response to the board's action was to compromise on their aggregation policy, allowing 50 percent of the projected need to be met through upgrading and 50 percent through new construction. This, too, proved unacceptable to the appeals board, and the CON program abandoned the aggregation method entirely. The change would justify approval of 4,200 new beds, as compared with the 2,800 the aggregation method would have allowed.

The CON program similarly gave way on what officials ultimately decided were unrealistic assumptions about downgrading chronic-disease and rehabilitation hospitals to SNF status. Although the state planned to encourage downgrading, by tying payment to reviews of the appropriateness of care, it was a mistake, said a planning official, to expect large savings from this effort. On grounds that these hospitals were treating patients who required intensive care (patients who could not gain admission to nursing homes), and that the hospitals' fixed costs should be covered to keep them in operation, rate setters and planners agreed to establish a rate specific to these facilities, to reduce it only gradually over time (rather than all at once), and to prevent new construction of this type of facility. As with its decision to eliminate the aggregation method, the state decided to give a higher priority to finding sufficient beds than to redistributing the existing supply to conform to standards of medical need or to saving money.

This general principle also led the state to recognize explicitly that the existing ratio of beds to population (especially for ICFs) could be

lowered only if the state made noninstitutional services more widely available. Although the state has not been prepared to raise expenditures on these services to the levels believed necessary to satisfy demand, it has incorporated "slots" for community care in its bed-need projections, which are reportedly to be followed *only* when the assumed slots are actually provided. Funds for noninstitutional services are to be targeted to people identified as probable candidates for nursing home use, and to areas that experience delays in placing hospital patients in nursing homes. The state is also experimenting with placement mechanisms to increase the likelihood that the patients most in need of care will get it.

At the same time, the state is altering its reimbursement policy to provide bonuses to homes that make a specified proportion of beds available to Medicaid patients, as well as to homes that maintain specified quality standards. In contrast to the regulatory approach, which works against the operators' financial interests, bonuses seek to make desirable behavior financially worthwhile. If targets for Medicaid patients are set too high, however, the bonus may be insufficient to change admission practices in nursing homes. Massachusetts is also exploring methods for adjusting reimbursement rates to reflect the degree of the patients' disability, in order to overcome the operators' reluctance to take those who need extra care. But, so far, rate setters have objected to patient-based rates as too complicated to implement.

Overall, it is difficult to tell whether the policy changes in Massachusetts are purely rhetorical or will increase the bed supply to better satisfy need. Nevertheless, the wholesale abandonment of service commitment proved to be politically unacceptable. Hence Massachusetts appears to be engaged in a systematic effort to balance cost with need for service, and to allocate limited resources effectively and efficiently.

Not all states are willing to alter their restrictive policies, even when they recognize the resulting inefficiencies and inequities. Georgia officials gave no indication that they planned to loosen their restrictions, and their noninstitutional services program was still in its infancy. Washington was reevaluating its restrictive policies but, in 1978, conflict between officials anxious to satisfy the demand for

service and officials unwilling to pay the price required for satisfaction made the outcome uncertain. In general, it is fair to say that the states perceive both gains and losses from regulating the bed supply in nursing homes. What they decide to do depends upon the weights they attach to each.

### Who Wins? Who Loses?

CON restriction is not the only mechanism a state can use to control what it spends on nursing home care. A more direct method, recognized by several states, is to limit the rates Medicaid will pay for nursing home beds. Theoretically, a state can set a rate, independent of the costs of an individual home, that will attract construction of the number of beds the state is willing to support. (An approach that reflects industry costs but not the costs of each individual home is consistent with the federal requirement, under Section 249, that Medicaid nursing home payment be reasonably related to costs.) Unless rates are related to a patient's condition, problems of discrimination against those who need extra care will arise if rate restrictions create a shortage of beds, just as problems arise with CON restrictions. But with free entry into the market (i.e., *without* CON restrictions), nursing homes will compete for patients. The result, some argue, will be both higher quality and greater efficiency in the delivery of care. In such circumstances, CON restrictions would not only be unnecessary but would also actually be destructive, for they would inhibit the competition on which desired performance depends.

