Section Three –
Medicaid Issues –

CERTIFICATE OF NEED

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Issue Statement

In North Carolina, Certificates of Need (CONs) are required prior to the development or expansion of health facilities or services: specifically, new beds in hospitals, nursing homes, Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), high technology equipment and home health services.

The Department of Human Resources, Division of Facility Services, is responsible for reviewing and determining the appropriateness of all certificate of need applications. Approval of a CON is contingent on whether there exists a need for additional beds or services based on the projected needs for these services. It is questionable whether the current process to grant CONs and the methodology to project need has served to control the development of new beds, services, and high technology equipment.

Background

The Certificate of Need process, adopted nationwide pursuant to the 1982 Amendments to the Social Security Act, produced state programs which have varied in practical application among the states. Overall, CON programs have been used to review and determine need for:

- Developing new or additional acute and rehabilitative hospital beds
- Developing or expanding nursing facilities or intermediate care facilities for the mentally retarded
- Purchasing new and costly high technology equipment

The CON process is directly linked to a state's Medicaid expenditures, given that Medicaid pays a significant portion of hospital and long-term care facility expenditures. For instance, it is estimated that nationally 11.4 percent of all hospital days are paid for by Medicaid and over 45 percent of payments to long-term care facilities are paid for by Medicaid.

In order to control Medicaid expenditures for hospitals and long-term care facilities, states have tied Medicaid reimbursement for their services to maximize statewide health care planning efforts and promote cost-effective reimbursement policies. For instance, several states have limited their reimbursement for capital expenditures to hospitals and nursing facilities which have low occupancy rates and do not need the same level of capital as those hospitals and nursing facilities that are operating more efficiently and economically.

Other states have taken a more proactive approach in controlling Medicaid expenditures by placing moratoriums on CONs for health services and long term care facilities, especially in areas of the state that may have an excess of hospital or nursing home beds.

The effectiveness of CON in controlling Medicaid expenditures varies among states. In general, states have had more success in controlling the growth of nursing facilities versus hospital beds and equipment expenditures. As indicated earlier, states' Medicaid expenditures account for more than 45 percent of expenditures for nursing homes, and a modest share of expenditures for hospitals and high technology equipment.

In North Carolina, State Medicaid expenditures for residents in nursing facilities account for 67 percent of all payments to these facilities, whereas Medicaid payments to hospitals accounted for only 14 percent of total hospital revenues. Only 12 percent of the Medicaid payment to hospitals represents expenditures for fixed and moveable medical equipment. Thus, while Medicaid payment levels can affect nursing facilities' willingness and ability to build and expand, payment policies may have little influence over hospitals' decisions.

In North Carolina, a CON is required prior to the development of hospitals and facilities identified in the State Health Facilities Plan. Services and facilities requiring a CON include:

- Renovating and constructing acute health service facilities including medical equipment
- Developing long term care nursing facilities or additional beds in these facilities
- Developing new psychiatric facilities and ICFs/MR beds
- Developing or expanding inpatient rehabilitation facilities
- Expanding or developing ambulatory surgical facilities

Under General Statute 131E-177, the Certificate of Need Section of the Division of Facility Services, (DFS), Department of Human Resources, is the designated Health Planning and Development Agency for North Carolina. DFS conducts statewide inventories of services and is responsible for determining the need for health services facilities including hospitals and nursing homes.

In 1992, the Division of Facility Services received 256 CON applications to develop or expand the health care services and facilities discussed above. Of these 256 applications, 148 were approved. The number of denied applications totalled 108.

Prior to applying for a CON, an entity must file a letter of intent with DFS which outlines the project, proposed costs and filing date of application. DFS then determines whether the proposed project requires a CON. If it is determined that the project requires a CON, DFS will determine the appropriate service category (delineated above), the type of application

form to be submitted, the applicable review period for each application, and the deadline for submitting a CON.

A CON application must include a processing fee. These fees are as follows:

Activity	Fee
Renovation or addition of beds to an existing ICF/MR	$400
Capital expenditures of less than $500,000	$1,000
Capital expenditures of $500,000 or more	.002% of capital expenditures

No fee may exceed $15,000.

