SKILLED NURSING UPDATE – FUTURE TRENDS TO CONSIDER

The U.S. nursing home industry faces daunting economic, regulatory and policy challenges as it anticipates a massive wave of baby boomers aging into infirmity, according to a gathering of industry executives at the University of Pennsylvania's Leonard Davis Institute of Health Economics (LDI).

Convened to gather raw material for a formal report on suggested reforms for the Centers for Medicare and Medicaid Services (CMS), the *National Summit on the Future of America's Nursing Home Industry* (the "Summit") focused on the changing demographics, reimbursement models, clinical practices, and government rules of elder care facilities.

The following information summarizes research conducted by the Institute of Health Economics, and the National Investment Center for Seniors Housing and Care (NIC), as well as other industry experts.

Massive Changes

The changes this industry is being hit with every day are massive and significant in terms of economic realities.

New Priority Level

We still tend to use the word "senior" but that has become a totally inappropriate description. Seniors span four and five decades now. They come from diverse backgrounds in terms of economic capabilities, family supports and ethnic origins. In some nursing homes, as many as five languages are spoken, increasing staffing costs and creating a quality-of-care issue in terms of understanding patient needs.

Telemedicine

Many of the problems were the result of the industry and regulators' "status quo mentality." New telemedicine technologies are just now beginning to be used in nursing homes.

As an example, in the middle of the night, on weekends, or holidays when a patient is suddenly having trouble breathing or experiencing chest pains, the doctor gets called and 90 percent of the time the physician says, "send them to the hospital." So, the 85-year-old patient is taken to the ER where, in most cases, he or she is admitted and spends three or four days as an inpatient. We know that when seniors are admitted to the hospital, they often become confused, have an increased likelihood of developing skin breakdown, incontinence and even delirium and they are exposed to hospital infections. And all of this generates unnecessary costs for the healthcare system.

We also know a good percentage of those patients never should have gone to the hospital, but they did because at 2 a.m. on a Sunday morning, the nursing home lacked the ability to tell if Mrs. Smith's medical needs required hospital admission or not. In recent years, new telemedicine systems have created the potential to do just that.

In 2015, Whitman and David Chess, MD, an Assistant Clinical Professor at the Yale University School of Medicine and CMO of the telemedicine firm TripleCare, conducted a telemedicine study at the Cobble Hill Health Center, a 360-bed skilled nursing facility in New York. Over a year's time, ***91 hospital transfers*** were avoided after the patients were evaluated in-house by a two-physician telemedicine review.

When we start looking at preventing avoidable hospital admissions, telemedicine can be a huge piece but not the only piece. There are a variety of things every facility needs to be doing that aren't getting done today, such a preventive practices and enhanced risk management practices.

Older and Sicker

Older and sicker demographics is another industry concern. Years ago, the average patient came in and stayed for three or four years. But today's nursing home population is coming much later. They're older, much sicker and require a lot more care. Their length of stay has dropped dramatically. Facilities are telling us the average stay is 90 to 100 days rather than several years. That means more resident turnover and more marketing costs."

Meanwhile, nursing homes face unprecedented levels of competition coming from every direction. Life Care retirement communities, PACE Programs, Assisted Living, Adult Day Care Centers, increased use of home care and a significant push by both state and federal agencies to keep seniors at home through home- and community-based programs. Changing reimbursement models, like CMS's Bundled Payment Program are encouraging the wider use of home care.

Orthopedic hospital patients that were previously being sent to nursing facilities for rehab are now bypassing those facilities completely. Hospitals are keeping them for an extra day or two and then discharging them to home-based health care therapy.

The preferred provider networks that have risen during the Affordable Care Act era are also heavily impacting nursing home economics. Such networks partner with only a few nursing homes in a given region. In one instance, a major provider network directed its patients to only five of the region's available 35 nursing homes which resulted in non-preferred facilities receiving significantly fewer Medicare and private pay patients.

Downward Spiral

Once a nursing home is in the non-preferred status, its census of Medicaid patients rises and that can begin a downward spiral. In 35 of 50 states Medicaid pays an average of $23 below the actual cost of providing care. If nursing homes are unable to attract Medicare or private pay residents, these facilities then start admitting even *more* Medicaid residents to help fill their beds—as financial losses continue to increase.

Severe Staffing Issues

Along with their struggle to attract sufficient numbers of better paying patients, nursing homes face a similar struggle recruiting and retaining staff. According to the Summit participants, this is an "enormous" issue with employee turnover rates in many facilities running as high as 60 or

70 percent. Whitman pointed out that even at the nurse's aide level, each time an employee leaves, it costs a facility between $2,000 and $10,000 to replace them.

Whitman cited difficulty in filling even nursing homes' most important position—Director of Nursing (DON): "You can have a Medicare Five-Star facility and the Director of Nursing leaves. The owners bring in another DON who isn't as strong and things deteriorate quickly. I'm concerned we don't have enough people coming into these DON and administrator positions. I don't see a lot of interest among young people—as an industry we need to do a better job at recruiting, educating and training young people for these critical positions."

