



Virginia Nursing Facilities and Certificate of Public Need

FALL 2015

EXECUTIVE SUMMARY

Virginia's Certificate of Public Need (COPN) program regulates the supply of nursing facility beds in the Commonwealth by trying to match the supply of these services with demonstrated need. COPN for nursing centers reduces the Commonwealth's health care costs in the Medicaid program. Virginia's goal in regulating acute health care services with COPN, which include inpatient and outpatient hospital services, are different: lowering overall health care costs and preserving the ability of hospitals to offer money-losing services.

Given that the vast majority of nursing center care, 82 percent, is paid for by state and federal government payers with whom providers have little to no opportunity to negotiate for higher reimbursement, nursing facilities do not operate in a free market. Eliminating COPN could significantly hurt the Commonwealth's ability to provide care to nursing facility patients and residents.

COSTS TO THE STATE

The Commonwealth of Virginia has a significant interest in controlling the costs for nursing care since 64 percent of nursing center residents have their care paid for by Medicaid. Moreover, the current approach of controlling the supply of nursing facility beds has successfully controlled nursing facility costs, which have grown much more modestly than other Medicaid long term care costs.

In addition, approval of new nursing centers inherently involves new costs for the state because the state Medicaid program reimburses capital costs. The capital costs of a newly constructed facility are higher than for an existing facility and the result is higher Medicaid costs for care at new facilities. The state would also incur higher costs with unlimited new nursing center construction because lower occupancy rates in existing centers reduces the economies of scale.

OTHER STATES' REGULATIONS

COPN offers a middle-ground regulatory approach for controlling nursing facility costs and is used by 36 states across the country. States that do not use COPN to regulate the supply of nursing center beds often regulate this sector by other means, such as periodic moratoria on approval of nursing center beds.

ACCESS TO CARE

Paradoxically, greater supply of new nursing center beds may also create access issues for low-income seniors, as new centers are typically more aggressive in seeking private pay patients to recover the costs of their construction and financing. Medicaid alone is not sufficient to make a new facility, or any facility for that matter, economically viable due to its low overall reimbursement levels. Accordingly, greater competition for the limited number of private pay patients could create access problems for low-income seniors.

HISTORY OF COPN FOR NURSING CENTER CARE IN VIRGINIA

According to a 1998 legislative review, Virginia's certificate of public need (COPN) law was enacted in 1973, a year before the federal government passed a national health planning law (which was subsequently repealed in 1976). COPN required that the Commissioner of Health find that a proposed health care facility was needed and in the public interest. This was the traditional standard for state and federal health planning.

Given the fiscal implications of nursing facility beds for the Medicaid program, Virginia has actually managed nursing center beds more aggressively than other COPN services, including an actual bed moratorium that was imposed in 1989. In 1996, the nursing facility bed moratorium was lifted and was replaced with the current Request for Application (RFA) process whereby the Commissioner of Health may periodically issue requests for application for new nursing facility beds in the Commonwealth where there is demonstrated need for such beds.

This RFA approach ensures that beds are available for residents who need them, while also being consistent with Virginia Medicaid's policy that predicates its reimbursement of nursing centers on the assumption that they maintain a high occupancy level, an assumption set forth in the regulation governing Virginia Medicaid reimbursement of Medicaid nursing facility services, 12VAC30-90-41-Nursing Facility Reimbursement Formula. This regulation has set target occupancy levels as high as 90 percent in the past and is currently set at 88 percent.

NURSING CENTER PREADMISSION SCREENING FIRST IMPLEMENTED IN VIRGINIA

The Commonwealth has a long history of policy initiatives to control long term care costs. For example, Virginia was the first state to implement nursing center preadmission screening in the 1970s. This policy, which continues to this day, ensures that only residents who need a nursing facility level of care, based on need for assistance with multiple activities of daily living, receive such care funded by Virginia Medicaid. Consequently, residents in Virginia nursing centers are very severely impaired in their ability to function independently compared to nursing center residents in other states.

