AMERICAN BANKRUPTCY INSTITUTE

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# Health Care Update


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CONCURRENT SESSION

2022

**ABI CARIBBEAN INSOLVENCY SYMPOSIUM (FEBRUARY 2022)**
**HEALTHCARE UPDATE PANEL MATERIALS**

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# 35TH SNF COST COMPARISON AND INDUSTRY TRENDS REPORT

EXECUTE ON THE FUNDAMENTALS AND EMBRACE NEW OPPORTUNITIES

*By Cory Rutledge, Stephen Taylor, Matthew Wocken, and Seth Wilson*

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# EXECUTIVE SUMMARY

## Executive Summary

Though chaos and fatigue have impacted skilled nursing facility (SNF) operators from coast to coast, we implore our readers to take a breath, pause, and remember that the factors that have influenced SNF success pre-COVID continue to be relevant. The disruption of 2020 makes it difficult to establish priorities, so our message is simple, and more critical than ever before: execute on the fundamentals.

While much of the recent conversation among skilled nursing providers has appropriately been on Provider Relief Funds (PRF), personal protective equipment (PPE), and the Paycheck Protection Program (PPP), don't lose sight of per patient day costs (PPDs), staffing levels, and reimbursement opportunities. National operating and financial metrics for SNFs are a great place to ascertain how a facility is performing in comparison to others in this challenging environment.

While the "blocking and tackling" of SNF operations continue to be paramount, the fragility of the skilled nursing ecosystem requires operators to bravely look into the future with a sense of optimism. That way, you can determine how to embrace new opportunities that can impact the sustainability of your business.

### Responding to top-of-mind trends

With COVID-19 undoubtedly impacting SNFs in 2020, we'll emphasize five trends that impact the operations and financial results of SNFs today. Understanding how to respond to these trends is critical to position your organization for future success.

**Cash burn has the industry on edge**

COVID-19 has created a liquidity crisis that the industry has never seen. The faucet of elective procedures and hospital discharges effectively turned off in mid-March, which had significant impact on the post-acute business of SNF operators. Even as hospital activity has trickled back, SNFs have faced public relations challenges and irregular admissions activity that have impacted their revenue streams to varying degrees — some incredibly severe, and others more mild.

In addition to the revenue shortage, operators face increased costs, primarily in the areas of staffing and PPE. Reports from April described a 1,000+% increase in PPE costs due to increased utilization and

## Executive Summary

increased price per unit, and anecdotally, we have heard about continued increases ranging from 200% to 2,000%, depending on the severity of outbreaks in a facility.

Without the available funding mechanisms, including PPP loans and PRF, the industry would be in shambles. But even with the funding, all operators — from single-site operators to publicly traded chains — continue to carefully monitor their cash burn to understand how quickly they need to return to normalized operations before they simply run out of cash.

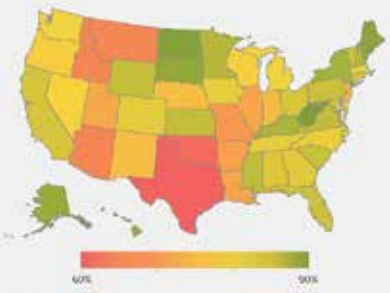
### CLA RESPONSE

We have combined our data analytics and financial modeling capabilities to create interactive, forward-looking models for clients. These models use historical operating and financial metrics as a baseline for future financial performance. With input from SNFs on future market capture, payor mix changes, operating expense changes, and other items impacting future financial performance, the end result is a model that you can use — continually — to assess future financial viability.

**Occupancy is down, and many are questioning how quickly it will recover**

The initial occupancy drop in Q1 and Q2 of 2020 are understandable, but the big question in the industry is how long occupancy levels will take to recover to pre-COVID levels. While the magnitude of the occupancy challenge varies by facility (as shown in the Occupancy Percentage by State graphic), overall occupancy medians have decreased by nearly 11 percentage points from December 31, 2019, to August 30, 2020.

### Occupancy Percentage by State




Source: CMS

The 2019 median occupancy rate, as reported in our 2019 SNF Cost Comparison and Industry Trends Report, was 84.5%. The onset of the pandemic drastically impacted occupancy on a national basis. While some markets have fared better than others, the national occupancy rate dipped to 75.0% as of May 31, 2020. It continued to decline throughout the summer and was 73.7% as of August 30, 2020.

Investors and operators alike continue to monitor occupancy rates, as this operating metric, along with a given state's Medicaid rate, has the most meaningful impact on the financial outcomes of SNFs. Reduced occupancy rates, particularly in urban markets, have operators, real estate investment trusts (REITs), and other SNF stakeholders believing we have "found the bottom" of the occupancy dip, and wondering how long it will take for SNF occupancy to approach pre-pandemic levels.

One recent report outlined the occupancy challenges in Connecticut, where the statewide average occupancy declined 15% from January to August — and almost five times as many SNFs were experiencing occupancy of 70% or less in August than were doing so in January. The 70% marker is particularly meaningful, because the state implemented a steep Medicaid cut for facilities with occupancy rates under 70%. Occupancy challenges don't impact all SNFs equally, and those hit particularly hard with reduced occupancy, whether due to COVID-19 or other factors, may struggle to survive.



## Executive Summary

Harder-hit clients suggest it may take 18 months before occupancy levels are back to normal. Others recognize that pre-COVID occupancy levels are simply not realistic and are "rightsizing" their entire operating model. As many SNF entities prepare 2021 budgets, there is considerable uncertainty around expected revenue in the coming year.

### CLA RESPONSE

Modeling scenarios for the severity and longevity of the occupancy dip, the recovery period, and the new normal have helped many SNF operators manage cash burn during these challenging times. CLA Intuition 2.0 is our way of helping organizations model occupancy scenarios and the financial results that follow.

**Operators cannot afford a PDPM misstep**

The fanfare of the Patient Driven Payment Model (PDPM) that dominated 2019 seems like a distant memory, but the importance of PDPM should not be forgotten in the current environment. Many operators have already invested in the training and analytics necessary to successfully adjust to PDPM. Others have struggled with the complexity of this payment model and continue to miss clinical and coding opportunities for appropriate reimbursement, which results in suboptimal rates. To state it plainly, operators cannot afford to leave PDPM reimbursement on the table.

### CLA RESPONSE

Our team of clinical and operational professionals have hands-on PDPM experience. Our PDPM post-implementation assessment process can help you review reimbursement rates and assess opportunities for improvements.

## Executive Summary

**Telehealth has emerged, and it is here to stay**

The prospect of telehealth implementation to improve clinical outcomes — particularly in response to COVID-19 — has the attention of many operators. The excitement of telehealth, however, is tempered due to the complexity involved in effectively utilizing the opportunity.

Operators continue to explore various technology solutions, a myriad of provider options (physician and nurse practitioner), and how to monetize this emerging business opportunity. To complicate things even more, telehealth requires new operating protocols for front line staff who are understandably exhausted and likely not enthused about another disruption to how they provide care.

Despite the challenges, telehealth creates an incredible opportunity to provide more care inside of the facility at a lower cost, while providing a much-needed revenue stream. And the CMS waivers that removed restrictions for SNF telehealth in response to COVID-19 appear to be here to stay. Throughout the remainder of 2020 and into 2021, determine your telehealth strategy and how to grasp and monetize this fast-moving opportunity.

### CLA RESPONSE

CLA works with a number of SNF companies to create telehealth connections and shape telehealth strategies. Whether the interaction between SNFs and telehealth companies is a simple vendor/customer relationship or something more robust, such as a joint venture, CLA is well equipped to advise you on options, and help you navigate this new and exciting opportunity.



## Executive Summary

**SNF M&A activity continues to flourish**

Merger and acquisition (M&A) transactions in long-term care topped $16 billion in 2019, which is a 22% increase from 2018. While transactions slowed in the first half of 2020, some investors seeking a real estate investment view SNFs as a viable option, particularly given the uncertainty of retail, restaurants, and other real estate products.

From the seller's perspective, previously mentioned industry challenges also help drive SNF transactions. Whether it is smaller operators struggling with the increased complexity of today's operating environment, or larger chains that are over-leveraged, some SNF owners see the uncertainty of 2020 as an opportunity to reduce exposure to skilled nursing or leave the skilled nursing sector altogether.

### CLA RESPONSE

SNF transactions are extremely complex. Approach the deal fully prepared to increase the likelihood of a successful outcome. CLA's health care transaction services team provides due diligence services, quality of earnings analysis, transaction tax services, and a variety of other services to SNF buyers and sellers. Whether you want to add to your portfolio or reduce your SNF exposure, CLA can bring industry experience and transaction knowledge to the table.