Why would a state prefer CON restrictions to reliance on the rate structure to control costs? We believe that the choice has to do with the risks state officials are willing to take. When a state tries to restrict its nursing home payments, the reaction is immediate and vociferous. The operators complain of insufficient funds and imminent bankruptcy. Although state officials may greet these claims with skepticism, standing fast poses a considerable risk. If the new rate is indeed too low, operators may lack the resources to provide adequate care. A new owner or another nursing home may ultimately replace the one that fails. But in the meantime patients may suffer. This risk is not

limited to the time when the rates are set, but is a constant element in a competitive market. If patients suffer, or appear likely to suffer, officials will be blamed. The political costs of the market's transition costs may be perceived as too great for state officials to bear. Although they may try to control their rates, they may end up paying more than they want to pay. To avoid uncertainty and political pressure, some states even prefer to pay higher rates, using CON methods both to protect the occupancy rates in nursing homes (assuring them adequate revenues), and to avoid greater utilization than the state is willing to finance.

Awarding monopoly power to nursing home operators at comfortable rates will undoubtedly reduce their threats to reduce the quality of care. But the combined strategy of high rates and restrictive CON policies by no means ensures that high-quality care will be provided. CON restrictions may therefore yield state officials only the control of expenditures. High rates accompanied by CON restrictions will probably cost the state less than high rates in the absence of restrictions on entry, even though these restrictions encourage inappropriate hospital use. These hospital stays may be paid for by Medicare (a federal, not a state program). Or, if paid for by Medicaid, they may fill otherwise-empty hospital beds, for which Medicaid (in most states) would pay a share of fixed costs anyway. Obviously, it is not possible to calculate actual costs without more detailed information. But it is possible that state expenses for hospital patients awaiting nursing home beds are significantly lower than expenses for the new beds that high Medicaid rates would encourage in the absence of entry restrictions.

If expenditure control is the only goal, then the states can be said to win from using CON restrictions. But if, instead, we consider expenditures in relation to services provided, the states appear to lose. By protecting established owners from competition, the states are undoubtedly supporting inefficiencies in production, and spending more for a given supply of beds than is theoretically necessary.

The states' loss in this respect is clearly the nursing home operators' gain. In every state we visited, they recognized the advantages of restricting entry. This was true whether the industry considered Medicaid rates sufficient or grossly inadequate. Where operators found the rates particularly low, they regarded CON restrictions as

essential to their survival. Without these restrictions, they feared that new entrants into the industry would rob them of patients; with fewer patients at low rates, they would be forced out of business. In California, for example, a spokesman for the nursing home association described his members as "happy as clams" with entry restrictions, and anxious to ensure that they covered all possible competitive threats, including the reclassification of hospital beds to nursing home status.

Even in the states where Medicaid rates make expansion or new building attractive, nursing home operators do not object to the CON process. In Georgia, which may be an extreme example, the industry was the prime mover behind CON legislation. Their interest was not to prohibit all expansion and new investment, but to establish a mechanism whereby the industry itself could decide who would build where. The state officials' circumvention of the CON program's industry-dominated council did not create opposition to the process. Instead, in Georgia as in other states, the industry tends to oppose specific applications of CON regulation rather than the overall concept of controlling entry. Thus, in Georgia, the industry has opposed CON officials' use of bed-need projections to inhibit sales and, in Massachusetts, the industry opposed highly restrictive estimates of medical need as a basis for bed-supply projections. A spokesman for the Massachusetts nursing home industry emphasized, however, that, despite their opposition to specific CON practices, association members—primarily owner-operators of single homes—were not anxious to expand. Interestingly, he explained their attack on stringent restrictions on bed supply as part of a strategy to get their rates raised for current operations. By demonstrating that more beds were needed, but were unavailable at current rates, the industry believed they could press the state to raise rates for all homes. Even if current operators did not want to expand, they therefore had a stake in convincing the state that more beds were desirable. As long as the state stopped short of allowing expansion that threatened occupancy levels, these operators would be satisfied.

In sum, whatever losses in efficiency CON restrictions impose on the state are gains in revenue and security to nursing home operators. The monopoly power that CON restrictions create is apparently far more valuable to these operators than any new investment they might

forego. Their stake in the CON process may explain why the states that are unable to limit their payments to nursing homes are able to use CON restrictions to take actions the industry opposes.