Currently, revenues from applications total almost $800,000, financing 75 percent of the costs associated with the administration of the CON program.

Once DFS determines an application is complete, it has 90 days to review the application. The period for review may be extended for an additional 60 days if the application exceeds DFS capacity for review. DFS reviews the application based on several criteria:

- Scope of services being offered
- Projected utilization of services or occupancy of facility
- Projected patient origin
- Appropriate numbers and types of staff
- Accessibility of services, especially to under insured, indigent patients
- Availability of necessary medical equipment

If the applicant meets or exceeds the criteria, a CON will be issued within 30 days.

Wide variation exists in the approaches taken by the thirty-eight states which continue to administer CON programs. Differences in regulatory approaches primarily result from the diverse purposes and interests served by each state's CON program. The intent of CON programs varies substantially in terms of the types of projects subject to CON review, administrative processes, and effectiveness in controlling state financing of capital costs earmarked for long-term care services. State CON programs may vary based on regulatory structure, evaluation criteria, and the link between CON and Medicaid reimbursement. Each of these are discussed below. A detailed matrix comparing CON programs across Health Care Financing Administration (HCFA) Region IV states is contained in the appendix to this paper.

A number of states set sunset dates for the repeal of their CON programs. However, as the sunset review dates for programs neared, some have decided to extend the sunset dates and

continue the programs. States which have extended sunset review dates include Indiana, until 1993, West Virginia and Tennessee, until 1997, and Montana, extended indefinitely.

Some states, including North Carolina, have introduced moratoria for the construction of nursing homes. Of the eight other states in the HCFA southeast region, only Mississippi has a moratorium on construction or renovation of new nursing facilities. Kentucky has a moratorium on construction or expansions of ICFs/MR. Florida has a moratorium on home health agencies or offices.

Among the states which do not operate CON programs, moratoria on the construction of new nursing beds or Medicaid beds are common. Texas, Colorado, Wyoming, New Mexico and Utah are among the states which do not have a CON program, but utilize moratoria and similar controls to contain health care costs. Virginia established a moratorium for long-term care beds in 1988, which remains in effect until 1993. An exception to the Virginia moratorium exists for the conversion of beds from acute care to nursing care beds. Texas and Indiana enforce a selective moratorium on nursing care bed construction. The limitation affects only Medicaid beds; private pay beds are exempt from the controls.

Two states, Maine and Mississippi, require legislative approval for the addition of new nursing beds. The requirement may be an effective tool in containing costs and enables the legislature to retain greater control of state expenditures for long-term nursing care. South Carolina recently repealed legislation requiring General Assembly approval of additional facility beds.

Most states determine whether construction or renovation of a health care facility requires a CON according to the total capital expenditures and the net change in bed supply. Many states set capital expenditure thresholds so low (Vermont, $300,00) that virtually all projects are reviewed, while other state thresholds are so high that few projects are subject to review (Nevada, $4 million). In 1987, North Carolina increased the capital expenditure threshold from $1,028,000 to $2,000,000. Other states capital thresholds for CON approval appear in Exhibit 1. Additionally, the North Carolina CON regulations contain provisions which encourage conversion of acute care beds to long-term care beds. Despite low occupancy rates in several hospitals, however, facilities are hesitant to convert beds.

EXHIBIT 1

CON THRESHOLDS FOR CAPITAL EXPENSES

State	Threshold
Alabama	$500,000
Alaska	$1,000,000
Arizona	$75,000
Arkansas	$500,000
California	N/A
Colorado[1]	N/A
Connecticut	$400,000
Delaware	$250,000
D.C.	$600,000
Florida	Any capital expense
Georgia	$515,592
Hawaii	$1,000,000
Idaho[1]	N/A
Illinois	$1,000,000
Indiana	N/A
Iowa	$400,000
Kansas[1]	N/A
Kentucky	$1,545,000
Louisiana	N/A
Maine[2]	$500,000
Maryland	$1,250,000
Massachusetts	Any substantial capital expense
Michigan	$750,000
Minnesota	$500,000
Mississippi	N/A