# Executive Summary

## A peek into 2020

In response to COVID-19, CMS has increased reporting requirements, which includes weekly reporting to the Center for Disease Control's National Healthcare Safety Network (CDC NHSN) system. Many of the data points in this file relate to resident and staff cases and deaths, but some of the data points provide an interesting perspective on how COVID-19 has impacted the operations of SNFs. To analyze occupancy and nursing shortage data, we created graphics and commentary that outline the 2020 occupancy (Occupancy Percentage by State on page 5) and nursing shortage trends (Shortage of Workforce in SNFs on right).

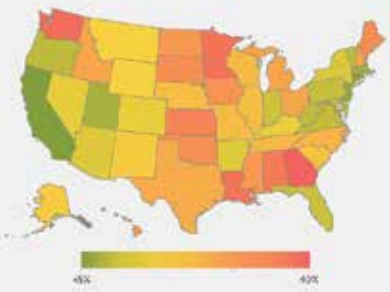
## Execute to create opportunity

The rate of change impacting SNFs has created chaos in the industry, and a survey from the American Health Care Association indicates that 72% of respondents cannot sustain current operations for another year. In fact, 40% said the current operating environment would have them out of business before March of 2021. This is dire news, but the stories that highlight the financial instability of SNFs also emphasize their importance in our society.

The stakes have never been higher, and we hope that this report provides clarity on the fundamentals of SNF finance and operations. Leverage the industry trends introduced in this publication to help you weather and push through the storm.

CLA exists to create opportunities — for our clients, our people, and our communities. We create opportunities for those we serve by getting to know our clients, which allows us to help them effectively. Our 35-year

### Shortage of Workforce in SNFs




Source: CMS

The workforce pressures that existed prior to COVID-19 have been exacerbated throughout 2020. On a national basis, 19.7% of facilities reported nursing or aide shortages as of May 31, 2020. That metric increased to 25.3% by August 30, 2020.

Anecdotally, we have heard that SNFs have found it increasingly difficult to recruit and retain front line talent due to a number of factors, including safety concerns related to COVID-19. As originally discussed in our 2019 report, workforce challenges continue to place pressure on operating margins as many operators continue to turn to the utilization of high-cost nursing pool and other means to combat nursing and aide shortages.

The Long-Term Care Workforce Crisis: A 2020 Report, produced by a number of Wisconsin long-term care provider associations, includes several key findings that point to an overall bleak picture for SNFs in the state. Most notably, the average caregiver vacancy rate is 23.5%, and there are an estimated 20,000+ vacant caregiver positions in long-term and residential facilities. Upwards of 50% of providers in the state feel unable to compete with other employers for qualified candidates, and 70% indicated there are no qualified applicants for caregiver openings. Wisconsin is merely one voice in a chorus of states that are pleading with state legislatures for higher Medicaid rates so that they can increase front line wages.



# Executive Summary

commitment to the SNF Cost Comparison and Industry Trends Report is evidence that we know the industry, but we would like to get to know you, too.

Stay tuned for future publications on state-specific metrics and PDPM analysis. In the meantime, please contact us so we can identify your needs and put our decades of SNF experience to work for you.

## Methodology

This publication provides benchmarks and ratios calculated using annual SNF cost report data released by the Centers for Medicare and Medicaid Services (CMS) as of July 2020. More than 14,000 cost reports are filed each year and, in a typical year, approximately 12,000 reports are included in this publication. For 2019 however, only approximately 6,000 cost reports were available for analysis. The lower number available for analysis in this year's publication is due to a pandemic-related Medicare cost report filing extension granted by CMS. Nevertheless, to address the industry's desire for timely and relevant information, we have published this report with the most readily available data as of July 2020 for all years presented.

Any cost reports that were not available for analysis in previous years' cost comparison reports have since been added, so amounts presented for 2015-2018 may differ from prior-year reports. Starting with a smaller sample size than usual, it's expected that the difference between what we're presenting for 2019 now and in future reports will be greater than usual. Our hope is to provide a summary of significant changes to 2019 values once the remaining data becomes available.

Each SNF's data was ranked numerically and stratified into percentiles. These summary statistics and our data perspectives are intended to provide a general understanding of financial and operational trends. This report is not intended to provide any conclusions about correlation and dependence within the data.

> Stay tuned for future publications on state-specific metrics and PDPM analysis. In the meantime, please contact us so we can identify your needs and put our decades of SNF experience to work for you.

# RATIO ANALYSIS

*Financial and Operational Key Performance Indicators*

## Ratio Analysis

### Operating margin

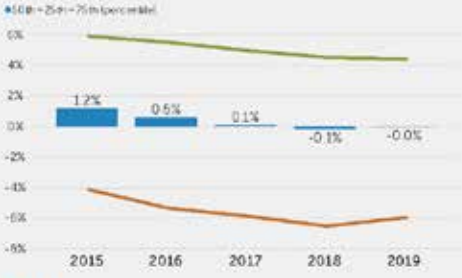
The operating margin measures the profitability of a SNF by comparing its net operating income or loss to its operating revenue. This ratio represents the profitability of a SNF's operations from its primary revenue sources, as it excludes contribution and investment income.

**2019 data perspective**

2018 revealed a negative median operating margin for the first time in the 34 years of our analysis of skilled nursing facility financial performance. The 2019 median operating margin does not reveal a measurable improvement in this metric. This is the third year in a row the operating margin has hovered around 0%.

A median operating margin of 0% means that roughly half of SNFs in the country are not operating at a profitable level. The lack of income generated from operations over the last three years puts into question the long-term financial viability of SNFs that are not able to find new ways to operate in and adapt to the rapidly changing environment. The unfavorable trend in the operating margin highlights the significant challenges the industry faces on numerous fronts, including occupancy, payment, regulatory, and workforce.

Many operators have seen increased reimbursement rates under PDPM. With an effective date of October 1, 2019, the impact on 2019 financial results was limited. Unfortunately, the impact in 2020 will likely be masked by the operational and financial consequences of COVID-19.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | -4.1% | -5.3% | -5.9% | -6.5% | -5.9% |
| 50th | 1.2% | 0.6% | 0.1% | -0.1% | 0.0% |
| 75th | 5.9% | 5.5% | 5.0% | 4.5% | 4.4% |

Source: CHS

> The lack of income generated from operations over the last three years puts into question the long-term financial viability of SNFs that are not able to find new ways to operate in and adapt to the rapidly changing environment.

## Ratio Analysis

### CMS Five-Star Ratings and financial performance

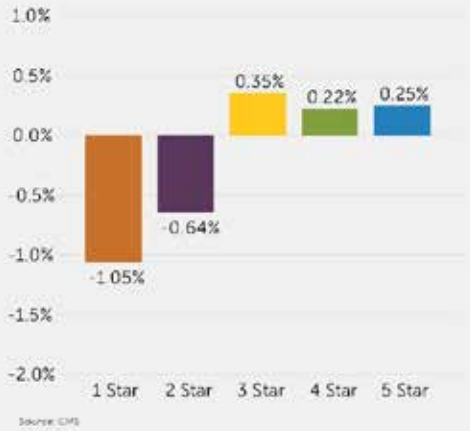
A heightened emphasis on star ratings from hospitals, funding agencies, and consumers has increased the importance of these ratings for SNFs. With the health care industry transitioning payment toward value and quality, this rating can impact financial performance. These indicators were initially introduced in our 34th Annual Report and explore the correlation between a SNF's overall star rating and both operating margin and occupancy percentage.

Given the trend in operating margins hovering around break-even over the last three years, we have extensively researched the drivers that impact SNF profitability. We have found the correlations at the median level between star ratings and financial performance to be one of the most insightful indicators, which we find particularly compelling as we seek to help our clients and the industry.

**2019 data perspective**

The median operating margin for SNFs across the country was 0% in 2019. However, SNFs that received an overall star rating of three stars or higher experienced an operating margin above that national median. SNFs that received an overall star rating of one or two stars experienced operating margins well below the national median. There is a difference of 130 basis points in the median operating margin between the overall five-star-rated facilities as compared to the overall one-star-rated facilities.

> SNFs that received an overall star rating of one or two stars experienced operating margins well below the national median.



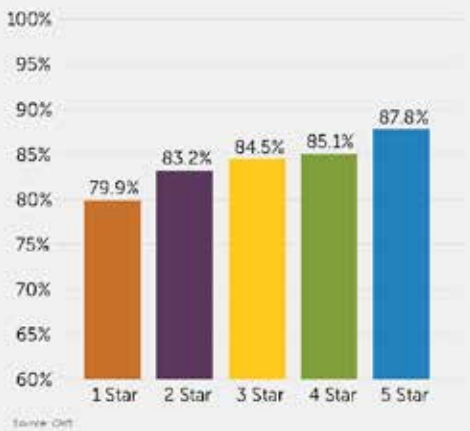



## Ratio Analysis

The 2019 median occupancy rate for SNFs across the country was 84.6%. Similar to the operating margin results, facilities with an overall rating of three stars or higher experienced occupancy approximately equal to or greater than the national median occupancy. At the median level, facilities with an overall rating of five stars experienced 87.8% occupancy in 2019. The data in the table suggests a correlation between the overall star rating of a facility and the occupancy of the facility. The higher the overall star rating, the more favorable the median occupancy is.

