

Protecting Florida's Most Vulnerable: Market-Based Reform to Improve Nursing Home Care

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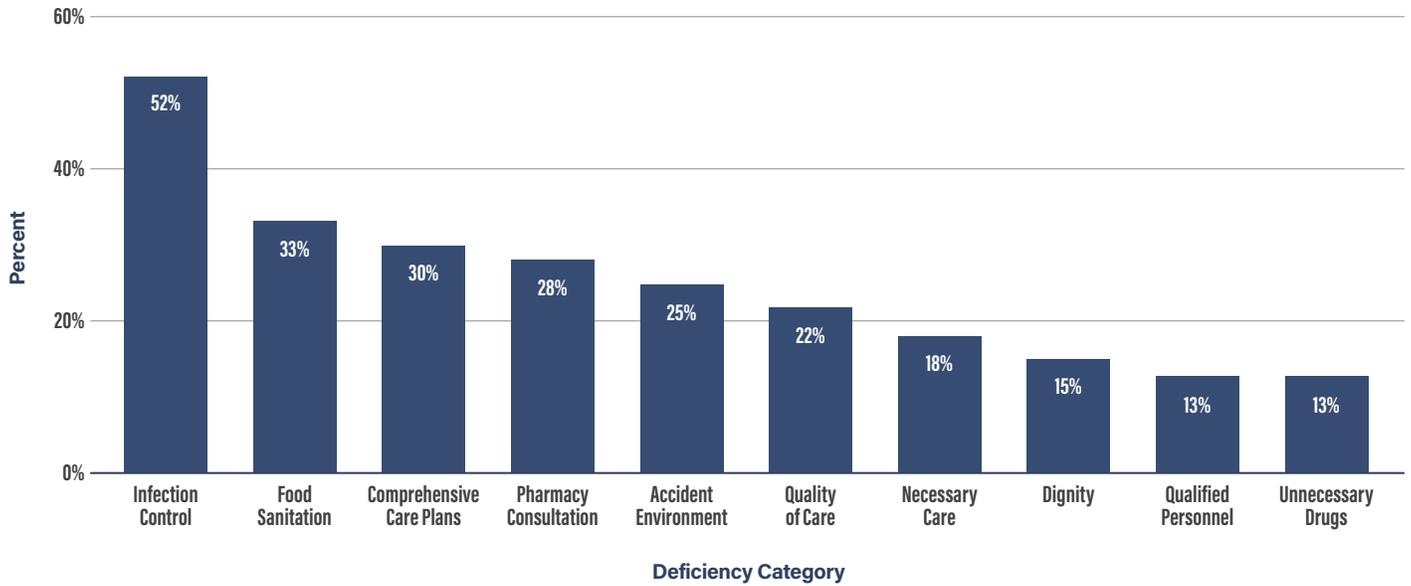
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1. Introduction

The COVID-19 pandemic has highlighted significant shortcomings in our healthcare system and, perhaps most particularly, in the nursing home industry. Strikingly, nursing home residents represent six percent of cases and 40 percent of fatalities nationwide. In Florida alone, more than 7,700 nursing home residents have died from COVID-19—about 40 percent of the state's total fatalities.¹

The tragedy unfolding in Florida's nursing homes is a consequence of long-standing failures in the industry nationwide. A recent report from the federal Government Accountability Office found that infection control problems were widespread before the pandemic.² In fact, infection control was the most common deficiency identified through regular inspections conducted by state survey agencies. Between 2013 and 2017, 82 percent of all facilities surveyed—and 87 percent of those surveyed in Florida—had an infection control deficiency in one or more years.³