1. State has no CON program 2. Nursing facility threshold only

EXHIBIT 1 (Continued)

CON THRESHOLDS FOR CAPITAL EXPENSES

State	Threshold
Missouri	$600,000
Montana[2]	$1,500,000
Nebraska	$1,253,346
Nevada	$4,000,000
New Hampshire	$400,000
New Jersey	$400,000
New Mexico[1]	N/A
New York	Varies by equipment and facility
North Carolina	$2,000,000
North Dakota	$600,000
Ohio	$2,000,000
Oklahoma	$500,000
Oregon	$500,000
Pennsylvania	$1,000,000
Rhode Island	$2,000,000
South Carolina	$400,000
South Dakota[1]	$400,000
Tennessee	N/A
Texas	$2,000,000
Utah	N/A
Vermont	N/A
Virginia[2]	$250,000
Washington	N/A
West Virginia	All capital expenditures
Wisconsin	$300,000
Wyoming[1]	$600,000

1. State has no CON program 2. Nursing facility threshold only

Source: 1992 Guide to the Nursing Home Industry, published by Health Care Investment Analysts and Arthur Andersen

Many states, including North Carolina, require CON approval for any transfers in ownership. Some states, however, waive the CON requirement when the state is notified of the purchase or acquisition in advance, and the new owner makes a commitment to not alter the bed complement or services provided by the facility. States which provide for this type of exemption include Rhode Island, Pennsylvania and Maryland. The fact that North Carolina does not have a specific provision regarding waiver of CON review for transfers in ownership reflects the State's commitment to use the CON program as a means to ensure the quality provision of care, by reviewing each prospective owner's fitness, willingness and ability to operate a nursing facility.

Some states attempt to ensure access to long-term care for Medicaid patients by requiring facilities to serve a percentage of Medicaid patients as a condition of CON approval. Pennsylvania and Maryland require facilities to serve a proportion of Medicaid patients equal to the current percentage of Medicaid patients served by existing facilities in the same geographic area of analysis. Massachusetts requires a new facility to provide sixty percent of its services to Medicaid patients. Other states, such as Illinois, do not require facilities to serve a percentage of Medicaid patients, but do consider access for Medicaid patients in the CON approval process.

Among the states with CON programs, approximately seventy-five percent charge an application fee in order to offset some of the costs of operating the program. Fee amounts in most states vary according to the total cost of the proposed project. Fees range from $100 in Kentucky to $30,000 in Tennessee. Approximately one-third of the states with application fees establish fee amounts which are sufficient to cover the costs of their CON programs. In addition to application fees, the states of New Hampshire and Maryland charge all facilities an annual administrative or user fee in order to offset CON program costs.

The geographic area of analysis used to project bed need varies among states. Although most states in the Health Care Financing Administration's southeast region use county as the geographic area of reference, others are using larger substate regions to project bed need. Florida and Mississippi both use multi-county areas to project bed need. A recent report in Maryland by Maryland Health Resources Planning Commission has estimated that bed need estimates using state versus county as the area of reference would decrease bed need estimates by 60 percent.

The North Carolina DFS evaluates need for expanding or developing new hospital beds by various methods, depending on the service or facility being proposed and demographic and geographic factors. For instance, the need for additional inpatient hospital capacity health services is based on six multi-county health services areas.

Bed need for long term care facilities is determined on an individual county basis, based on the number of beds per 1,000 population for persons in the following age groups:

- under 65 years of age
- 65-74 years of age
- 75-84 years of age
- 85 years and older

While many states use similar age groups, this approach is institutionally biased. That is, it assumes that the current rate of institutionalization is appropriate. This approach does not take into account alternatives to facility-based care (i.e., home and community services) which are available to residents in the community.