While there are numerous factors that drive occupancy and margin, these observations demonstrate that facilities with an overall rating of three stars or greater tend to have higher median operating margins and occupancy percentages.

> Facilities with an overall rating of three stars or greater tend to have higher median operating margins and occupancy percentages.



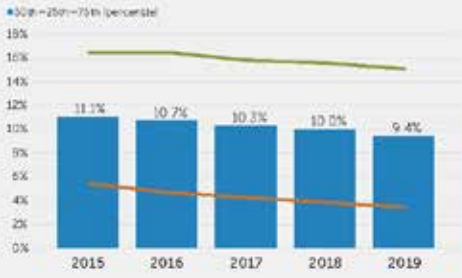
# Ratio Analysis

## Earnings before interest, depreciation, and amortization

Earnings before interest, depreciation, and amortization (EBIDA) is a commonly used profitability measure because it eliminates capital-related costs. It is a rough measurement of cash flow for skilled nursing operators, so changes measured in this ratio provide a sense for how providers generate cash.

**2019 data perspective**

After a continual annual decrease of approximately 40 basis points from 2015 through 2016, SNFs have experienced the largest annual decrease in this metric over the last five years with a median EBIDA metric of 9.4% in 2019 — a decrease of 60 basis points from 2018. The decrease in EBIDA margin year over year is closely correlated with the decrease in operating margin. The continual decline in EBIDA margin may put pressure on your ability to generate cash flow to pay debt service or rent payments and cover your cost of capital.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 5.4% | 4.7% | 4.3% | 3.6% | 3.4% |
| 50th | 11.1% | 10.7% | 10.3% | 10.0% | 9.4% |
| 75th | 16.4% | 16.5% | 15.8% | 15.6% | 15.1% |

Source: CAS

SNFs have experienced the largest annual decrease in this metric over the last five years.



# Ratio Analysis

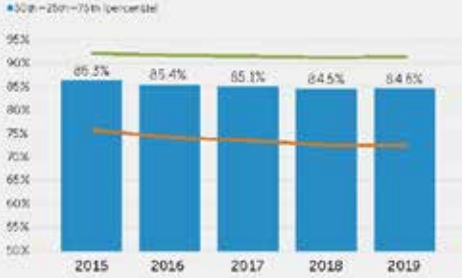
## Occupancy percentage

A SNF's occupancy percentage is a measure of resident days provided during the year compared to the total available days based on the number of licensed beds. Higher occupancy levels typically allow more operating flexibility due to higher revenues for the SNF to help cover annual fixed costs.

**2019 data perspective**

The influence of value-based payments and the increased proliferation of managed care have had adverse impacts on SNF occupancy by reducing SNF admissions and shortening average lengths of stay. The 2019 data shows a slight uptick in SNF occupancy after years of a continued negative occupancy trend, although 2020 occupancy declines more than offset progress made in 2019.

Occupancy struggles tend to exacerbate the financial challenges for SNFs. As post-acute networks and Medicare Advantage plans continue their enhanced focus on quality and value, we expect to see greater variance in occupancy levels as some providers might retain a larger percentage of post-acute discharges from hospitals.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 75.8% | 74.2% | 73.6% | 72.5% | 72.6% |
| 50th | 85.3% | 85.4% | 85.1% | 84.5% | 84.6% |
| 75th | 92.1% | 91.7% | 91.5% | 91.2% | 91.4% |

Source: CAS

The 2019 data shows a slight uptick in SNF occupancy after years of a continued negative occupancy trend, although as noted in this publication, 2020 occupancy declines more than offset progress made in 2019.

# Ratio Analysis

## Payor mix

The average payor mix measures the percentage of occupied resident days paid by various payor sources.

**2019 data perspective**

The 2019 data shows a measurable decrease in the percentage of days covered by Medicare in SNFs. In 2019 there was a decrease of 90 basis points in the Medicare mix, which is now down to 9.4% of total days.

Along with the decrease in Medicare mix there was a corresponding 1% increase in other payors which includes Medicare Advantage, private pay, and other payors. The trend with these changes can be attributed to a number of factors, including:

- The rise in Medicare Advantage
- Lower hospitalizations
- Shorter lengths of stay in both the hospital and SNF setting
- Care substitutions such as home health and outpatient therapy

Given the fact that Medicaid rates are historically lower than the cost of providing care in many states, providers are competing for Medicare and other post-acute residents, as those payors tend to generate positive margins. Medicaid days as a percentage of total days remained fairly consistent with the 2018 numbers and account for approximately 62% of total resident days. Medicare and many Medicare Advantage plans are implementing more value-based payment mechanisms, which highlight the need for facilities to monitor and improve quality metrics.

We believe you should measure your business in two distinct categories: the short-term rehabilitation residents, and the long-term stay residents. With a focus on these two very different resident types, you can more effectively monitor operations and financial outcomes.


Source: CMS

> The 2019 data shows a measurable decrease in the percentage of days covered by Medicare in SNFs.



# Ratio Analysis

## Nursing pool utilization

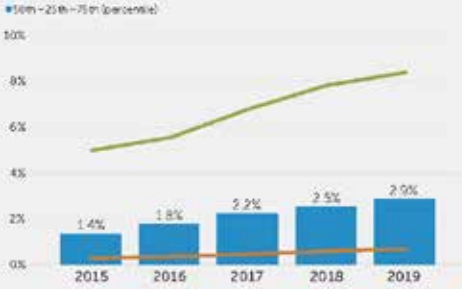
These metrics provide additional perspective on one of the biggest challenges facing skilled nursing facilities: workforce. Our analysis demonstrates that more facilities are utilizing nursing pool, and those facilities engaging with nursing pool are doing so at a higher percentage of their total nursing hours.

**2019 data perspective**

In 2019, the percentage of SNFs that utilized nursing pool hours in some fashion remained fairly consistent with the 2018 metric. However, the amount of hours that SNFs utilized pool labor to supplement their staffing needs in 2019 increased 40 basis points to 2.9% in 2019. This continual increase in the amount of pool hours utilized supports the staffing challenges faced by the industry and confirms that this staffing crisis is worsening each year. Since 2015 the amount of median nursing pool hours utilized has more than doubled from 1.4% to 2.9%.

As we look at the three primary nursing roles in a SNF — nursing aides, LPNs and RNs — all three roles are experiencing a similar trend: operators who use nursing pool are satisfying a larger percentage of their total nursing hours across all three nursing disciplines with nursing pool. In addition to the obvious financial implications, many operators view nursing pool as less desirable from a staff continuity standpoint.

**Nursing Pool Hours as Percentage of Total Nursing**




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 0.3% | 0.4% | 0.5% | 0.6% | 0.7% |
| 50th | 1.4% | 1.8% | 2.2% | 2.5% | 2.9% |
| 75th | 5.0% | 5.5% | 6.8% | 7.6% | 8.4% |
| Providers with pool | 31% | 36% | 39% | 43% | 42% |

Source: CMS

> Since 2015 the amount of median nursing pool hours utilized has more than doubled from 1.4% to 2.9%.

## Ratio Analysis

### Days revenue in accounts receivable

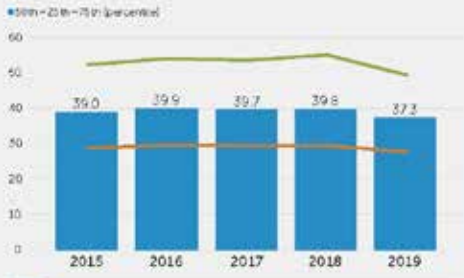
This ratio calculates the average number of days that receivables are outstanding, or how quickly a facility converts its receivables to cash.

A lower value of days revenue in accounts receivable is desirable, as it indicates that a facility takes less time to convert its receivables to cash. Historically, more than 70% of resident service revenue is paid by third-party payors that traditionally pay for services following the month of service. Therefore, a value of approximately 30 days of revenue in accounts receivable should be an attainable goal for SNFs.

Improved technology solutions have increased the efficiency of business offices in the collection of third-party receivables over the past decade. However, as penetration rates of Medicare Advantage plans have increased, the technology improvements have been offset by the complexity of Medicare Advantage billing, and providers have struggled to maintain timely collections.