According to the relevant regulation, 12VAC30-60-303. "Preadmission Screening Criteria for Long-Term Care":

A. Functional dependency alone is not sufficient to demonstrate the need for nursing facility care or placement or authorization for community-based care.

B. An individual shall only be considered to meet the nursing facility criteria **when both the functional capacity of the individual and his medical or nursing needs meet the following requirements** [emphasis added]. Even when an individual meets nursing facility criteria, placement

in a noninstitutional setting shall be evaluated before actual nursing facility placement is considered.

THE PREDOMINANT PAYER FOR NURSING FACILITY CARE IN VIRGINIA: MEDICAID

COPN is a state government program that regulates a range of health care services in Virginia with the goal of helping control health care costs. COPN applies both to nursing facility beds and certain acute health care services, such as inpatient hospital beds, diagnostic imaging, and ambulatory surgery. However, the policy goals vary by type of service.

For acute health care services, COPN preserves the ability of health care providers to offer needed services that are not financially self-sustaining. COPN for acute health care services also has a more general goal of reducing overall health system costs.

In the case of nursing facility beds, COPN serves to control the state's own budget costs, as the Virginia Medicaid Program is the predominant source of payment for nursing beds in the Commonwealth. In 2013, Virginia Health Information (VHI) found that Medicaid represents 64 percent of the utilization for the 252 nursing facilities in Virginia reporting data. While Medicaid represented 64 percent of the caseload, it only accounted for 45 percent of the net revenue, demonstrating the significant cost savings achieved through the state's low payment rates to nursing centers, a policy that is not sustainable without COPN.

Medicare, a federal program for seniors and certain disabled persons, accounted for another 18 percent of nursing facility utilization in 2013, according to VHI. Medicare offers a limited skilled nursing care benefit (a higher level of nursing facility care) and does not cover custodial nursing care at all. Medicare has a 100 day per stay limit for skilled nursing care for rehabilitation after a qualifying condition (such as a stroke or certain surgeries).

Medicare and Medicaid combined accounted for 82 percent of nursing facility utilization in Virginia in 2013. While Medicare is only 18 percent of the utilization (compared to Medicaid's 64 percent), Medicare accounts for 35 percent of the net patient revenue (in contrast with Medicaid's 45 percent). To put this in perspective, while Medicaid accounts for 3.5 times as much of the nursing facility utilization in Virginia than Medicare does, Medicare provides nearly as much revenue. This demonstrates the importance of Medicare, as well as a more limited number of private pay and privately insured patients, on the financial sustainability of Virginia nursing centers. It is important to note also that while most Virginians have private health insurance for acute care, it is estimated that a very small percentage have long term care insurance.

Medicaid is also the dominant payer for nursing care nationally. The Kaiser Family Foundation noted in a 2011 report that Medicaid was the primary payer for 63 percent of nursing facility residents nationwide in 2010, almost identical to the 2013 figure for Virginia of 64 percent. Medicare was the primary payer for 14 percent, and 22 percent

were either private pay patients or had long term care insurance. Many of these private pay patients were “spending down” their assets to ultimately qualify for Medicaid-financed care.

Recognizing the central role that Medicaid plays in financing nursing facility care, the Virginia General Assembly has supported public policies for decades that regulate the supply of nursing facility beds. This includes the current COPN approach, as well as past moratoria on the construction of new nursing facility beds. As noted on the Virginia Department of Health’s web site:

State law requires that all nursing facilities obtain a license to operate in Virginia. There are more than 279 nursing facilities containing 31,927 beds located throughout Virginia. All but fifteen nursing facilities are certified for federal reimbursement under Medicare and Medicaid.