Some states have addressed this shortcoming by including the wide array of long term care services available in the community in their projections of nursing home bed needs. New Jersey requires CON approval of nursing homes, residential health care, home health and continuing care communities, and relies on the applicant's agreement to include other long-term care alternatives (e.g., personal care) in their service packages. This assists in overcoming inappropriate placements. The State also mandates a minimum thirty-six percent occupancy by direct placement Medicaid or Medicare patients before CON consideration is allowed. Any consideration of CON requests must first confirm to these more stringent tests.

The need for ICFs/MR, psychiatric inpatient services and substance abuse inpatient and residential services in North Carolina is determined by a formula based on need in 41 mental health catchment areas. Bed need projections for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are based on population multiplied by .0002832 (incidence of MR/1000), from which the community ICF/MR beds already available in each area are subtracted. The need for short term psychiatric beds is based on days of care, length of stay and other demographics for all psychiatric patients.

In the State of North Carolina, the rate approved as part of the CON application process is the maximum rate of reimbursement under Medicaid for the first two years. Traditionally, Medicaid establishes rates for the facility's first two years of operation which equal the costs approved in the CON. Most states in the HCFA Southeast Region do not use the costs approved in the CON to establish Medicaid rates to new facilities. Instead, they reimburse new facilities the average rate calculated for all facilities. Other states, including New Hampshire and Massachusetts, use costs approved in the CON to establish Medicaid reimbursement rates for capital costs only.

Findings

Finding 1: The Certificate of Need process has not been effective in controlling the development and expansion of hospital beds and purchase of high technology equipment in North Carolina.

In FY91, acute care hospitals in North Carolina had 21,881 licensed beds, excluding rehabilitation, long term care, psychiatry and substance abuse capacity. Slightly less than 5 million days of care were provided in these beds, for an average occupancy of 60.4 percent, a decrease of over 6 percent from FY85 occupancy rates and 10 percent less than the national average of occupancy rates for all hospitals.

In addition, the average cost per hospitalization in North Carolina increased by 75 percent between 1985 and 1991. A major factor related to this increase is the proliferation of high technology medical equipment and the growing frequency of expensive procedures (i.e. heart surgery). Adjacent hospitals have purchased similar equipment to be able to compete with each other and attract quality physicians to their staff.

Finding 2: North Carolina's current methodology for projecting need for additional long-term care facilities beds can be improved.

Although the ratio of nursing facility beds to 100,000 population is relatively lower in North Carolina than in other states (Exhibit 2), and occupancy is relatively high, there are other factors to consider in determining how many nursing facility beds there should be.

- The nursing home bed projection methodology considers only institutional services. This continues to build a bias toward institutional, more expensive care. To gain control over long-term care expenditures, the State must promote both institutional and community care.

  To address the "woodwork effect" (the increase that occurs when individuals who were treated by family members at no cost to the Medicaid program, obtain home- and community-based care services from Medicaid when they are available) a strong screening instrument, which measures patient needs to assure appropriate payment is needed. Stringent screening criteria could free some existing beds.

- North Carolina Medicaid pays for a higher proportion of nursing home days than states do nationally -- about 67 percent compared to 45 percent. In addition, as discussed in the nursing facilities reimbursement issue paper, Medicaid reimburses about 99 percent of Medicaid costs per diem. In other words, almost two-thirds of every new nursing home bed that comes on line is paid for by the State. The State has a major stake in the expansion of nursing home beds.

EXHIBIT 2

NURSING FACILITY BEDS

State	Date	Number of Beds per 1,000 AGE 65+	Number of Beds Per 1,000 AGE 75+
Missouri	1/92	82.74	182.57
Nebraska	1992	82.48	175.07
Minnesota	2/92	80.85	173.56
Kansas	5/92	80.63	173.78
Oklahoma	1992	79.79	159.32
Indiana	10/91	79.49	188.14
Louisiana	1992	79.34	189.92
South Dakota	1991	78.52	164.9
Iowa	12/91	77.64	164.83
North Dakota	2/92	76.99	161.1
Wisconsin	1992	74.23	163.0
Arkansas	2/92	71.13	159.94
Montana	2/92	68.79	153.33
Texas	1992	68.09	162.68
Connecticut	1992	67.81	156.84
Illinois	12/91	67.27	155.21
Rhode Island	1992	67.09	153.5
Ohio	1992	63.54	152.94
Massachusetts	3/92	62.84	141.64
Maine	3/92	61.58	140.04
Wyoming	3/92	60.4	144.95
Georgia	3/92	59.52	144.27
Colorado	12/91	58.91	143.1
Delaware	1992	58.9	152.7
Vermont	1992	58.7	131.1