FIGURE 1. Percent of Facilities with Top 10 Deficiencies



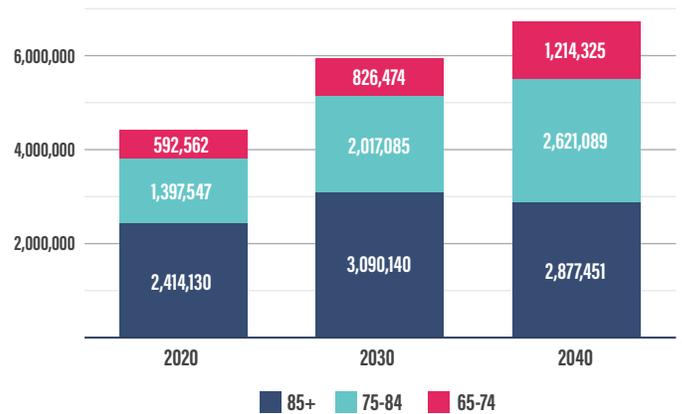
Source: Kaiser Family Foundation’s State Health Facts

The problem isn’t limited to infection control. In 2019 alone, a staggering 95 percent of facilities in Florida were cited with at least one violation of the Centers for Medicare and Medicaid Services’ (CMS) quality standards.⁴ Large percentages of Florida’s nursing homes had violations across a variety of categories including food sanitation, personnel qualifications, and inappropriate use of drugs (FIGURE 1).⁵

Ensuring the quality and affordability of nursing home care is especially important in Florida, where more than 20 percent of the population is over 65 years old. Today, Florida has approximately 700 licensed nursing homes caring for over 70,000 residents.⁶ That makes Florida home to the 6th highest number of nursing home residents in the nation. The demand for nursing home care is likely to increase as the share of the population over 65 years old is projected to climb to 1 in 4 Floridians by 2035.⁷ The population over 85 years old will more than double by 2040 (FIGURE 2).

As Florida’s elderly population continues to grow, the Sunshine State has a tremendous opportunity to become a national leader in the transformation of nursing home care. The remainder of this policy study outlines obstacles to, and opportunities for, the improvement of nursing home care in Florida. Section 2 explains respective roles of regulation, competition, and consumer access to information in improving nursing home quality. Section 3 describes the effects of Certificate of Need laws on costs, quality, and competition. Section 4 discusses promising innovations in the nursing home industry and potential policy barriers to their implementation. Finally, Section 5 provides recommendations for reform.

FIGURE 2. Projected Elderly Population in Florida



Source: Florida Office of Economic and Demographic Research

2. The Role of Regulation, Competition, and Information

The modern framework for nursing home regulation and oversight largely originates from the Nursing Home Reform Amendment to the Omnibus Budget Reconciliation Act of 1987. The act and associated regulations issued by the Centers for Medicare and Medicaid Services (CMS) establish residents’ rights and outline requirements for nearly every aspect of nursing home care. Nursing home facilities must meet these minimum requirements to be eligible for payments through Medicare and Medicaid—the two

largest sources of payment in the industry.

Enforcement of state and federal regulations is primarily the responsibility of state survey agencies who conduct regular inspections of facilities to ensure their compliance. When violations are detected, CMS and state agencies may issue penalties. Depending on the severity of violations, facilities may be subject to monetary penalties, mandatory training, temporary management, or denial of payments through Medicare and Medicaid. States may also issue their own regulatory standards in addition to federal requirements.

In 2016, CMS conducted a comprehensive review of existing federal regulations considering substantial innovations and changes in the industry over the past 30 years. The review culminated in the promulgation of a new rule which significantly expanded oversight in some areas while reducing other requirements that were deemed to be duplicative or overly burdensome.⁸ In response to these changes to federal rules, a debate has emerged among policymakers, industry groups, and resident advocacy organizations around the limitations and tradeoffs associated with regulation.⁹

The American Health Care Association, the largest trade association in the country for skilled nursing facilities, has characterized federal regulations as costly and overly burdensome. In a 2017 letter to HHS Secretary Tom Price, the Association argued that, given slim margins in the industry, “any small hiccup or lawsuit can result in a negative margin and force providers to close their doors.”¹⁰

Meanwhile, resident advocacy groups have praised new protections provided under the 2016 reforms and continue to push for additional regulation. For example, the Center for Medicare Advocacy celebrated new protections against abuse and additional training requirements but criticized the lack of minimum staffing requirements.¹¹

Considering the vulnerability of nursing home residents, there is a clear role for regulation and oversight. However, excessive requirements can impose unnecessary costs on care providers, distract from the core objectives of oversight agencies, and limit the potential for innovation. Regulation should therefore be clear, concise, and focused on preventing harm and abuse.