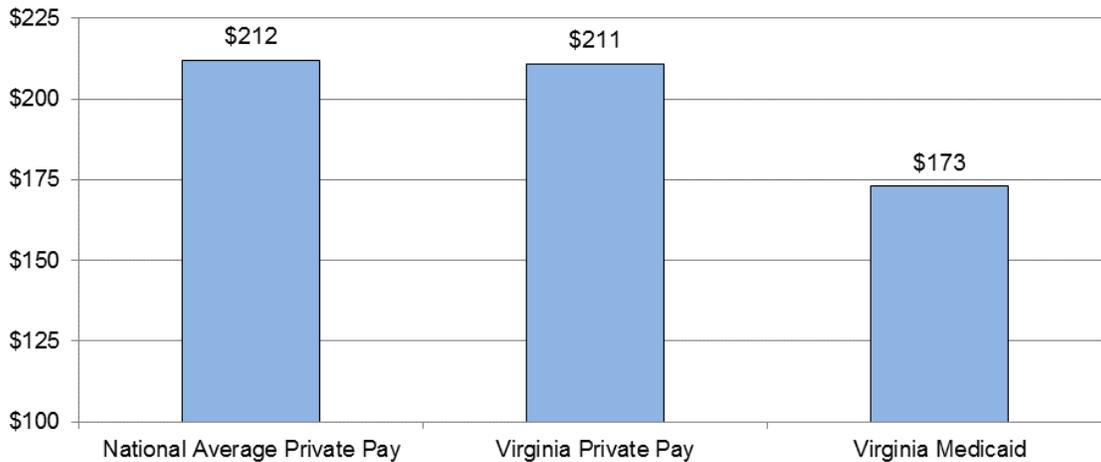
Also worth noting, although less significant, approval of new nursing facilities inherently involves new costs for the state because the state Medicaid program reimburses capital costs through Medicaid’s “fair rental value” calculation. The capital costs of a newly constructed center, which reflect financing costs and the not yet depreciated value of the physical plant, are higher than for an existing center and the result is higher Medicaid costs for care at new centers. Unlimited new construction of nursing centers also results in lower occupancy for existing facilities, making them less efficient due to fewer economies of scale. The result is higher costs per resident at the existing facility, and higher overall costs for the state.

VIRGINIA MEDICAID LAGS OTHER PAYERS FOR NURSING CENTER CARE

The state has regulated the supply of nursing center beds in the Commonwealth since the Virginia Medicaid program began covering nursing services in the early 1970s. While some nursing center residents enter facilities as private pay patients, typically they exhaust their savings and subsequently qualify for Medicaid. Medicaid then supplements an individual’s own income, minus a modest personal needs allowance, up to the total allowable costs per day.

Genworth, a Virginia-based financial services company that is a major long term care insurer, publishes an annual survey of long term care costs. Its 2014 review found that the median cost of a semi-private room in a nursing center in Virginia was \$77,015, which equates to \$211 per day. By contrast, Virginia Medicaid pays 18 percent less than this amount, an average of \$173 per day (Figure 1). The precise amount varies from center to center based on the artificially limited allowable costs and other factors.

FIGURE 1
PRIVATE PAY MEDICAID PAYMENT FOR NURSING CENTER CARE IN VIRGINIA



Source: DMAS (Medicaid figure), Genworth “2014 Cost of Care Survey”

The gap between Virginia Medicaid reimbursement and private pay rates equates to almost \$14,000 annually per nursing facility bed. As the average nursing facility in Virginia has 114 beds according to VHI, this means that a typical Virginia nursing facility with 64 percent of its residents funded by Medicaid is receiving \$1.3 million less from Medicaid than market rates. Multiplying by 252 centers reporting data to VHI, the Virginia Medicaid program pays approximately \$323 million less than market rates (half state funds, half federal funds), which explains the state’s hesitancy in recent decades to adopt a “free market” approach to nursing center supply. The result would be the state having to pay much higher rates, severe access issues for low income elderly, or a combination of the two problems.