EXHIBIT 2 (Continued)

NURSING FACILITY BEDS

State	Date	Number of Beds per 1,000 AGE 65+	Number of Beds Per 1,000 AGE 75+
Tennessee	1992	54.48	128.06
New Hampshire	1992	53.26	122.69
Pennsylvania	12/91	53.18	126.51
Utah	1992	51.39	124.45
Maryland	1992	51.36	129.63
Kentucky	1992	50.7	118.8
Washington	1992	48.41	115.18
Idaho	1992	48.21	113.49
Mississippi	1992	47.23	107.11
Alaska	1992	47.16	154.67
Michigan	1992	45.53	110.07
New York	1992	44.82	103.64
Alabama	1992	43.53	102.65
Virginia	1992	42.42	105.81
New Jersey	3/92	42.31	102.06
North Carolina	1992	40.15	106.16
New Mexico	1992	39.55	96.87
South Carolina	2/92	39.29	102.51
West Virginia	11/91	37.49	88.24
Oregon	1991	37.41	86.72
California	1992	36.98	89.73
Arizona	1992	33.38	84.68
Nevada	1992	29.46	88.39
Florida	3/92	28.31	66.38
Hawaii	12/90	26.28	69.71

Source: 1992 Guide to the Nursing Home Industry, published by Health Care Investment Analysts and Arthur Andersen

The DFS estimates that during the period from FY91 and FY92 over 6,500 new nursing home beds will have been constructed. However, the State projects that an additional 400 beds will be needed to meet the needs of long term care population. As indicated earlier, alternatives to nursing home care are not factored into the bed need methodology.

The Division of Facility Services has approved 160 additional ICFs/MR beds for next year, even though the Division of Developmental Disabilities has indicated that 236 individuals currently residing in these facilities do not need this level of care and their needs would more appropriately be served by home- and community-based care. In addition, the Division has recently surveyed ICF/MR providers to determine the number of individuals currently waiting for services. The results of this survey indicated that only 96 individuals were identified as waiting for ICF/MR placement. The additional ICF/MR beds will be costly to the State; these findings suggest some of these expenditures may not be necessary.

Finding 3: North Carolina CON does not address major medical equipment purchases.

In 1987, the CON law eliminated a separate threshold of $600,000 for the purchase of major medical equipment. Costly new technologies -- lithotripters, MRI scanners, linear accelerations -- are not subject to review because expenditures for these services can fall under the $2 million capital expenditures threshold. These are costly services and increase the cost of medical services to all consumers. While Medicaid's inpatient hospital reimbursement methodology has controlled capital expenditures, other payors bear the additional costs of these services.

Finding 4: Application fees collected by the Certificate of Need program do not cover the cost of this program.

Fees collected by the CON process do not cover the costs incurred by the CON program. Currently, the DFS budget for the CON program is $800,000. Fees generated by the program cover 75 percent of program expenses. Other states with CON agencies have increased fees or downsized staff to fund this program without state revenue.

Recommendations

Recommendation 1: Change the current bed need formula by expanding the size of current health planning areas to include larger geographic regions and including alternative (non-institutional) services.

The bed need formula uses counties, multiple counties and arbitrary regions as the geographic planning areas for projecting health facility bed need. Other states have indicated that expanding these areas to include several counties has provided more accurate portrayal of bed need than single county projections. Specifically, the State should combine similar services in their health planning areas. For instance, acute psychiatric and general

acute hospitals could have the same planning areas. Nursing homes and ICFs/MR should have similar planning areas since the nursing home bed methodology includes projections for adults who are under 65 years of age.