Moreover, regulation only creates minimum standards for care. It is essential that the nursing home industry also face positive incentives to provide care beyond any minimum standards. As in any other industry, competition is the best means to create incentives for providers to go beyond the minimum standards required by regulation.

Of course, consumers must have adequate information for competition to be effective at improving quality. Research has indicated that the availability of information about the quality of nursing homes can influence consumer choices and incentivize providers to improve quality ratings.¹² However, quality indicators are most

effective when they are easy to interpret.¹³ Greater effort should therefore be made to increase public awareness of nursing home comparison tools available through state and federal governments and to ensure that these tools provide reliable measures of quality that are easily interpreted by consumers.¹⁴

Importantly, the efficacy of information may itself be dependent on competition among care providers. A study examining the effects of nursing home report cards found that “nursing homes residing in more competitive markets improved their reported quality more than facilities in less competitive markets.”¹⁵ This is an intuitive finding given that information about the quality of nursing homes is only effective insofar as consumers have sufficient choice among potential providers. As a report from the Government Accountability Office notes, the federal Nursing Home Compare tool “encourages consumers making a decision about a nursing home to consider those with positive quality indicator scores—a use of market forces to encourage poorly performing homes to improve quality of care or face the loss of revenue.”¹⁶ Consequently, reform is needed to increase competition and incentivize providers to improve the quality of care.

3. Certificate of Need

Certificate of Need (CON) laws require healthcare providers to receive government approval in order to construct new facilities, expand existing ones, or offer new medical services. New York became the first state to enact a CON law in 1964. Over the next decade, 26 other states adopted CON laws. Further expansion of CON laws occurred in response to the National Health Planning and Resources Development Act of 1974—which required states to enact CON laws in order to receive federal funding. By 1982, every state except for Louisiana had some form of CON program. Since the federal mandate was repealed in 1987, several states have eliminated or modified their CON laws.¹⁷

Florida’s CON program was created in 1973 and has been reformed several times in the past 15 years.¹⁸ In 2019, Florida passed CS/HB 21, which eliminated CON laws for general hospitals, comprehensive rehabilitation, specialty hospitals, and tertiary health services.¹⁹ CON requirements were maintained for nursing homes, skilled nursing facilities, hospice programs, and intermediate care facilities for the developmentally disabled.²⁰

3.1 Evidence on Certificate of Need Laws

CON laws were promoted under the misguided notion that unregulated competition could lead to unnecessary spending and increase healthcare costs. This line of reasoning is, in part, based on a theory referred to as “Roemer’s Law.” Essentially, Roemer’s Law posits that a bed built is a bed filled. In other words, an increase in

supply will lead to an increase in healthcare use in excess of actual patient needs. CON laws therefore serve as a supply constraint on healthcare services and facilities in an effort to limit costs.

However, research indicates that CON laws have failed to accomplish the goals of preventing over-investment and reining in healthcare costs. A report from the Mercatus Center at George Mason University surveyed 20 peer-reviewed studies spanning four decades to examine the effects of CON laws along the dimensions of (1) per unit costs, prices, and charges; (2) total expenditures; (3) efficiency; and (4) investment.²¹ The findings in each of these categories are presented in **TABLE 1**.

TABLE 1. Summary of Certificate of Need Research

Per Unit Costs, Prices, and Charges	Three out of four studies found CON to be “associated with higher per unit prices, costs, or charges, while the fourth—which focused only on per diem Medicaid charges for nursing-home and long-term care—found that repeal of CON had no statistically significant effect on those charges.”
Total Expenditures	Seven out of twelve studies found that CON laws increased expenditures. Two found no statistically significant results while another two found that CON laws increased some expenditures while reducing others. Only one study associated CON laws with reduced expenditures, but the relationship was indirect.
Efficiency	The studies pertaining to hospital efficiency—how cost-effectively hospitals transform inputs into outputs—found mixed results. Two out of four concluded that CON laws lead to greater efficiency. Of the remaining two, one found evidence of reduced efficiency while the other found no statistically significant effect.
Investment	Two studies examined the effect of CON laws on reducing unnecessary investment. One found that CON laws change the composition of investments but fail to reduce investments overall. The other suggested that hospitals actually increased investment in anticipation of CON laws that would complicate future investments.