Simply put, private pay patients and Medicare skilled nursing patients undergoing rehabilitation subsidize the cost of Medicaid’s comparatively low reimbursement rate. The COPN policy is essential to the state’s ability to, in effect, pay less than the cost of care for nursing centers. Without COPN, it would be possible for new entrants to focus exclusively on private pay and Medicare patients, leaving facilities with all or almost all Medicaid patients unable to deliver quality care and survive financially. This could in turn force existing providers to limit acceptance of new Medicaid patients or stop taking such patients altogether, thereby resulting in access issues for low-income seniors who rely on Medicaid to finance nursing center care.

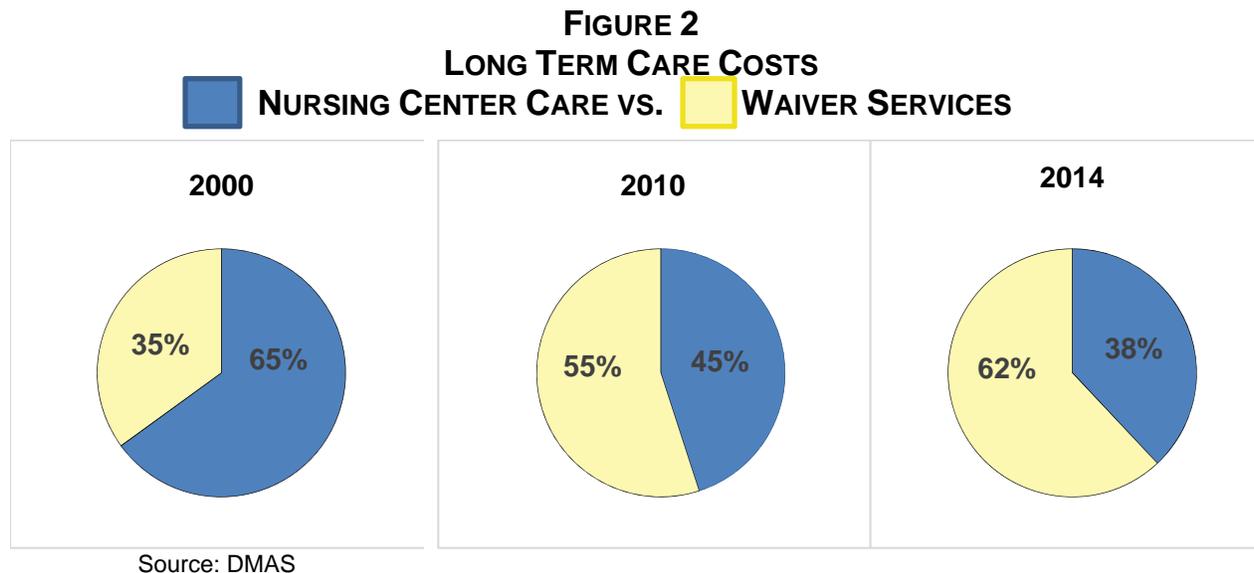
Regarding quality of care, nursing centers are among the most intensely regulated facilities, even among health care service providers. Nursing facilities in Virginia are both licensed by the Virginia Department of Health (VDH) to operate in Virginia and certified by the U.S. Centers for Medicare and Medicaid Services (CMS) to participate in Medicaid and Medicare. Since substantial revamping of these federal certification requirements in 1986, nursing facility certification is notably stringent even in comparison to other regulated health services.

ALTERNATIVES TO NURSING CENTER CARE DRIVE MEDICAID LTC SPENDING

While the Medicaid program is the predominant payer for nursing care center both in Virginia and nationally, nursing facilities represent the minority of overall Virginia long term care (LTC) spending. Home and community based services, which offer an alternative to nursing center care, are collectively referred to as waiver services as they are not required to be offered under federal law. Over time, Virginia Medicaid costs for these waiver services have grown more quickly than nursing facility costs. These costs now represent a majority of Virginia's Medicaid LTC spending.