Maryland has recently studied the implications of increasing the size of its geographic planning areas from individual county-based to multiple counties. For FY94, the State health facilities planning agency projected the need for 1,076 additional comprehensive care beds. Maryland found if need were projected statewide versus county-based, the projection would have been only 319 beds, 70 percent less than the projected amount under the current bed need methodology.

Another major shortcoming of the current bed need projection methodology is its reliance on current rates of institutionalization. It does not currently take into account persons who have been identified as actually needing services or individuals who would be deflected from ICF/MR care to home- and community-based services. Including potential utilization of home- and community-based services by individuals seeking ICF/MR or nursing care will provide a more accurate projection of bed need.

Recommendation 2: North Carolina should implement a moratorium on developing ICF/MR beds.

The Certificate of Need program has approved the development of 160 new ICF/MR beds for FY93. However, the actual need for these new beds is questionable considering the Division of Developmental Disabilities has identified 236 individuals residing in ICFs/MR who no longer need the level of care provided in these facilities. In addition, the Division has documented, through a provider survey, that 96 individuals are currently requesting ICF/MR services. If the 236 ICF/MR residents, who are considered inappropriately placed, were transitioned to home- and community-based services, the supply of ICF/MR beds would be sufficient for several years, based on the actual number of individuals currently waiting for ICF/MR services.

If beds were not allowed to come on-line at the current rate, there would be increased demand on community-based services, which are more cost-effective, provided under the Medicaid waiver program for individuals who are older or mentally retarded. The Medicaid Waiver program is currently at or near capacity. Further recommendations regarding expansion of the Medicaid waiver program are presented in Issue Paper 7.

Because the State is considering the development of case-mix based rates which are based on the resources needed to treat recipients, some inappropriate placements may be avoided. A move to a prospective capital reimbursement methodology may also stem growth. However, in the interim, a moratorium can achieve savings.

Implications:

- In addition to achieving greater control over expenditures for ICF/MR services, recipients will be more appropriately placed for services.

- Additional community services should be made available.

*Recommendation 3: **CON should continue for long-term care beds; reimbursement system changes should be used to promote savings.***

Without CON, nursing home expenditures in the State will increase dramatically. Until more community-based services are available, and stringent screening criteria to assess patient needs are implemented, CON is necessary.

Implications:

- New community-based services must be made available.

- Stringent patient screening is necessary to ensure appropriate placement and utilization of community-based services.

*Recommendation 4: **Decrease the capital threshold to $500,000 for projects requiring CON approval.***

A decrease in the capital threshold to $500,000 will put North Carolina more in line with other states' thresholds for major medical equipment.

Capital thresholds used for CON review in other states vary from $300,000 to $4 million. Only four states have capital thresholds lower than $500,000. However, other states have recently decreased their capital thresholds for CON approval in order to control the growth and proliferation of facilities and equipment. Minnesota has recently enacted legislation which requires review of major capital projects and equipment purchases of $500,000 or more. Currently, North Carolina has implemented a one-year moratorium on the purchase of some forms of new high technology. By decreasing the capital threshold, most high technology purchases would be reviewed by the CON process.

Implications:

- To be effective, CON applications must be denied if there is no demonstrated need, based on more broadly defined planning areas (Recommendation 1).

Recommendation 5: The CON Program should be self-funded.

The Certificate of Need Program is funded by a mix of revenue derived from application fees and State general revenues. Many states' CON programs are funded completely by CON application fees. North Carolina should make the CON program self-funded by increasing application fees and the ceiling on fees for applications by 50-75 percent. This is commensurate with ceilings in other states in the HCFA Southeast Region.

Implications:

- Costs of CON are passed back to consumers/other payors.

Cost Savings

Cost savings for implementing the above recommendations appear in Exhibit 3 and 4. The following assumptions were made for developing cost savings by placing a moratorium on ICFs/MR beds.