Consideration of winners and losers from CON restrictions is not complete without evaluating their effects on patients. CON restrictions influence price, access, and quality of care. Because patients eligible for Medicaid must pay all their income toward nursing home care, and because their income must be less than the Medicaid rate, price is an issue only for private patients. In the absence of competition, private patients face higher charges than would occur in an open market. Furthermore, although private patients have the advantage in nursing home admissions, CON restrictions will reduce the choices available to them, choices they would have in an open market. CON restrictions unquestionably make access a problem for Medicaid patients, particularly those who need intensive care. The effects of competition on quality are less clear. On the one hand, some states use CON review to prohibit unsatisfactory operators from expanding. Although we have described the problems with this approach, it may give the operators a greater incentive to provide high-quality care. On the other hand, we know that when they cannot find empty beds, the states have difficulty enforcing licensure standards for existing operators. In this respect, CON restrictions clearly detract from the quality of care.

It is difficult not only to determine the combined effect of these factors, but also to compare this effect with the quality of care in an open market. As noted earlier, some officials fear that the "transition costs" of a competitive market—with nursing homes going in and out of business—will cause patients considerable harm. Others believe that the market is not so volatile as to cause serious disruption. Rather, they argue, the threat of competition and some excess of beds over patients will force the operators to maintain good quality in order to stay in business. Implicit in this view is the belief that patients or their agents (families or social workers) can and will evaluate quality in choosing among nursing homes.

Without more evidence, the effects of CON restrictions on quality remain an open question. But the outcome in other areas seems fairly straightforward. Patients lose; nursing home operators win; the state



loses in efficiency and gains in budgetary control. It is tempting to conclude, on these grounds, that CON regulation of nursing homes is undesirable. To a state under fiscal and political pressure, however, this conclusion hardly seems helpful. When the political and fiscal environment of a state is taken into account, some broader conclusions are possible.

If fiscal pressure is indeed producing inefficient choices in a state's nursing home policy, it may be appropriate to reconsider the structure of financing for nursing home care. It is questionable whether the availability of nursing home care should depend on economic conditions that vary from state to state and are largely outside the control of any individual state. Shifts in national economic activity mean that some states lose a sizable share of their labor force, so that the elderly constitute a larger share of the state population. The result is a decrease in the state's revenue sources, accompanied by an increase in the number of persons likely to seek publicly financed nursing home care. CON restrictions are one way such states try to cope with inadequate revenues, obviously to the detriment of the needy population. To reduce the pressure for restricting expenditures, the federal government should play a greater role in financing nursing home care.

With or without this change, it is necessary to consider policy measures that can reduce the negative consequences of CON restrictions. If the states cannot satisfy the demand for nursing home beds, they must develop mechanisms for rationing whatever beds they have. There are two strategies for achieving an appropriate bed allocation. The first is a regulatory strategy that relies heavily on utilization review. If the Medicaid provisions allowing recipients free choice of providers were dropped, the state could assert its authority to tell patients where they could go, and to tell nursing homes which patients they could accept. A home could not choose a patient who needed little care over a patient needing considerable care if the Medicaid program would authorize benefits only for the sicker patient. This regulatory approach to rationing assumes far more rigorous restrictions on coverage than have apparently been applied to date. Furthermore, these restrictions would encounter opposition from operators, who would continue to avoid patients whose care required greater expenditures. The regulatory approach to rationing, compli-

cated by the probable opposition of Medicaid recipients and by the difficulties of coordinating and controlling a complex bureaucratic system, hardly seems destined for success.

Altering financial incentives, with reinforcement from utilization review, appears to be a far more promising strategy for allocating beds. To encourage the allocation of beds according to the need for care, a reimbursement system must have several elements. First, rates must vary with the patients' need for care, in order to discourage discrimination against those who need extra care. Second, rates must reward the delivery of appropriate care to all patients. Payments should increase with improvements in patients' health status, and should reward the operators for discharging patients who no longer need nursing home care. Rewards of this sort require utilization review or the planning of patient care in order to work. Using incentives to support a review system should increase its probability of success. But even incentives are unlikely to force discharges unless patients have some other place to go. If the less sick patients are to make room for the very sick, it may be necessary to finance services in the community.

These recommendations are hardly original and are probably difficult to implement. The experience of the states reported here, however, underlines their importance. If policy makers continue to rely on restricting the bed supply to control costs, without confronting questions of bed allocation, government is accepting the inequities and inefficiencies that result.

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