According to a House Appropriations staff presentation, spending for waiver services nearly quadrupled between state fiscal years 2000 and 2010, while spending for nursing facility services grew much less rapidly in spite of medical cost inflation and increased patient acuity. In fiscal year (FY) 2000, nursing facility costs for Virginia Medicaid were \$470.9 million and the costs of waiver services were \$256.6 million. By 2010, spending for LTC waiver services by Virginia Medicaid significantly outstripped spending for nursing center services (Figure 2).

Put another way, in 2000 nursing center care represented 65 percent of Virginia Medicaid LTC costs and waiver services represented only 35 percent. By 2010, waiver services represented 55 percent of Virginia Medicaid LTC costs and nursing centers represented only 45 percent. This trend has continued. According to DMAS, in FY 2014 waiver services represented 62 percent of Medicaid long term care costs and nursing center care represented only 38 percent, nearly reversing the proportion of costs from FY 2000.



While waiver services represent most Virginia Medicaid long term care spending, nursing facility care is still a substantial amount, \$847 million in state fiscal year 2014, which accounts for the state's interest in controlling the number of nursing facility beds.

Although nursing center care is only a small part of overall Virginia Medicaid costs, Virginia Medicaid funding is a large portion of the revenue received by nursing facilities. The General Assembly rightly views additional nursing center beds as a potential cost to the Medicaid program, particularly to the extent that oversupply of nursing center beds threatens the state’s continued ability to pay less than the cost of care.

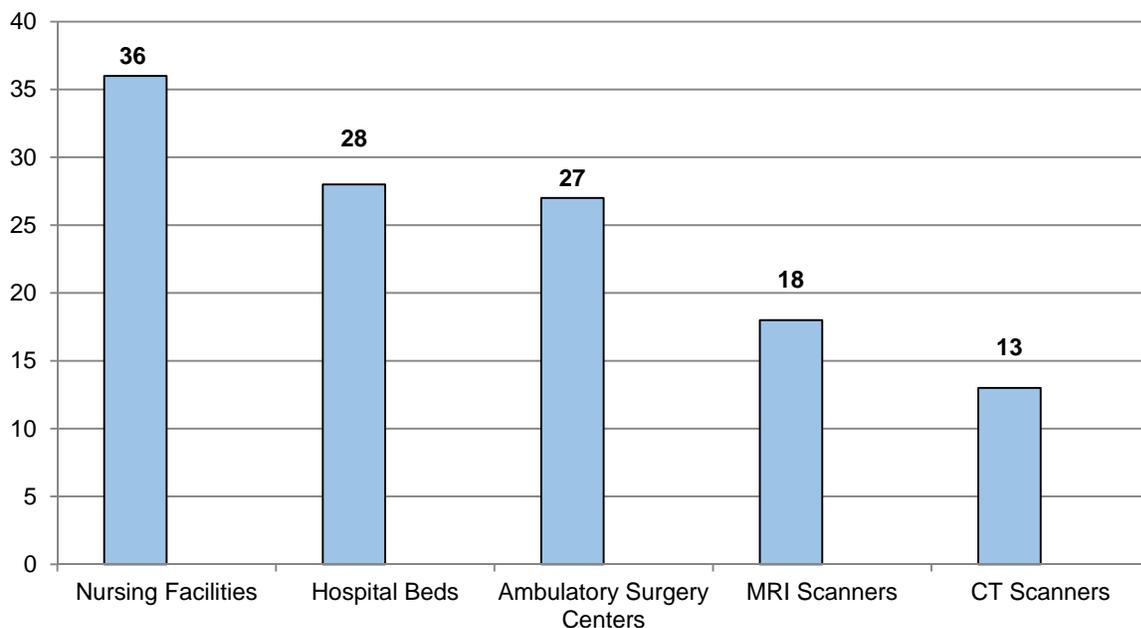
WIDE USE OF COPN TO CONTROL NURSING CENTER COSTS ACROSS THE U.S.