Source: Matthew D. Mitchell, “Do Certificate-of-Need Laws Limit Spending?” Mercatus Working Paper, the Mercatus Center at George Mason University, 2016. <https://www.mercatus.org/system/files/mercatus-mitchell-con-healthcare-spending-v3.pdf>

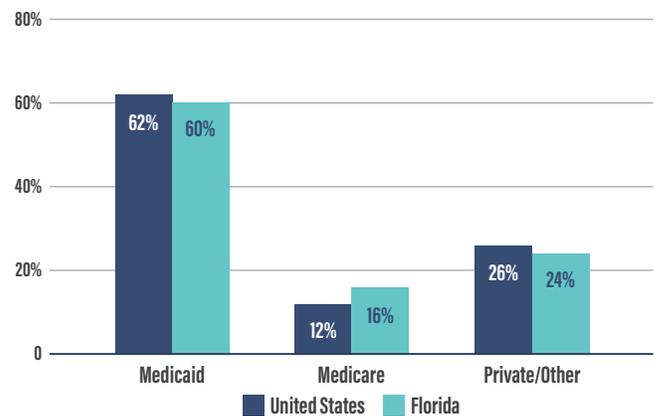
3.2 Nursing Home Certificate of Need Laws

Currently, 35 states have CON requirements for nursing home facilities or beds (**FIGURE 3**). Fifteen (15) states do not have CON requirements for nursing homes, but one of these states, Wisconsin, maintains a similar approval process for nursing home beds. Most of these states repealed their CON laws in the 1980s. Most recently, Wisconsin and New Hampshire repealed their CON laws in 2000 and 2016 respectively.²²

3.2.1 THE EFFECT OF NURSING HOME CON ON MEDICAID EXPENDITURES

Medicaid is the largest payer for nursing home care in Florida and the United States (**FIGURE 4**). In 2019, Medicaid was the primary payer for approximately 60 percent of Florida nursing home residents compared to Medicare at 16 percent and private sources at 24 percent.²³

FIGURE 4. Distribution of Certified Nursing Facility Residents by Primary Payer Source



Source: Kaiser Family Foundation’s State Health Facts.

Despite the overwhelming empirical evidence that CON laws do not reduce healthcare costs, proponents argue that limiting the number of nursing home beds will control Medicare and Medicaid costs. The literature on nursing home CON laws specifically is more limited, but also fails to associate the laws with lower expenditures. The two most recent peer-reviewed studies examining the relationship between nursing home CON laws and Medicaid expenditures are discussed in more detail below.

A 2003 article published in the *Journal of Medical Care Organization, Provision, and Financing* examined the effects of nursing home CON laws and construction moratoria between 1981 and 1998. During that period, 16 states repealed their CON laws and 25 imposed moratoria on the construction of new nursing homes. The authors found no statistically significant effect of CON repeal

allow the market to respond freely to price changes or federal policies.²⁸

In sum, the research indicates that nursing home certificate of need laws do not reduce Medicaid expenditures. They do, however, grant incumbent nursing home care providers undue market power and erect barriers to entry for competing providers. In effect, CON laws reduce choice for consumers and reduce competitive incentives to provide higher quality care. Based on this evidence, it is reasonable to conclude that eliminating CON laws would encourage greater competition without increasing costs.