**2019 data perspective**

2019 days in accounts receivable shows an improvement in the metric compared to the historical medians. The 2019 metric decreased by 2.5 days when compared to 2018. As Medicare Advantage plans continue to increase their skilled nursing market share, the administrative resources and skill sets required to effectively bill, collect, and manage information requests from payors also increases. With the operational challenges of the industry — as evidenced by the operating margin and EBIDA margin — you should continue to focus on timing the collection of your receivables to improve this metric.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 28.7 | 29.6 | 29.5 | 29.5 | 27.7 |
| 50th | 39.0 | 39.9 | 39.7 | 39.8 | 37.3 |
| 75th | 52.3 | 54.1 | 53.6 | 55.1 | 49.4 |

Source: CMS

> With the operational challenges of the industry — as evidenced by the operating margin and EBIDA margin — you should continue to focus on timing the collection of your receivables to improve this metric.



# APPENDIX

*Financial and Operational Indicators*

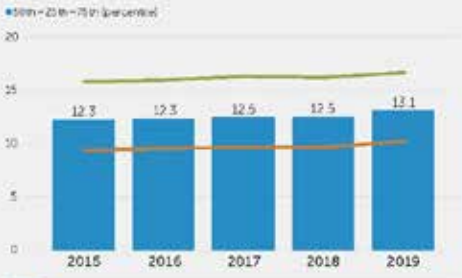
# Appendix

## Average age of plant

This ratio measures the average age of a facility by estimating the number of years depreciation has already been realized for a facility by dividing accumulated depreciation by depreciation expense.

A lower value indicates a newer facility, or that a major remodeling project was recently completed. A higher value may indicate that a facility may be in need of remodeling or renovation and that the facility should evaluate its current level of reinvestment and financing options for fixed asset replacements. Analyze this ratio in relation to liquidity and profitability metrics since you can potentially improve days cash on hand by deferring capital improvements.

To position for long-term success, consider the changing expectations of the post-acute consumer. Higher margin residents tend to be rehabilitation short-stay residents, and the median age of those individuals is lower than traditional long-stay residents. Therefore, to remain relevant, cater to the expectations of today's residents and their adult children, which may require a facility to invest in renovations.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 9.4 | 9.5 | 9.7 | 9.6 | 10.2 |
| 50th | 12.3 | 12.3 | 12.5 | 12.5 | 13.1 |
| 75th | 15.6 | 16.0 | 16.3 | 16.2 | 16.7 |

Source: CHS

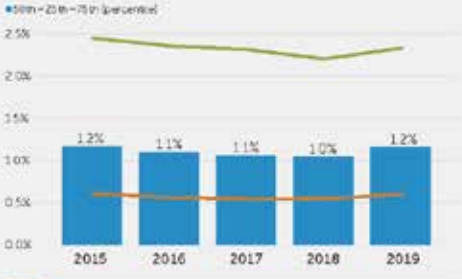


# Appendix

## Capital spending ratio

The capital spending ratio measures the capital spending of a facility as a percentage of annual operating revenues and indicates how aggressively a facility re-invests its revenue back into its facility.

The capital spending ratio is an inverse to the age of plant indicator as a lower ratio can indicate a facility is not reinvesting back into the physical plant. Conversely, a higher ratio suggests a facility is being proactive in their annual capital purchases. Analyze this ratio in relation to the liquidity and operating margins to determine the appropriate level of capital investment that should go back into the facility.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 0.6% | 0.6% | 0.5% | 0.6% | 0.6% |
| 50th | 1.2% | 1.1% | 1.1% | 1.0% | 1.2% |
| 75th | 2.5% | 2.4% | 2.3% | 2.2% | 2.3% |

Source: CHS

# Appendix

## Net margin ratio

The net margin ratio measures a facility's efficiency in controlling costs in relation to its total revenue. This profitability measure is calculated by comparing a facility's net income or loss to its total revenue.

The ability to maintain your net margin ratio is vital for long-term sustainability. With challenges in reimbursement levels and occupancy, this has often been accomplished through controlling expenses. While frugality is important, it is also critical to seek out strategies to diversify your business or differentiate your facility in a way that supports financial sustainability.


| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | -3.7% | -4.9% | -5.3% | -6.1% | -5.3% |
| 50th | 1.4% | 0.9% | 0.5% | 0.1% | 0.3% |
| 75th | 5.2% | 5.6% | 5.4% | 4.6% | 4.9% |

Source: CHS

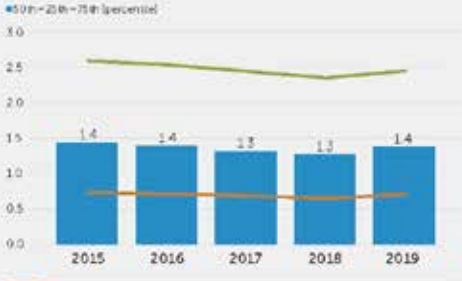


# Appendix

## Current ratio

The current ratio measures the liquidity of a facility and is used to determine the degree to which current liabilities are covered by current assets or the ability to pay short-term obligations when due. Current assets consist of cash and other assets such as accounts receivable, prepaid expenses, and investments that can be easily converted into cash. Current liabilities include accounts payable, accrued expenses, current portion of long-term debt, and other obligations payable within one year.

The higher the current ratio, the greater the ability to meet short-term obligations. A high liquidity must be weighed against the ability to obtain higher investment earnings by investing in longer-term investments. A ratio of less than one may represent a severe liquidity problem. A trend of a decreasing current ratio may provide an early signal of financial difficulties.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 0.7 | 0.7 | 0.7 | 0.6 | 0.7 |
| 50th | 1.4 | 1.4 | 1.3 | 1.3 | 1.4 |
| 75th | 2.5 | 2.5 | 2.4 | 2.3 | 2.4 |

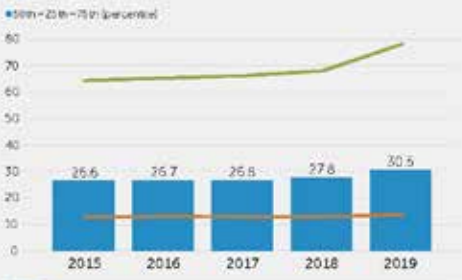
Source: CHS

# Appendix

## Days cash on hand

This ratio measures how long cash on hand will cover average expenses. Similar to the current ratio, a high number of days cash on hand is considered favorable. However, an extremely high ratio may indicate that your facility could earn a higher rate of return by investing in longer-term investments.

This ratio is representative of the liquid resources available to cover average daily expenses. It is important to note, however, that many SNF organizations move cash to related parties, which means the ratio may not make up the full cash picture of a SNF.




| | 2015 | 2016 | 2017 | 2018 | 2019 |
|---|---|---|---|---|---|
| 25th | 12.7 | 13.0 | 12.9 | 12.9 | 13.7 |
| 50th | 26.6 | 26.7 | 26.8 | 27.8 | 30.5 |
| 75th | 64.4 | 65.3 | 66.2 | 68.1 | 76.1 |

Source: CMS



# Appendix

## Wages per compensated hour

Not only are personnel costs the primary expense in your operations, but staffing challenges are the primary concern for most providers. Therefore, it is important to monitor these costs and the factors that affect them.

| Year | Nursing admin | RN | LPN | Aide | Social services | Plant | Housekeeping | Laundry | Dietary | Admin |
|---|---|---|---|---|---|---|---|---|---|---|
| 2015 | $33.52 | $33.04 | $25.12 | $14.17 | $19.02 | $17.98 | $10.71 | $10.39 | $12.12 | $26.40 |
| 2016 | $34.58 | $34.44 | $26.07 | $14.72 | $19.70 | $18.39 | $10.96 | $10.68 | $12.50 | $26.70 |
| 2017 | $35.40 | $35.56 | $26.93 | $15.36 | $20.22 | $18.64 | $11.33 | $11.11 | $12.89 | $27.46 |
| 2018 | $36.07 | $36.80 | $27.81 | $15.09 | $20.95 | $19.47 | $11.73 | $11.44 | $13.25 | $28.25 |
| 2019 | $36.53 | $37.14 | $28.20 | $15.62 | $21.19 | $19.68 | $11.98 | $11.59 | $13.43 | $28.03 |

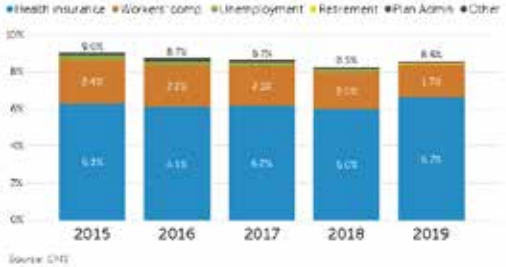
Source: CMS

## Fringe benefits

In addition to direct payroll costs, fringe benefits are additional costs of labor. Fringe benefits include:

- Medical, life, and other group insurance
- Workers' compensation insurance
- Pension or retirement contribution
- Uniform allowance
- Miscellaneous employee benefits

### Benefits As a Percentage Of Salaries




Source: CMS

# Appendix

## Hours per resident day

This ratio calculates the actual compensated hours paid per resident day.