States have adopted various approaches for regulating medical services although a majority continue to use COPN to regulate the number of nursing center beds. According to the National Conference of State Legislatures “Certificate of Need State Laws,” as of 2015, 36 states and the District of Columbia use a COPN process for nursing facility beds, if not an outright moratorium. Figure 3 shows the number of states regulating other services or equipment.

In short, every state with an active COPN program regulates nursing facilities. COPN is a very common cost control policy for long term care in both the South and the mid-Atlantic. The 36 states that regulate nursing centers beds through certificate of need include:

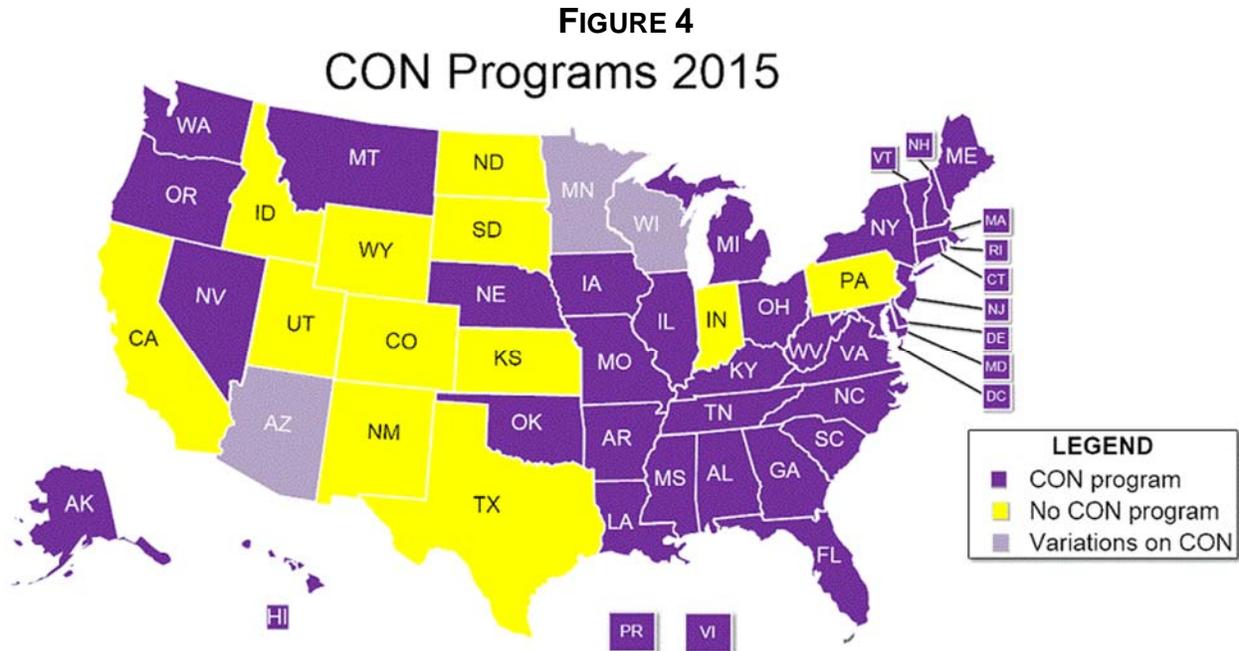
- All of Virginia’s neighboring states (plus the District of Columbia): Kentucky, Maryland, North Carolina, Tennessee, and West Virginia.
- Ten other Southern states: Alabama, Arkansas, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

**FIGURE 3
NUMBER OF STATES REGULATING SELECTED SERVICES USING COPN LAWS**



Source: National Conference of State Legislatures “State Certificate of Need Laws,” September 2015 update

Figure 4 shows the states that regulated nursing facility beds through COPN in 2015. Every Southern state except Texas regulates nursing facility beds through COPN. As noted previously, some of these 36 states go beyond COPN and have imposed actual bed moratoria, similar to what was in place in Virginia from 1989 to 1996.