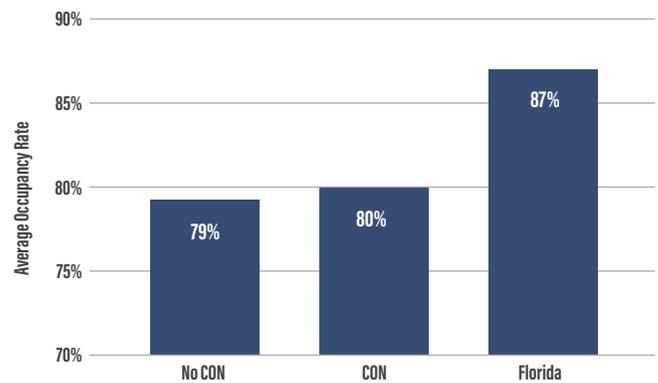
3.2.2 THE EFFECT OF NURSING HOME CON ON OCCUPANCY RATES AND QUALITY OF CARE

Proponents also argue that CON requirements improve quality by ensuring high occupancy rates. They suggest that eliminating Florida's CON program would lead to a dramatic increase in the number of nursing home facilities and beds. As a result, facility occupancy rates would decline, revenues would fall, and care providers would be unable to cover the costs required to provide quality care.²⁹ However, the available research does not support these claims.

A recent study found that both CON requirements and higher occupancy rates are actually associated with lower quality of care using county-level data in 48 states from 2012 to 2014.³⁰ The authors used scores from the National Nursing Home Survey which measures the cleanliness of the facility, staffing adequacy, and satisfaction ratings from a sample of residents in each facility. After controlling for other relevant demographic and economic factors, the authors found that survey scores are about 18 to 24 percent lower in states with CON requirements. Moreover, a one-point increase in the occupancy rate was found to result in a 0.5 percent reduction in survey scores on average. These results were robust under a variety of statistical models and tests.

There is also little evidence that high occupancy rates are dependent on the presence of CON requirements. Occupancy rates are comparable between states with CON laws and those without. As shown in **FIGURE 5**, the average occupancy rate in states with CON laws is 80 percent compared to 79 percent in states without CON laws. At 89 percent, the occupancy rate in Florida is unusually high. Only six other states have higher occupancy rates than Florida—two of which do not have CON laws.³¹

FIGURE 5. Certified Nursing Facility Occupancy Rates in States With and Without CON Laws



Source: Kaiser Family Foundation's State Health Facts.

There are better explanations for the variation in occupancy rates across states. For one, nursing homes are not popular compared to alternative options for eldercare. A 2007 Kaiser Family Foundation poll found that 64 percent of respondents over the age of 65 preferred to receive care in their own home. Only four percent preferred to receive care in a nursing home.³²

More recently, a 2016 survey conducted by the Associated Press-NORC Center for Public Affairs Research found similar results. The AP-NORC poll found that 77 percent of U.S. adults over 40 preferred to receive care in their own home compared to just four percent who preferred nursing home care.³³ Given the stated preferences of older adults, rapid growth in the home health industry may be a better explanation for declining nursing home occupancy rates than the absence of CON laws. To the extent that alternatives to nursing home care are available in each state, consumers are likely to pursue those alternatives.

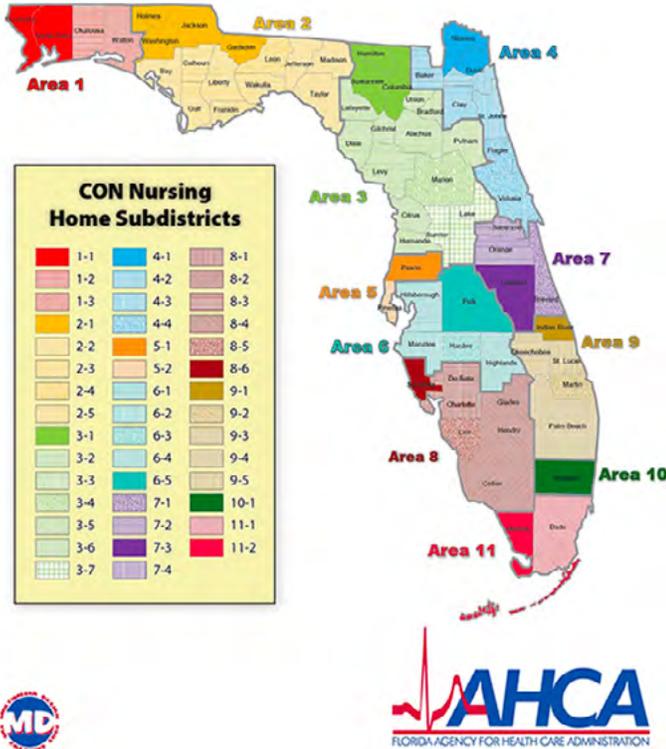
3.3 The Unintended Consequences of Florida's Nursing Home Certificate of Need Program