Star Rating System

Another area of concern is the Centers for Medicare and Medicaid Services (CMS) Five-Star Quality Rating System. Whitman noted that both consumers and providers now frequently use that system when making decisions.

Launched in 2008, the national rating system was designed to make it easier for consumers to compare nursing homes. It uses information collected from health care surveys, quality measures and staffing patterns to rate a nursing home from one to five stars, much like a restaurant review system.

Whitman said the industry is being hurt by the way the star rating system is currently applied because, despite its wide acceptance, it is not a true reflection of an individual facility's quality.

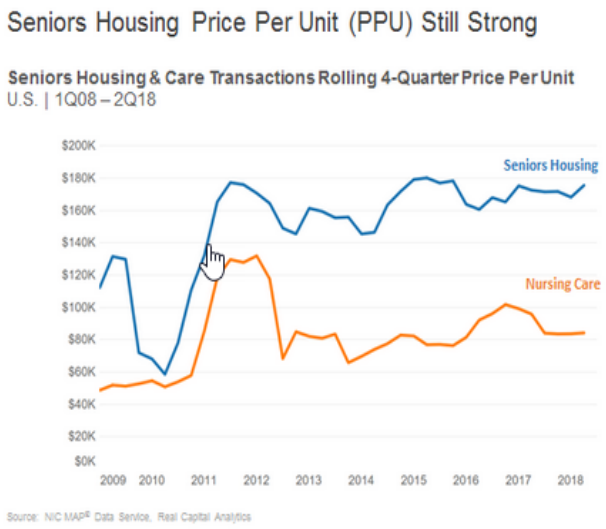
Star System Segments

In the greater Philadelphia market, there are 178 nursing homes: 25 percent are in the five-star category; 23 percent are four; 20 percent are three; and, more than 30 percent are in the one- or two-star category. These last two are at the greatest risk of not being selected for preferred provider networks.

Historically, after two or three years of struggling in this downward spiral, a facility would be put on fast track for closure by the state because of their inability to meet regulatory requirements and decreasing quality of care for its residents. But if you have 30 percent of the facilities close, you don't have enough capacity to absorb all those patients. And what are we going to do when the baby boomers hit the market and we need more and more beds? There's a big opportunity to make some needed changes here.

Pricing Trends

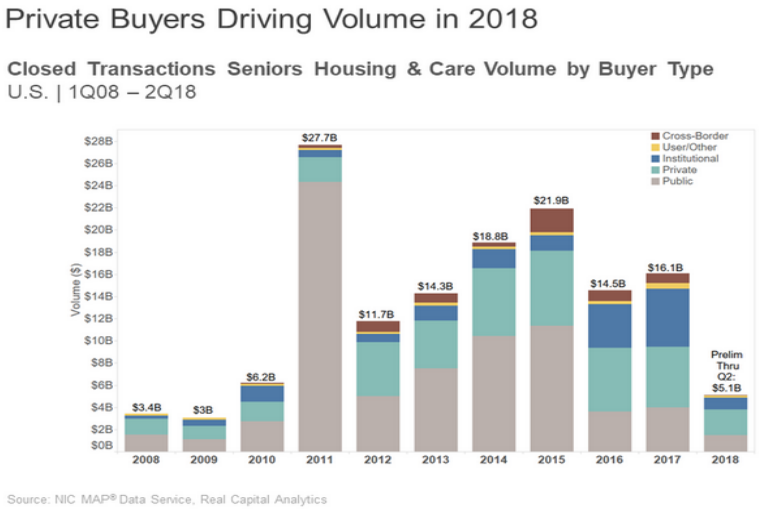
The skilled nursing sector saw yet another downward trend in the second quarter 2018, this time in the price-per-bed metric as measured by data from the National Investment Center for Seniors Housing & Care (NIC).



For the second quarter of this year, the price per bed for skilled nursing facilities sat at $84,200. Though the price represents a slight increase from the first quarter's figure of $83,700, it is still down 12.1% from the second quarter of 2017 when it was $95,800, according to a blog post written by NIC senior principal Bill Kauffman.

Switching gears and looking at the buyer composition through the second quarter of 2018, the total dollar volume closed across all buyers was $5.1 billion. The private buyer has been the most active participant so far, representing almost half of the closed volume (45%), at $2.3 billion through the second quarter of 2018 and averaging more than $1 billion a quarter.

For comparison purposes, the private buyer represented 34 percent of total volume in 2017, registering $5.5 billion. However, the private buyer volume did decrease 42 percent from the first quarter to the second quarter 2018 from $1.5 billion to $800 million. Private volume for the second quarter of 2018 decreased 38 percent from the second quarter of 2017, when it totaled $1.4 billion.



The Implications of PDPM for Skilled Nursing

By NIC, Jan 2, 2019 8:36:44 AM

Medicare is changing the way skilled nursing operators are paid, effective October 2019. The new Patient-Driven Payment Model (PDPM) system replaces Resource Utilization Groups (RUGs) and will dramatically shift predictors of financial success, while raising new compliance issues. PDPM represents a massive shift in how CMS is reimbursing nursing homes for Medicare patients.