### Median Paid Nursing Hours Per Resident Day


Source: CMS

### Median Paid Hours Per Resident Day (Excluding Nursing)


Source: CMS



# Appendix

## Total costs per resident day

| Percentile | Nursing | Social services | Ancillary | Plant | Housekeeping | Laundry | Dietary | Admin | Benefits | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| 25th | $73.10 | $2.31 | $15.38 | $9.61 | $4.75 | $1.86 | $16.13 | $35.77 | $11.65 | $170.58 |
| 50th | $92.92 | $3.78 | $22.01 | $11.83 | $6.11 | $2.72 | $19.17 | $47.49 | $19.00 | $225.02 |
| 75th | $115.55 | $6.19 | $31.05 | $15.40 | $8.00 | $3.75 | $24.12 | $61.37 | $28.93 | $294.77 |

Source: CMS

## Salaries per resident day

| Percentile | Nursing | Social services | Plant | Housekeeping | Laundry | Dietary | Admin | Total |
|---|---|---|---|---|---|---|---|---|
| 25th | $62.46 | $1.59 | $1.72 | $0.98 | $0.00 | $6.49 | $7.59 | $81.03 |
| 50th | $77.62 | $3.36 | $2.37 | $4.27 | $1.20 | $8.91 | $9.67 | $107.60 |
| 75th | $98.17 | $5.46 | $3.39 | $5.91 | $2.12 | $11.89 | $13.27 | $140.22 |

Source: CMS

## Salaries per compensated hour

| Percentile | Nursing admin | RN | LPN | Aide | Total nursing | Social services | Plant | Housekeeping | Laundry | Dietary | Admin |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 25th | $31.35 | $31.97 | $24.41 | $13.79 | $17.95 | $17.20 | $16.91 | $10.29 | $9.78 | $11.58 | $24.23 |
| 50th | $36.07 | $36.80 | $27.81 | $16.09 | $20.13 | $20.95 | $19.47 | $11.73 | $11.44 | $13.25 | $28.25 |
| 75th | $43.00 | $42.47 | $32.12 | $18.68 | $22.57 | $25.26 | $22.41 | $13.26 | $13.13 | $15.11 | $33.23 |

Source: CMS

## Appendix – Indicator Formulas

Page 12

**Operating Margin =** Net Operating Income (Loss) / Operating Revenue

Page 15

**EBIDA =** Net Income (Loss) or Change in Unrestricted Net Assets + Interest Expense + Depreciation Expense + Amortization Expense / Total Revenue

Page 16

**Occupancy Percentage =** Resident Days / Facility Beds × 365

Page 17

**Payor Mix =** Resident Day Mix / Total Resident Days

Page 19

**Days Revenue in Accounts Receivable =** Accounts Receivable / (Resident Revenue/365)

Page 21

**Average Age of Plant =** Accumulated Depreciation / Depreciation Expense

Page 22

**Capital Spending Ratio =** Capital Purchases / Operating Revenues

Page 23

**Net Margin Ratio =** Net Income (Loss) or Change in Unrestricted Net Assets / Total Revenue

Page 24

**Current Ratio =** Current Assets / Current Liabilities

Page 25

**Days Cash on Hand =** Cash and Cash Equivalents / (Operating Expenses − Depreciation) / 365

Page 26

**Wages Per Compensated Hour =** Wages / Compensated Hours

Page 26

**Payroll Taxes and Fringe Benefits =** Benefits Mix / Total Salary Expense

Page 27

**Hours Per Resident Day =** Compensated Hours / Resident Days



## About CLA

### The CLA promise

CLA exists to create opportunities for our clients, our people, and our communities through industry-focused wealth advisory, outsourcing, audit, tax, and consulting services. With more than 6,200 people, 120 U.S. locations, and a global affiliation, we promise to ***know you and help you***. For more information visit CLAconnect.com

*Investment advisory services are offered through CliftonLarsonAllen Wealth Advisors, LLC, an SEC-registered investment advisor.*


## THE FOUR ESSENTIAL ELEMENTS OF THE CLA PROMISE

**OUR PURPOSE**
CLA exists to create opportunities — for our clients, our people, and our communities.

**OUR PROMISE**
We promise to know you and help you.

**OUR CLA FAMILY CULTURE**
We're one family, working together to create opportunities.

**OUR STRATEGIC ADVANTAGES**
Deep industry specialization
Seamless, integrated capabilities
Premier resource for private businesses and owners
Inspired careers



## About CLA

### Our dedication to health care

CLA has developed one of the nation's largest health care practices. Our team includes CPAs and a diverse range of experienced professionals with backgrounds and skill sets ranging from CEOs and CFOs to RNs, certified coders, and certified medical practice executives. Our professionals are regular contributors in national publications and at national and regional conferences. By working together, we help our clients build enterprise value through strategy, operations, finance, and compliance services.

## OUR HEALTH CARE NETWORK

Our practice consists of **470+** Firm wide health care professionals

**90+** Firm-wide health care principals

We currently serve **10,100+** Health care clients

Which includes **3,200+** Aging services providers (e.g., nursing facilities, life plan communities (CCRCs), assisted living facilities, HUD housing)

**200+** Home care, hospice, and other community based providers

**900+** Hospitals and health systems, including approximately 80 critical access hospitals

**5,800+** Physicians, dentists, and medical practices

# About CLA

## Services for SNF operators and investors

Our customized services support the evolving needs of organizations serving aging adults. We are a premier resource for health care providers, and offer deep industry specialization and seamless integrated capabilities to those we serve. These advantages propel us forward as we create opportunities, develop relationships, and provide value for skilled nursing facilities as we help our people grow their careers.

Due to escalating operating costs, personnel shortages, and changing reimbursement models, skilled nursing operators and investors are being forced to reexamine the way they do business. CLA understands that these challenges require more than ordinary answers; they require forward-thinking and creative solutions that will help carry you forward. We proactively stay informed of industry trends and the regulatory and operational environment to help position your organization for upcoming challenges and opportunities.


## We can help

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Wealth Advisory | Outsourcing | Audit, Tax, and Consulting

AHCA AMERICAN HEALTH CARE ASSOCIATION

NCAL NATIONAL CENTER FOR ASSISTED LIVING

# State of the Long Term Care Industry:

## Survey of nursing home and assisted living providers show industry facing significant workforce crisis

## September 2021

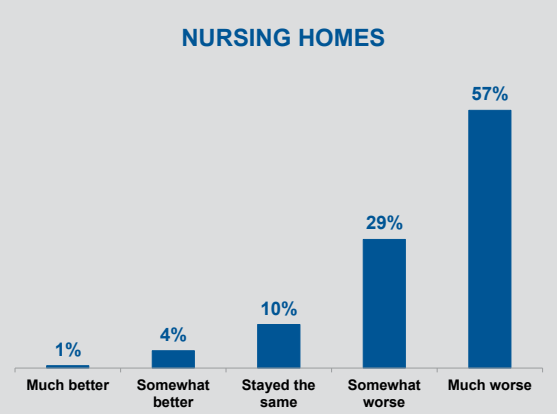
1

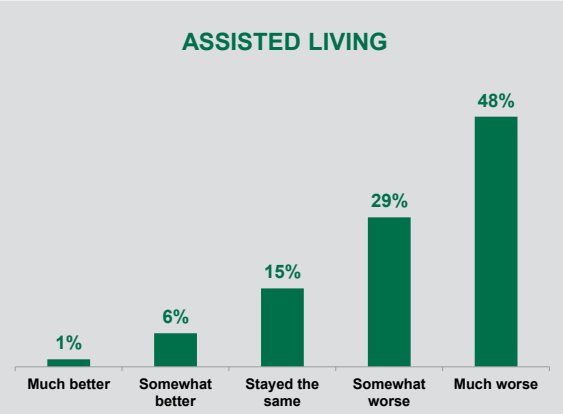
AHCA AMERICAN HEALTH CARE ASSOCIATION

NCAL NATIONAL CENTER FOR ASSISTED LIVING

**86% of nursing homes and 77% of assisted living providers said their workforce situation has gotten worse over the last three months.**

**Q: Since June 2021, would you say your organization's overall workforce situation has generally gotten better or worse?**