The bulk of evidence suggests that CON laws fail to achieve the goals of reducing costs, improving quality, or increasing occupancy rates. On the contrary, the evidence suggests that CON laws are associated with lower quality and higher costs. Moreover, the design of Florida's CON program may have significant distortionary impacts which benefit incumbent care providers to the detriment of consumers and potential competitors.

The Agency for Health Care Administration (AHCA) oversees Florida's CON program. The agency divides the state into 11 "districts" or "areas" which are then subdivided into subdistricts (**FIGURE 6**). CON approval decisions are dependent on the projected need for additional beds on the subdistrict level. Need pro-

jections are based on a formula and published by the agency twice a year. The formula uses current usage patterns and expected demographic changes to estimate the future nursing home bed need over a three-year planning horizon.

FIGURE 6. CON Nursing Home Subdistricts



Source: Florida Agency For Health Care Administration

While nursing home CON laws do not inherently lead to higher occupancy rates, Florida statute directs AHCA to “establish by rule a nursing-home-bed-need methodology that has a goal of maintaining a subdistrict average occupancy rate of 92 percent.”³⁴ Accordingly, the projected need determined by the AHCA formula is “adjusted to reflect the current subdistrict occupancy... and a desired standard of 92 percent occupancy.”³⁵ If the current occupancy rate is less than 85 percent, the agency sets the need in the subdistrict to zero “regardless of whether the formula would otherwise show a net need.”³⁶

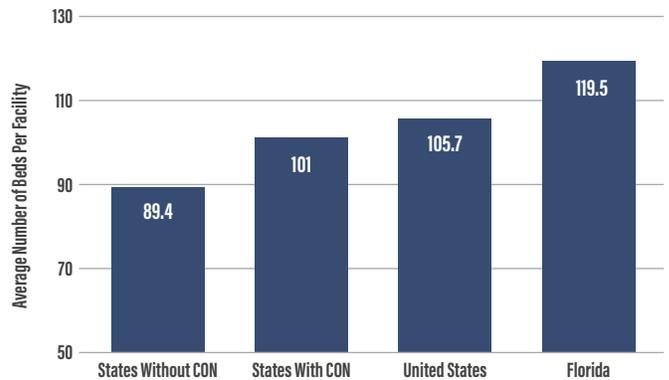
This objective benefits existing nursing home care providers at the expense of consumers and potential competitors. When high occupancy rates result from government mandates, it necessarily requires a restriction of competition. In effect, this eliminates competitive incentives to improve quality and limits the choices available to consumers.

Moreover, Florida’s CON program tends to lead to older, larger nursing facilities by protecting existing providers from competition and favoring expansions over new construction. CON

requirements limit the construction of new, state-of-the-art facilities. Instead, older outdated facilities are kept afloat by anti-competitive restrictions on new development. As a result, over 30 percent of Florida’s nursing homes were built before 1981 and about 16 percent are over 50 years old.³⁷

Florida also tends to have larger facilities on average than other states, especially compared to those without CON requirements (FIGURE 7). Documents obtained from AHCA provide facility-level information on 647 facilities in Florida. According to this data, Florida nursing homes have an average of 125 beds per facility. The largest facility has over 400 beds, and just over 20 percent have fewer than 100 beds.³⁸

FIGURE 7. Average Number of Beds Per Facility



Source: Kaiser Family Foundation’s State Health Facts.