It has been just about 20 years since the current system was put in place. Transitioning to PDPM is not another "RUG update," it really is a theoretical and conceptual shift in how nursing homes are reimbursed for Medicare patients. It is restating many of the values embedded within the Affordable Care Act and may be an evolution out of the ACA, something that many people, along with MedPAC, have been advocating for in the skilled nursing environment for quite some time. PDPM is also a stepping stone to a unified payment system for post-acute care, which will replace it in a couple of years.

Because PDPM is just for Medicare reimbursement, many people will say "yes, but the Medicare population in skilled nursing is shrinking." The reality is that many of the Medicare managed care programs will follow the values embedded within PDPM, along with the actual structure, and abandon the current RUGs system. Even though it's just for Medicare, it will have a ripple effect through not only managed Medicare but also the Medicaid Case Mix state. They're using the current RUGs system to understand and reimburse for Medicaid. That will be impacted as well.

This might also be the federal government tipping their hand to indicate how they value skilled nursing and what role they see it playing. PDPM rewards facilities that take care of very sick elders. They're not rewarding an arbitrary allocation of therapy minutes. That is not to say that therapy isn't essential in skilled nursing care—it will not be the tail wagging the dog. In the continuum of post-acute care, CMS is valuing skilled nursing to provide medical/nursing and rehabilitation to complex elders who often have a host of comorbidities. The upside is when, a few years from now, we get to a unified payment system in which all post-acute care will be paid at the same rate agnostic to the setting, skilled nursing will be the best, most cost-effective, institutionally based care setting. The long-term view is that PDPM is really setting us up for future success—in a perfect world.

There is also another very important part of PDPM. A lot of very smart people are trying to "figure out" how to win under PDPM. It happens in every industry—when the rules change, players come up with strategies to win the game. When you dig into PDPM, you see that what CMS has done is quite brilliant. If you try to manipulate one part of the assessment, it will hurt another part of the assessment. There are checks and balances built into the system. It's as if they've given providers enough rope to hang themselves. They've basically said "we're not going to be overly prescriptive about when you have to do this or that assessment, or how you have to think about this concept. We're going to let providers do the right thing. But we're going to monitor the hell out of you, and if you abuse it, you're going to get severely penalized."

The Challenges of Securing Needed Capital for Skilled Nursing

- **A tremendous need for capital exists**, both to upgrade technology and to reposition or replace aging buildings to meet the demands of higher-acuity patients, as well as payors and care partners. With half of the skilled nursing properties in the top 99 metro markets having been built before 1980, investment in real estate and operations is imperative for future success.
- **Significant amounts of capital currently flow into the seniors housing and care industry** with the majority being allocated to private pay seniors housing. The lack of available data and transparency in skilled nursing, relative to seniors housing, contributes to a lower level of investment in the sector.
- **The skilled nursing sector needs to attract new investors,** e.g., real estate investors and private equity health care investors, to fund the needed transformation of buildings and technology and to prepare for the oncoming wave of aging Americans.
- **To gain investor confidence, the sector must be able to access and deliver better data** that is timely, relevant and consistent.
- There is a school of thought that because senior housing is a management-intensive business, its risk profile dictates that spreads should remain well above other asset classes. And, indeed the sector is dealing with declining occupancy levels, rising operating costs and interest rates that are creeping up — factors that, all things equal, should drive up cap rates. But respondents in **JLL's** newly-released **Mid-Year 2018 Seniors Housing Investor Survey** clearly don't subscribe to this theory as 57 percent of them predicted that senior housing cap rates will compress relative to other asset types while 11 percent predicted that spreads will increase, and 32 percent said that spreads will remain about the same.
- In short, the senior housing sector has been, and still is, a seller's market as new capital sources try to enter the space and demand for quality assets exceeds supply. The sector is drawing investment and competition for product is heating up–**all of which suggests that it is the returns that will be squeezed instead of the cap rates.**

A More Mainstream Investment

There is speculation that the spread between core real estate, such as multi-family or industrial assets and senior housing, will tighten despite senior housing's historically higher cap rates.

One reason for this belief is the assumption that senior housing is becoming a more mainstream investment segment and that transparency and competition will result in seniors housing capitalization rates falling relative to other asset classes.

Valuations are Rising

The survey also signaled that valuations will rise for many of these subcategories within senior housing. Seniors-only apartments and age-in-place seniors housing (which is any combination of independent living, assisted living and memory care) are turning investor heads for their rising values.

Independent and assisted living facilities continued to be the most sought-after assets with 72 percent of respondents saying they were very or extremely desirable. Free standing independent living facilities were respondents' second favorite with 58 percent ranking them as very or extremely desirable. Freestanding nursing care facilities and entry-fee CCRCs ranked last with 71 percent and 66 percent of respondents ranking them as not so or not at all desirable, respectively.

Three-Month Marketing Time

Over one-third of survey respondents reported marketing time for seniors-only apartments to be three months or less, an indication of the limited supply and investor appetite.

Independent and assisted living were anticipated to be marketed for three months longer on average. However, survey respondents reported the length of the marketing period for skilled nursing and CCRCs could be up to 12 months on average, due to a more limited buyer pool, as well as the complexity of license transfers.

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