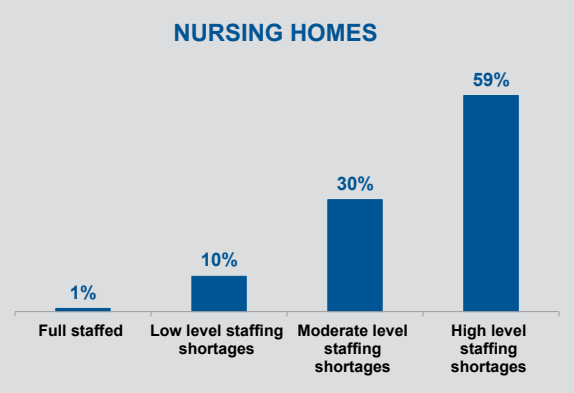

Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

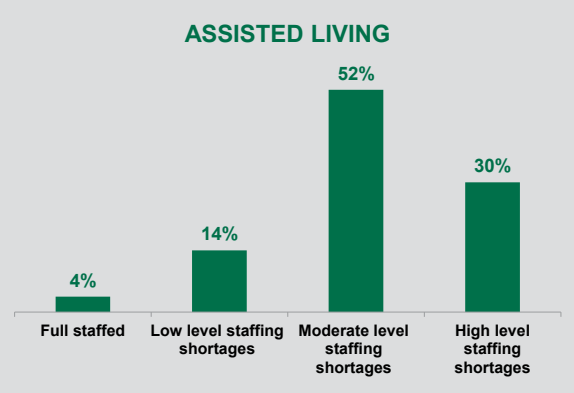
2

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

## Nearly every nursing home (99%) and assisted living community (96%) in the U.S. is facing a staffing shortage.

**Q: What is your current staffing situation?**



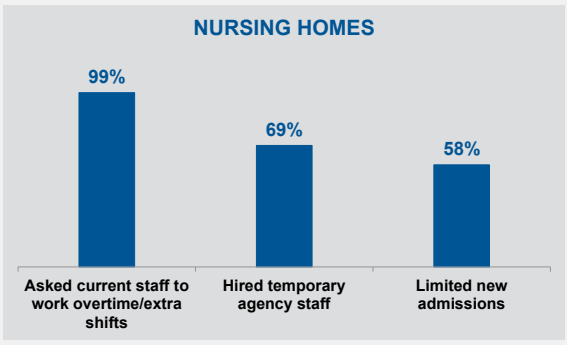

Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

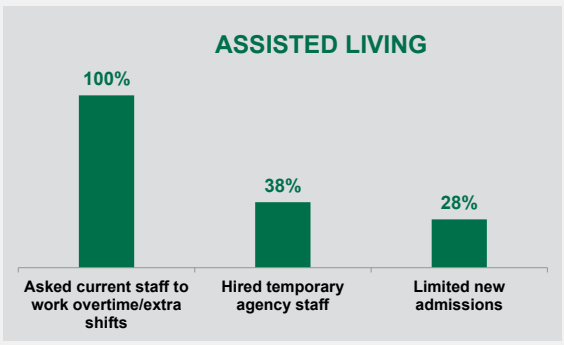
3

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

## Nearly every nursing home and assisted living community is asking staff to work overtime or extra shifts. 58% of nursing homes are limiting new admissions due to staffing shortages.

**Q. What adjustments have you made due to staffing shortages?**



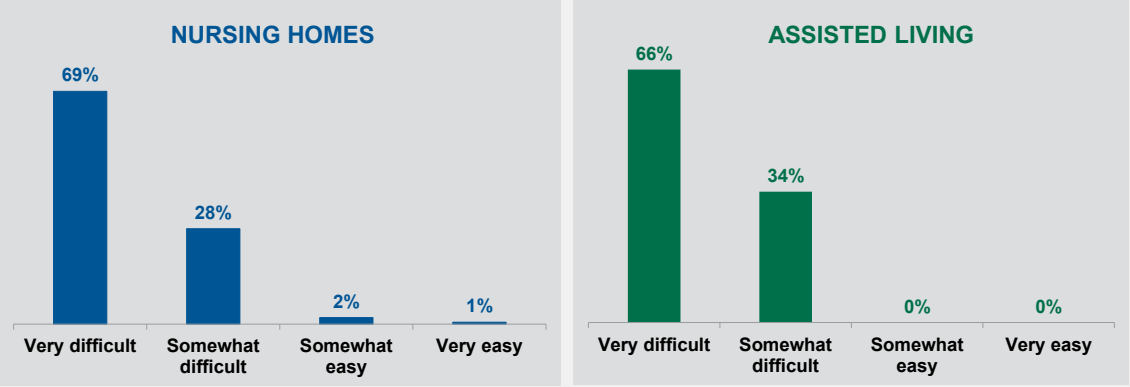

4

Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

**Nearly every nursing home and assisted living provider is having a difficult time hiring new staff with nearly 7 out of 10 saying they are having a very difficult time.**

**Q. How would you rate your ability to hire new staff?**



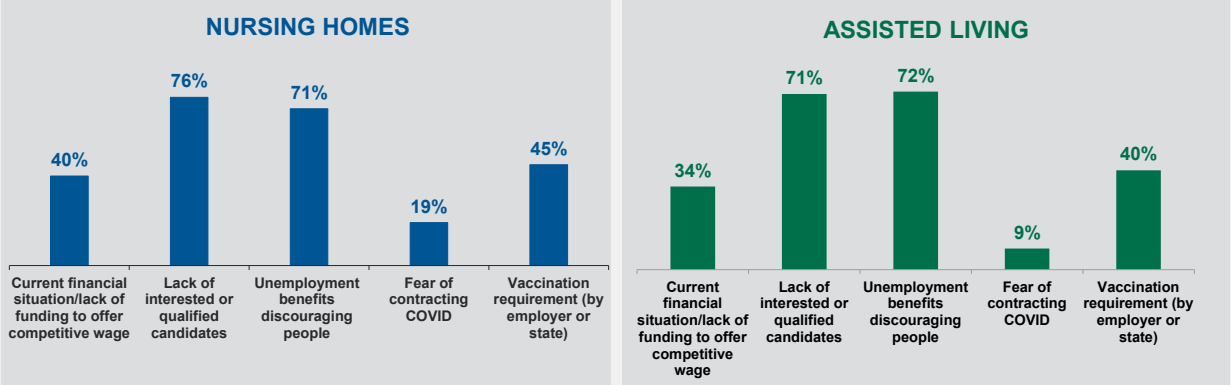

Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

5

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

**More than 7 out of 10 long term care facilities said a lack of qualified candidates and unemployment benefits have been the biggest obstacles in hiring new staff.**

**Q. What has been the biggest obstacle in hiring new staff?**



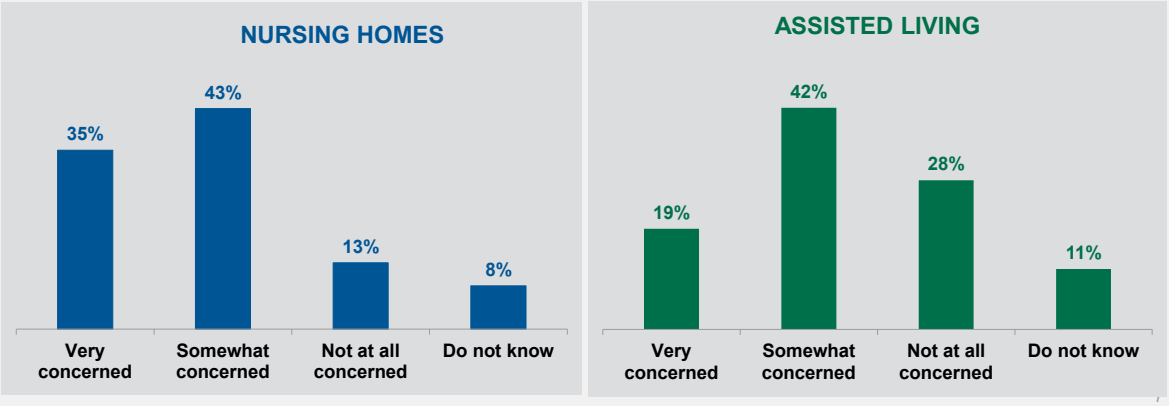

Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

6

AHCA AMERICAN HEALTH CARE ASSOCIATION NCAL NATIONAL CENTER FOR ASSISTED LIVING

**78% of nursing homes and 61% of assisted living communities are concerned workforce challenges might force them to close. More than one-third of nursing homes are very concerned about having to shut down their facility(ies).**

**Q. How concerned are you that if your workforce challenges persist that you may have to close your facility(ies)?**




Source: American Health Care Association & National Center for Assisted Living Survey of 1,183 Nursing Home and Assisted Living Providers, September 2021

CHAPTER 11:

1) PRE-FILING – What is health care?

a) 11 U.S.C. § 101(27A): The term "health care business"—

(A) means any public or private entity (without regard to whether that entity is organized for profit or not for profit) that is primarily engaged in offering to the general public facilities and services for—