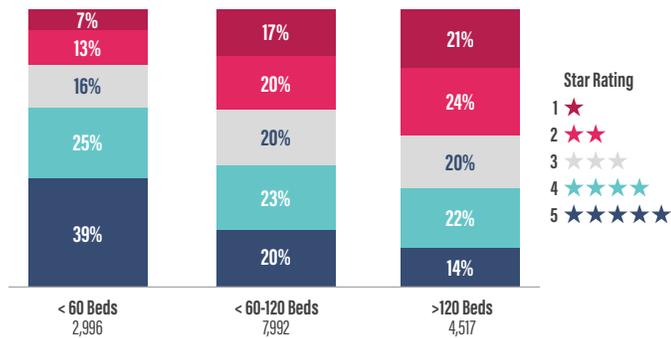
Additional data from the Kaiser Family Foundation allows for inter-state comparison. According to the KFF data, Florida has approximately 120 beds per facility compared to the national average of 106 beds.³⁹ States with CON laws have an average of 101 beds per facility while states without CON have an average of 89 beds per facility. This effect may be partially explained by population size and density, but CON may also play a role. For instance, California is a large, geographically-diverse state that is comparable to Florida. Yet the average number of beds per facility in California, 98.5, is considerably lower than in Florida.

■ As a result, over 30 percent of Florida’s nursing homes were built before 1981 and about 16 percent are over 50 years old.

A 2015 issue brief from the Kaiser Family Foundation examined trends in the Centers for Medicare and Medicaid Services Five-Star Quality Rating System. The report compared ratings across a variety of facility characteristics including facility size measured by the number of licensed beds in each facility. The findings indicate that larger facilities tended to receive lower quality ratings

than facilities with fewer beds (**FIGURE 8**). The trend was consistent between nonprofit and for-profit providers.⁴⁰

FIGURE 8. Quality Rating by Nursing Home Size



Note: Analysis is based on the overall composite star rating score for nursing homes. Analysis includes only nursing homes certified by either Medicare or Medicaid and excludes nursing homes with unavailable star ratings.

Source: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

This trend is supported by peer-reviewed academic publications. A 2017 paper published in *The Journals of Gerontology* examined the relationship between deficiencies reported by state surveyors with facility staffing hours per resident day, resident characteristics, facility characteristics, and states. The authors found that “smaller facilities (16–60 beds and 60–119 beds) were less likely to have quality of care and quality of life deficiencies and had fewer total deficiencies than larger facilities.”⁴¹ Another study found that larger facilities were associated with lower satisfaction ratings among the families of nursing home residents.⁴²

CON laws not only fail to achieve their goals, but they are also actually counterproductive to the extent that they reduce competitive incentives to improve quality, limit construction of new facilities, and tend to result in large-scale institutional care settings. The next section explores promising developments in the nursing home industry and how CON laws and other regulations may present barriers to innovative care models.

4. Opportunities for Innovation

There is a growing movement in the industry to rethink the traditional approach to nursing home care. The goal of this “culture change” movement is to move away from an impersonal, clinical model that conceptualizes nursing homes as primarily healthcare institutions. In its place, the culture change movement seeks to foster a person-centered approach that prioritizes resident autonomy and quality of life.

The Pioneer Network, a major leader in the movement, defines culture change as “the transformation of older adult services, based on person-directed values and practices where the voices of elders and those working with them are considered and respected.” They identify “choice, dignity, respect, self-determination and purposeful living” as core values of person-directed care.⁴³

Several care models for implementing culture change have arisen internationally and in the United States.⁴⁴ For the purposes of this policy study, culture change initiatives that emphasize the importance of small-scale, home-like care environments are of particular interest because state-level policy can create unnecessary hurdles to their implementation.⁴⁵ The Green House model is the most prominent example of such initiatives in the United States.

Under the Green House model, care is provided in small homes with a maximum of 12 residents. Each resident has their own private bedroom and bathroom. A shared living space including an open kitchen and communal dining table are at the center of the home. The goal of the architecture is to encourage a sense of community and shed the institutional nature of traditional nursing facilities while maintaining comparable levels of care. Organizationally, the Green House model is less hierarchical than traditional facilities and lends greater autonomy to residents and direct care providers.