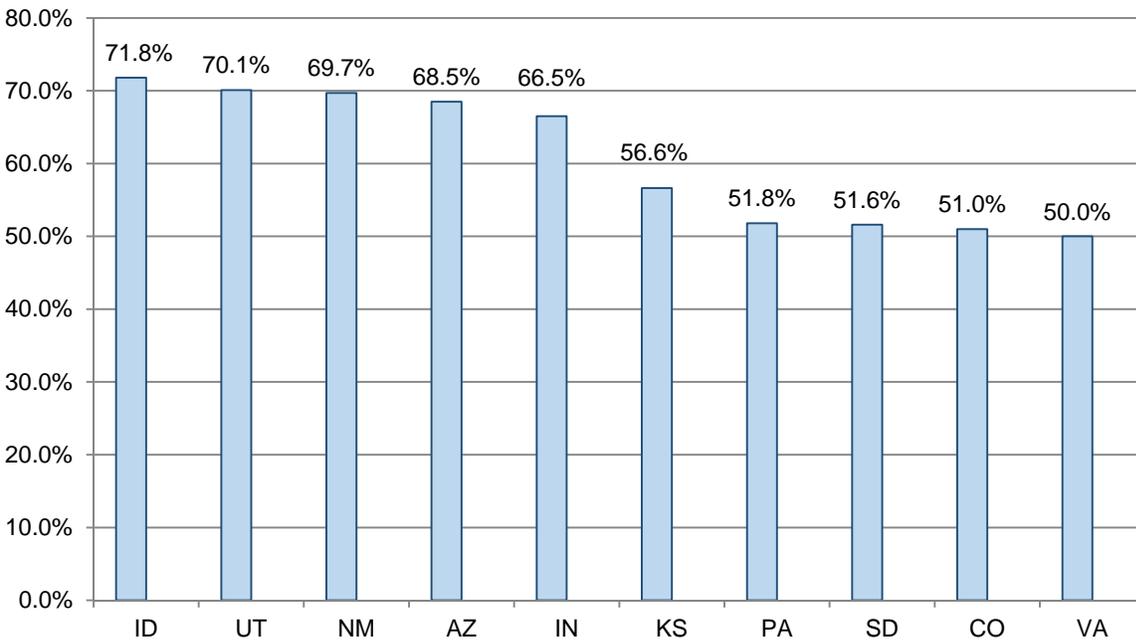


Source: National Conference of State Legislatures, September 2015

As Figure 4 shows, every state east of the Mississippi River, with the exceptions of Indiana and Pennsylvania, have COPN laws, and even those two states regulate nursing center beds in other ways. Indiana passed a nursing facility bed moratorium in 2015, showing that even in the absence of a COPN law, there is close attention paid to the regulation of nursing facility beds.

Reviewing the map of states with COPN laws also reveals that most of the 14 states without such laws are in the Southwest or the Mountain West. It should be noted that in most of these states, with the exception of California, Wyoming, Minnesota, and North Dakota, the federal government funds more of the state's overall Medicaid costs than is the case in Virginia, where the federal government funds 50 percent of the costs. In some cases the federal share of Medicaid is dramatically higher in these other states. This means the financial risk to the state of any incremental Medicaid expenditure is proportionally less. Figure 5 shows this comparison.

FIGURE 5
FY 2015 FEDERAL MEDICAL ASSISTANCE MATCH PERCENTAGE FOR
SELECTED STATES WITHOUT COPN FOR NURSING CENTER BEDS



Source: *Federal Register* (rounded to one decimal place)

STATES WITHOUT COPN USE OTHER REGULATORY MEANS TO RESTRICT THE SUPPLY OF NURSING CENTER BEDS

While 14 states do not use COPN to control the supply of nursing center beds, these states still regulate the supply of nursing center beds. Moratoria on new nursing facility beds are a common tactic that has been used for decades. As the Urban Institute noted in a 1998 report,

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 Medicaid¹.