- Annually, 140 new ICF/MR beds were developed, no new bed development would occur.
- The 140 individuals who would have received ICF/MR services would be deflected to home- and community-based services.
- A seven percent increase in program costs for current ICF/MR residents and waiver participants.

Savings associated with the first year of the moratorium would be approximately $2.4 million. Cumulative savings if the moratorium were extended for ten years would be $113 million.

If the CON program were self-funded, additional State revenue from application fees would total $200,000. Estimated cost savings also include a seven percent increase in costs to operate the CON program. Therefore cumulative revenue generated would total $2.8 million.

Cost savings estimates for decreasing the capital threshold to $500,000 and changing the current bed need formula would be difficult. Potential changes in utilization of medical procedures which require expensive technology would effect overall costs. Cost savings attributed to changing the size of the health planning areas would depend on several factors including the size of these areas and the consistency of planning areas across facilities and services.

EXHIBIT 3

MORATORIUM ON ICFs/MR ($ MILLIONS)

Fiscal Year	93	94	95	96	97	98	99	0	1	2
Current Program[1]	$88.6	$104.3	$121.2	$140.7	$162.3	$186.2	$212.6	$241.7	$273.4	$309.2
Implement Moratorium[2]	--	$96.4	$107.0	$118.4	$130.5	$143.5	$152.3	$172.3	$188.2	$206.1
Cost Savings (State Share)	--	$2.4	$4.4	$6.9	$9.8	$13.2	$18.6	$21.5	$26.4	$31.9
Cumulative Savings	--	$2.4	$6.8	$13.7	$23.5	$36.7	$55.3	$76.8	$103.2	$135.1

Total savings over period: $113.1 million

Assumptions:

- 140 bed increase per year (trended since 1982)
- ICFs/MR beds remain at 1,412
- Deflection of 140 potential recipients to home and community services
- 7 percent increase in program costs

EXHIBIT 4

SELF-FUND CON PROGRAM

Fiscal Year	93	94	95	96	97	98	99	0	1	2
Current Program	$600,000	$642,000	$686,940	$735,025	$786,477	$841,531	$900,438	$963,468	$1,030,911	$1,103,075
Proposed Program	$800,000	$856,000	$915,920	$980,034	$1,048,636	$1,122,040	$1,200,538	$1,284,624	$1,374,540	$1,470,766
Savings	$200,000	$214,000	$228,980	$245,009	$262,159	$280,509	$300,100	$321,156	$343,637	$367,691
Cumulative Savings	$200,000	$414,000	$624,780	$887,989	$1,150,148	$1,430,657	$1,730,757	$2,051,913	$2,395,550	$2,763,241

Assumes 7 percent annual growth in cost related to CON program

APPENDIX

CERTIFICATE OF NEED
STATE COMPARISONS

	North Carolina	Alabama	Florida	Georgia	Kentucky	Mississippi	South Carolina	Tennessee
State Department responsible for oversight of CON process	Department of Human Resources Division of Facility Services Certificate of Need section	State Health Planning and Development Agency	Agency for Health Case Administration	State Health Planning Agency Regulatory Review Division	Cabinet for Human Resources Interim Office of Health Planning and Certification	State Department of Health Health Planning and Resource Development	Department of Health and Environmental Control	Health Facilities Commission
When CON is required	All services are identified as needed in State Medical Facilities Plan	New construction of facilities exceeding $1.5 M and all new beds	New construction of facilities exceeding $1.0M and all new beds	Any new construction or additional beds	Any new construction of additional beds	Nursing facilities - any new construction or bed increase of ten or ten percent ICFs/MR - any new construction or additional beds	Construction of LTC facility change in bed complement of one or more, capital expenditures for health care exceeding $1.0M.	Nursing homes - Bed expansion over ten new beds or ten percent of licensed capacity or new facility ICF/MR - Any new or additional beds
Application fee	Range from $1,000 - $15,000 determined according to dollar value of capital expenditures	One percent of estimated cost of project $2,000 (minimum) - $12,000 (maximum)	0.15 X capital construction costs plus an additional $5,000 $5,000 (minimum) - $22,000 (maximum)	.1 percent of projects capital costs. Minimum $500 to maximum of $20,000	$100 fee for projects with capital expenditures up to $150,000. .07 percent of capital expenditures $150,000- $5,000,000	.5 percent of capital expenditures $500 (minimum) - $25,000 (maximum)	.5 percent of total project costs if less than $1.4M, $500 minimum. If greater than $1.4M, $7,000 application fee, with an additional $7,500 upon CON approval	.0225 percent of capital costs $1,000 (minimum) - $30,000 (maximum)
Moratorium	1981-1984	No	No (facilities) Yes (Home health corporations).	No	Yes	Yes, since 1981	No	No
Sunset date for program	No	No	No	No	No	No	No	July 1996
Length of Process	140 days	90 days	90-100 days	90-120 days	150 days	45-90 days	90-120 days	120 days