(i) the diagnosis or treatment of injury, deformity, or disease; and

(ii) surgical, drug treatment, psychiatric, or obstetric care; and

(B) includes—

(i) any—

(I) general or specialized hospital;

(II) ancillary ambulatory, emergency, or surgical treatment facility;

(III) hospice;

(IV) home health agency; and

(V) other health care institution that is similar to an entity referred to in subclause (I), (II), (III), or (IV); and

(ii) any long-term care facility, including any—

(I) skilled nursing facility;

(II) intermediate care facility;

(III) assisted living facility;

(IV) home for the aged;

(V) domiciliary care facility; and

(VI) health care institution that is related to a facility referred to in subclause (I), (II), (III), (IV), or (V), if that institution is primarily engaged in offering room, board, laundry, or personal assistance with activities of daily living and incidentals to activities of daily living.

b) 11 U.S.C. § 101(27B): The term "incidental property" means, with respect to a debtor's principal residence—

(A) property commonly conveyed with a principal residence in the area where the real property is located;

(B) all easements, rights, appurtenances, fixtures, rents, royalties, mineral rights, oil or gas rights or profits, water rights, escrow funds, or insurance proceeds; and

(C) all replacements or additions.

c) 11 U.S.C. § 101(40A): The term "patient" means any individual who obtains or receives services from a health care business.

d) 11 U.S.C. § 101(40B): "Patient Records" means any record relating to a patient, including a written document or a record recorded in a magnetic, optical or other form of electronic medium

e) FED. R. BANKR. PROC. 1021

i) The petition controls designation as a health care business unless otherwise ordered.

ii) An interested party may move for a determination.

2) PRE-FILING – Is chapter 11 the right fit?

a) Federal & state regulation is inconsistent w/ bankruptcy goal of maximation of return to creditors.

b) One commentator: Chapter 11 is "insufficiently specific" as to healthcare.

c) Multiple parties, including:

i) Debtor(s);

ii) Creditors;

iii) Vendors;

iv) Regulators:

(1) Federal:

(a) DHHS;

(b) CMS; and

(c) Many others (*e.g.*, FDA, CDC, VA);

(2) State:

(a) Certificate of Need; and

(b) Licenses (e.g., Doctors; specialties).

v) Contract parties (Doctors groups; emergency room MDs);

vi) Patients; and

vii) Insurance companies.

d) Is the operation a Single Asset Real Estate entity?

i) Unique provisions in the Bankruptcy Code.

ii) Forces prompt reorganization or stay relief.

e) Are SBRA provisions available (sub-chapter V of chapter 11)

f) Chapter 9: Adjustment of Debts of a Municipality may apply if the hospital is part of the local government.

g) But what is the alternative (what is more organized for a reorganization or sale)?

3) PRE-FILING – Structure of debtor

a) Large entity or single owner;

b) Single or multiple properties;

c) Operations by 3d party operator (local or large); and

d) Fee or lease location(s).

4) PRE-FILING – Some Additional Planning Issues.

a) Consider authority to file.

i) Review corporate documents (charter, shareholders/members agreements, etc.)

ii) Follow voting requirements.

iii) Debtor remote entity?

b) Staffing:

i) Can existing management handle a complex chapter 11 case?

ii) Communications to avert typical bankruptcy fears.

c) Restructuring professionals

i) Legal counsel in a highly specialized industry.

ii) Is a restructuring officer required by the secured lender?

iii) Is an investment banker required?

d) Post-petition financing

i) Current lender or 3d party?

ii) Projections – do not forget bankruptcy costs.

iii) See infra re budgeting problems during COVID-19 era.

e) What is the initial exit plan (knowing it may change)?

5) PRE-FILING - Negotiations with secured lenders.

a) Review of Collateral Documents.

b) New collateral or guaranties

c) Forbearance Agreements.

i) Fact-based concessions: amount due; in default; release.

ii) Liquidity concessions from lender:

(1) Deferral of principal and/or interest payments

(2) Deferral of reserve obligations

iii) Waiver of stay

(1) Some locations might enforce (Fl., Ga., Pa.)

(2) Most probably would not

iv) Waiver of right to extend exclusivity (likely in a cash collateral/DIP order anyway)

v) Clean up collateral issues – this is the time to look for lender.

vi) Fees (but there is often no alternative)

6) PRE-FILING – Liquidity Concerns

a) Budgeting is critical at all stages.

b) Risk of Medicare/caid recoupment; audit?

c) Consider sources of unencumbered cash.

i) Lender must take control.

ii) Move to a different bank?

(1) Can the lawyer give this advice?

(2) Lawyers - watch out for your retainer; lien still exists.

d) Lender concessions (see forbearance agreement discussion supra)

e) Federal and local financial support programs.

i) PPP/Gov't Loans (is it a gift?).

ii) Local funds for employers and employees.

7) POST-FILING – First Day orders
   a) Prepared pre-filing; take your legal fees before filing.
   b) E.g., DIP financing; bank accounts; utilities; insurance; wages; prepetition expenses; notice procedures
8) POST-FILING – Budgeting
   a) The first budget(s) are prepared in anticipation of filing.
   b) Necessary to get a DIP financing or cash collateral order.
   c) Rule of thumb – 13 weeks
      i) But are longer term budgets possible during the COVID-19 era?
         (1) Pre-COVID-19, history allowed some certainty (e.g., conventions)
         (2) No pattern for a pandemic recovery
      ii) Maybe not just an average of best/worst case, but multiple budgets w/ many assumptions and variables.
9) POST-FILING - Management.
   a) Debtor-in-possession concept.
      i) Dance w/ the one that brought ya'.
      ii) Consider whether a push for a ch 11 trustee is likely.
   b) Directors and officers continue in place.
      i) Need to follow corporate formalities.
      ii) Generally, the business judgment standard; i.e., a fiduciary duty is owed to the company.
      iii) But with a bankruptcy overlay; i.e., an obligation to look out for the best interests of creditors and interest holders.
      iv) Consider salary levels – will they raise eyebrows.
      v) Do you need an employee retention plan?
10) POST-FILING – Oversight
   a) Bankruptcy Court
      i) Patient Care Ombudsman. 11 U.S.C. § 333. (*See* Outline.)
      ii) It's not just money; a living, breathing person is at risk
   b) United States Trustee (at least initially).

i) Meeting with officers regarding obligations
ii) First meeting of Creditors

c) Unsecured Creditors Committee.
i) Looking for $$ for constituency
ii) The significant opening negotiations involve:
(1) DIP Financing terms
(2) Time and funds to review secured creditor priorities.
(3) Retention of avoidance actions
iii) Need for Bankruptcy Court approval of certain actions.
(1) Financing – preliminary and final
(2) Sale of assets OCB
(a) Some or substantially all.
(b) Urgent need; i.e. prior to a reorganization plan.
(3) Assumption or rejection of leases and executory contracts
(4) Disclosure statement and plan.

d) Federal and state regulators
i) CMS; Medicare
ii) State; Medicaid
iii) Entity specific

11) POST-FILING - Operations.

a) Is the Healthcare entity operating?
i) Plans for reopening or full operations.
ii) Federal or local limitations on operations
iii) Budgeting is critical and this is a critical consideration.

b) COVID-19
i) Loss of high $$ services
ii) Free money

c) Hiring and retaining employees.
i) Upper management – KERP

ii) Day-to-day help (e.g., skilled vs. unskilled)

iii) Burnout

iv) Higher pay elsewhere

v) 3d party contracts (i.e., Doctor's group; emergency room MD)

d) Hygiene protocols.

e) 11 U.S.C. § 362(b)(28): There is an exception to the automatic stay for HHS's ability to exclude a debtor from Medicare or other federal health care programs.

12) POST-FILING – Closure.

a) Upon closure, the trustee and DIP must take care of the patients.

i) 11 U.S.C. § 704(a)(12): use all reasonable and best efforts to transfer patients from a health care business that is in the process of being closed to an appropriate health care business that—

(A) is in the vicinity of the health care business that is closing;

(B) provides the patient with services that are substantially similar to those provided by the health care business that is in the process of being closed; and

(C) maintains a reasonable quality of care.