Both states east of the Mississippi that do not have COPN for nursing facilities, Indiana and Pennsylvania, have used or are using moratoria or the equivalent to regulate the supply of nursing center beds.

While Pennsylvania sunset its COPN program in 1996, it began regulating and tightly restricting enrollment of new nursing facility beds in Medicaid as well as transfer of Medicaid-eligible beds among existing nursing facilities the same year. Given the

¹ Joshua M. Wiener, et. al., Urban Institute, “Controlling the Supply of Long-term Care Providers at the State Level,” an occasional paper (number 22) in the *Assessing the New Federalism* series, 1998.

importance of Medicaid as a payment source for nursing centers, this policy in effect regulated the supply of new nursing facilities. A June 2012 final regulation formalized what had previously been a policy practice, in response to a Pennsylvania Supreme Court decision that ruled the agency's policy position had been an un-promulgated regulation and would not remain effective without being formally promulgated².

West of the Mississippi, states that do not have COPN for nursing facilities also use other means to restrict the supply of nursing facility beds. For example:

- Minnesota's legislature imposed a moratorium on new nursing facility beds in 2014. The statute imposing the moratorium stated: "The legislature declares that a moratorium on the licensure and medical assistance certification of new nursing home beds and construction projects that exceed \$1,000,000 is necessary to control nursing home expenditure growth³." As the Minnesota Department of Health's web site notes: "Minnesota currently has a moratorium law (MN-Statute 144A-071) restricting the establishment of new nursing homes or the licensure of additional nursing home beds."
- North Dakota has had periodic moratoria on nursing facility beds. For example, a moratorium expired in 2007 but then was extended to 2009⁴.
- South Dakota had a moratorium on new nursing facility beds for more than 20 years until 2012. That year the state adopted a somewhat more flexible process allowing allocation of new beds to areas with a demonstrated shortage of beds from a pool of beds from facilities that had closed⁵. The first award of new beds was 20 additional beds for the Rapid City area in February 2014⁶.

CONCLUSION

The use of COPN for nursing center beds has achieved the goal of reducing Virginia Medicaid program's financial exposure for the cost of nursing center beds. While nursing facility beds are only about 10 percent of total Medicaid spending in Virginia, Medicaid is the predominant payer for nursing facility beds.

Under COPN, nursing center costs have grown much more slowly than costs for long term care waiver services, which have no such regulation.

Given that the vast majority (82 percent) of nursing center care is paid for by state and federal government payers with whom providers have little to no opportunity to

² Karl Thallner and Susan Edwards, Reed Smith, "Pennsylvania Revises Review Process for New Nursing Facility Beds: the Uphill Battle Continues," July 10, 2012.

³ *2014 Minnesota Statutes*, Office of the Minnesota Reviser of Statutes, 144A.071 MORATORIUM ON CERTIFICATION OF NURSING HOME BEDS

⁴ AARP review of long term care policy in North Dakota.

⁵ South Dakota legislative web site.

⁶ South Dakota Health Department, "Health Department Awards Additional Nursing Home Beds in Rapid City," March 7, 2014, <http://news.sd.gov/newsitem.aspx?id=15815>

negotiate for higher reimbursement, nursing facilities do not operate in a free market. Eliminating COPN could significantly hurt the Commonwealth's ability to provide care to nursing facility patients and residents.

Virginia's approach is a middle-ground between no regulation of the supply of nursing center beds and the moratoria on such beds that are applied in some states, including Virginia in the past. Every Southern state but Texas uses COPN to regulate nursing facility beds; nationally 36 states plus the District of Columbia use this approach. This includes every one of Virginia's neighboring states. Even among the 14 states that do not have COPN, other policies, including more restrictive ones such as moratoria, are used to regulate the supply of nursing center beds.