APPENDIX (Continued)

CERTIFICATE OF NEED
STATE COMPARISONS

	North Carolina	Alabama	Florida	Georgia	Kentucky	Mississippi	South Carolina	Tennessee
Average hours needed to approve CON	N/A	40 hours	N/A	32-40	N/A	N/A	80 hours	8 hours to deem, 24-32 to review
How many CON applications did you receive in most recent year	256 (FY 92)	133 (FY 91)	334 (FY 91)	156 (FY 91)	264 (FY 91)	1 - nursing facilities 1 - ICFs/MRs	66 (12) ICFs/MR	68 (FY 91) 22 ICF/MRs*
How many CON applications were approved	148	66 (FY 91)	164 (FY 91)	107 (FY 91)	135 (FY 91)	1	55 11 ICFs/MR	All
Occupancy Rates	96.93 (FY 89)	97.19 (FY 89)	96.95	97.89 (68%)	97.94 (51%)	99.12	97.47	97.35
Beds/1,000 65+	40.15	43.53	28.31	59.52	50.70	47.23	39.29	54.48
Beds/100 75+	106.16	102.65	66.38	144.27	118.80	107.11	102.51	128.06
Methodology to determine need	Uses a model that targets use rates of four age cohorts 0-64 (.5 beds per 1,000); 65-74 (10 beds per 1,000); 75 to 84 (44 beds per 1,000); 85+ (160 beds per 1,000)	Uses current utilization, population, occupancy factor of 97 percent and a ceiling of 40 beds/1,000 population	Current utilization and projected population of 65 and 75 year olds	Based on bed per 1,000 projected population 65 and over	Based on beds per 1,000 for four ages	Bed need methodology has a standard of 49.37 beds per 1,000 age 65 or older	Bed methodology based on 39 beds per 1,000 age 65+	Nursing homes and ICF/MRs need based on age cohorts (for over 65 years) and estimated number of bed days
Approval of legislature necessary for construction of new nursing home beds	No	No	No	No	No	No	No	No

APPENDIX (Continued)

CERTIFICATE OF NEED
STATE COMPARISONS

	North Carolina	Alabama	Florida	Georgia	Kentucky	Mississippi	South Carolina	Tennessee
Geographic areas of analysis	Nursing homes - county ICFs/MR - 41 mental health areas (prior to 1992 based on HSA areas)	Nursing homes - county ICF/MRs - state DD agency	Nursing home subdistricts (multiple counties)	County - nursing homes	County - nursing homes	Nine multi-county planning districts per nursing facilities Four planning areas for MR	County	Nursing homes - county ICF/MRs - MSA
Use of CON process to establish Medicaid reimbursement rates	Rate approved in CON is maximum rate under Medicaid for first two years of operation	N/A	No	Capital and operating costs approved in CON will effect reimbursement rate	No	Does not determine rate	Does not determine rates. CON final approval is contingent on Medicaid funds available.	No

Source: - KPMG Peat Marwick telephone survey of state CON agencies
- 1991 Guide to the Nursing Home Industry, published by Health Care Investment Analysts and Arthur Andersen