Research has supported the quality-of-life benefits of the Green House model. A 2007 study found that residents in Green House nursing homes reported higher quality of life than residents in traditional facilities along several dimensions including privacy, dignity, autonomy, and food enjoyment.⁴⁶ Importantly, the quality-of-life improvements in Green House homes can be achieved at costs comparable to traditional nursing homes.⁴⁷

Empirical evidence on the clinical outcomes associated with the Green House model are less clear, but generally indicate little or no significant difference compared to traditional facilities. Mixed findings from empirical research may be due to methodological differences across studies and variation in the implementation of the Green House model.⁴⁸ One of the more robust analyses of the Green House model’s impact on quality identified improvements in rehospitalizations and other measures of quality including the number of bedfast residents, catheter use, and the incidence of pressure ulcers. As the authors noted, “The absence of evidence of a decline in other clinical quality measures in [Green House] nursing homes should reassure anyone concerned that [Green Houses] might have sacrificed clinical quality for improved quality of life.”⁴⁹

These findings indicate that there are promising opportunities for innovation in the nursing home industry, but there is insufficient evidence to favor one care model over others. While culture change initiatives and the Green House model may provide some residents with greater quality of life, feelings of at-homeness are

subjective. For example, one study found that some residents feel “at home” in traditional facilities.⁵⁰ As the authors concluded, “There is no one size fits all approach.”⁵¹

From a policy perspective, barriers to innovation ought to be lowered and choice maximized without explicitly encouraging the adoption of any particular model. As experiences with culture change initiatives have revealed, private efforts to improve quality of life and clinical outcomes are possible outside of government policy. The key is to unlock the potential for innovation by ensuring that regulations are not overly prescriptive while also providing an appropriate level of accountability.

For example, building standards can limit the ability to create home-like facilities. While Florida’s building codes for nursing homes have special provisions for home-like facilities, the remaining requirements are still highly restrictive and may prevent residents from exercising control over the furniture and layout within their private rooms. Care should be taken to ensure that building standards allow appropriate flexibility and are limited to those necessary to ensuring safety.

Florida’s CON program also presents a barrier to the construction of small-scale facilities by limiting new construction.⁵² Ultimately, the size and style of nursing homes constructed should be determined by the market and consumer preferences rather than a centralized bureaucracy.

5. Policy Recommendations and Conclusions

Nursing home care is among the most highly regulated industries in the country. Considering the vulnerability of nursing home residents and the potential for neglect and abuse, some degree of regulation and oversight is necessary and appropriate. However, policymakers must acknowledge the limitations and tradeoffs associated with regulation.

First, it is important to align regulatory standards with available funding through Medicare and Medicaid. Regulatory compliance can be costly for care providers, so additional regulations may require additional spending on the part of state and federal government. Regulations should therefore be clear, concise, and



limited to those that are necessary to ensure safety and prevent abuse. Regulations should also be focused on holding providers accountable for outcomes rather than inputs.

Second, lawmakers must recognize that regulatory requirements only create minimum standards of care. They do not create incentives for providers to go beyond those minimum standards. The best way to encourage quality beyond regulatory standards is competition. Hence, anti-competitive policies like Certificate of Need laws should be eliminated. Overwhelming evidence suggests that CON laws do not achieve their goals of reining in costs or improving quality. They do, however, tend to result in large-scale institutional care settings, protect incumbent providers from competition, and prevent the construction of new and innovative facilities. The costs of these unintended consequences far outweigh any potential or perceived benefits.

Finally, transparency and access to information are essential for consumers to assess the quality of nursing homes. Efforts should be made to improve the Florida Health Finder tool to provide quality indicators that are easily interpreted and reliable. Combined with a vibrant, competitive market, this will provide Floridians with the information they need to make decisions regarding care for themselves and their loved ones.

In the coming years, a growing elderly population will require the construction of additional facilities across the state. Consequently, Florida is faced with an opportunity to chart a course for the future of nursing home care. It is incumbent upon us to embrace that future, rely on evidence-based policy decisions and abandon the top-down approach of the past to ensure quality and unleash the limitless potential of innovation.

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