[A DIP or trustee has the same obligations. 11 U.S.C. § 1106(a)(1).]

b) 11 U.S.C. § 508(b)(8) – an eighth priority claim for the actual and necessary costs of closing a health care business, including moving patients and disposal of records.

c) Destruction of patient records.

i) 11 U.S.C. § 101(40B): The term "patient records" means any record relating to a patient, including a written document or a record recorded in a magnetic, optical, or other form of electronic medium.

ii) Follow federal and state law.

iii) 11 U.S.C. § 351: Notification obligations for disposal of patient records when there are insufficient funds.

iv) FED. R. BANKR. PROC. 6011: Further detail regarding notice and destruction obligations.

d) WARN Act – requires a qualifying employer (49+ employee) to provide its employees with 60 days' notice of a closing or mass layoff with some

exceptions (unforeseen business circumstance or faltering business exception)

i) A trustee might succeed to WARN obligations if operate; but if liquidating fiduciary, compliance with WARN not necessary

ii) If sold as a going concern, WARN notice obligations likely not applicable

13) POST-FILING – Sale of Substantially All Assets Outside the Ordinary Course of Business.

a) Auction process

b) Break-up fee

c) Marketing

d) Very likely pitting the secured creditors against the Committee, both pressuring the DIP in opposite directions.

e) Is there cash out there looking for a home.

i) What might otherwise be a failing property could bring value?

ii) Large vs. Smaller Markets

(1) *E.g.,* NYC vs. Midwest.

(2) Are there opportunities to move up or down market.

f) Consider costs to sell – like a transfer tax avoidable with a plan.

g) Assumption or rejection of leases for medical equipment

h) Due diligence and the Medicare provider number.

i) Due diligence.

(1) The sale is generally fast tracked, so any review is limited.

(2) A second buyer (non- stalking horse) must generally rely on stalking horse (hope it did a decent job).

(3) Federal and state regulations are complex, so problems are hard to find regardless.

(4) There are possible hidden claims (*e.g.,* malpractice).

ii) Keeping the Medicare provider number has rewards and risks:

(1) Smooth(er) transition.

(2) Liability for recovery of overpayments and other problems of seller follows the number.

(3) An indemnification agreement is likely, but how helpful is a promise form a bankruptcy entity?

iii) Obtaining a new Medicare provider number also has rewards and risk.

(1) The liability of the seller does not follow.

(2) Medicare/caid is on hold until a new provider number is issued; the process takes time.

iv) Health care entities' obligations to repay government $$ is coming due.

(1) Loans must be repaid.

(2) Reporting obligations must be followed.

(3) The floodgates were opened during COVID-19:

(a) Medicare suspended many (most?) of its review procedures during COVID-19 to get $$ in the hands of the health care providers fast.

(b) Audits will very likely result in repayment obligations and the related recoupment efforts.

i) Operations transfer agreement to memorialize the allocation of responsibilities

j) If there is no plan, no discharge.

k) Should anticipate concerns about addressing successor medical malpractice liability

l) If selling a not for profit organization, must consider deed restrictions on donated real estate and use of proceeds acquired through charitable donations; consider whether AG offices will intervene

14) POST-FILING - Reorganization

a) Preparation of a Disclosure Statement and Plan

i) Exit Financing

ii) Second-tier lender cramdown issues

iii) Tossing a bone to the Unsecured Creditors (post-Jevik)

iv) Assumption/assignment issues

(1) Medicare/Medicaid provider numbers

(2) Accepting some risk vs. time

b) Projections – see budgeting concerns supra
   i) At least five years, maybe 10 in the COVID-19 era
   ii) Different markets (healthcare entities) are rebounding at different rates.
      (1) E.g., Nursing homes vs. home healthcare
      (2) Out-patient/high $$ procedures vs. preparing for the next wave
      (3) Different categories w/in a healthcare sector are also improving or failing.

c) Valuation Concerns
      (1) Is there an opportunity for a low cramdown valuation?
         (a) This is one reason bankruptcy cases are not as prevalent – yet.
         (b) Uncertainty breeds fear
      (2) New COVID-19 era appraisals are required.
      (3) There are not many transactions to suggest a FMV.
      (4) Cap rate is uncertain.

d) Lender Considerations
   i) Consider alternatives – e.g., an opportunity to sell the note.
      (1) Loan to own – buyer wants to own the property.
      (2) Often involves relief from personal guaranties to induce debtor cooperation.
   ii) 1111(b) Election

e) Feasibility
   i) More likely than not (maybe not that high of a standard)
   ii) Why not give the debtor a chance – provided, that:
      (1) There is a source of cash (e.g., equity)
      (2) Something is probably going on if major constituencies still disagree.

f) Discharge of fraud claims: 11 U.S.C. § 1141(d)(6): Notwithstanding paragraph (1) [general discharge], the confirmation of a plan does not discharge a debtor that is a corporation from any debt—

(A) of a kind specified in paragraph (2)(A) or (2)(B) of section 523(a) [fraud and false statements] that is owed to a domestic governmental unit, or owed to a person as the result of an action filed under subchapter III of chapter 37 of title 31 or any similar State statute; or

(B) for a tax or customs duty with respect to which the debtor—

(i) made a fraudulent return; or

(ii) willfully attempted in any manner to evade or to defeat such tax or such customs duty.

# USEFULNESS OF PATIENT CARE OMBUDSMAN

Prepared by: Jeana M. Mason
Law Clerk for Chief Judge Gregory R. Schaaf,
U.S. Bankruptcy Court for the E.D. of Kentucky[1]

I. Patient Care Ombudsman ("PCO") – 11 U.S.C. § 333.

A. Why is a PCO appointed?

1. The purpose of appointing a PCO is to monitor the quality of patient care and represent the interests of patients of a health care business. 11 U.S.C. § 333(a)(1).

B. When must a court order the appointment of a PCO?

1. A court shall order the appointment of a PCO within thirty (30) days of the commencement of the bankruptcy case if the debtor is a health care business that has filed a chapter 7, 9, or 11 bankruptcy unless the appointment "is not necessary for the protection of patients under the specific facts of the case." *Id.*

2. The term "health care business" –

a. means any public or private entity that is primarily engaged in offering to the general public facilities and services for:

i. the diagnosis or treatment of injury, deformity, or disease; and

ii. surgical, drug treatment, psychiatric, or obstetric care; and

b. includes hospitals, treatment facilities, hospice, home health agencies, and long-term care facilities. 11 U.S.C. § 101(27A).

3. If the court initially determines that a PCO is not necessary, interested parties may file a motion for an order to appoint one at any time. FED. R. BANKR. P. 2007.2(b).

C. How do courts determine that a PCO is not necessary for the protection of patients?

1. An interested party may file a motion to prevent the appointment of a PCO within twenty-one (21) days of the petition date or within the time otherwise fixed by the court. FED. R. BANKR. P. 2007.2(a).

[1] This document is not intended to express the opinions of the Court, but instead to provide general information regarding the topics discussed herein.

2. The movant must demonstrate that a PCO is not necessary for the protection of patients under the facts of the case. *In re Starmark Clinics, LP*, 388 B.R. 729, 734 (Bankr. S.D. Tex. 2008).

    a. The movant must satisfy this burden even if its request is unopposed. Kelly McDonald, *Litigating the Appointment of a Patient Care Ombudsman*, AM. BANKR. INST. (Apr. 22, 2020, 1:41 PM), https://www.abi.org/committee-post/litigating-the-appointment-of-a-patient-care-ombudsman.

3. Courts have developed factors to determine whether a PCO is not necessary for the protection of patients.

    a. *In re Alternate Fam. Care*, 377 B.R. 754, 758 (Bankr. S.D. Fla. 2007) used the following non-exclusive factors for the analysis:

        i. the cause of the bankruptcy;

        ii. the presence and role of licensing or supervising entities;

        iii. the debtor's past history of patient care;

        iv. the ability of patients to protect their rights;

        v. the level of dependency of patients at the facility;

        vi. the likelihood of tension between interests of the patients and the debtor;

        vii. the potential injury to patients if the debtor drastically reduced patient care;

        viii. the presence and sufficiency of internal safeguards to ensure an appropriate level of care; and

        ix. the impact of the cost of an ombudsman on the likelihood of a successful reorganization.

    b. *In re Valley Health Sys.*, 381 B.R. 756, 761 (Bankr. C.D. Cal. 2008) considered additional factors, including:

        i. the high quality of the debtor's existing patient care;

        ii. the debtor's financial ability to maintain high quality patient care;

        iii. the existence of an internal ombudsman program to protect the rights of patients; and

        iv. the level of monitoring and oversight by federal, state, local, or professional association programs that render the services of an ombudsman redundant.

4. No one factor is dispositive – courts have "considerable discretion to weigh the facts of each case when determining whether an ombudsman is required." *In re Smiley Dental Arlington, PLLC*, 503 B.R. 680, 688 (Bankr. N.D. Tex. 2013).

    a. In bankruptcies prompted by issues unrelated to patient care, courts have found that appointment of a PCO is not necessary for the protection of patients.

        i. *In re Denali Fam. Servs.*, No. A13-00114-GS, 2013 WL 1755481, at *4 (Bankr. D. Alaska Apr. 24, 2013) (bankruptcy prompted by tax liabilities and extraneous expenses);

        ii. *In re Saber*, 369 B.R 631, 637 (Bankr. D. Colo. 2007) (bankruptcy prompted by the issuance of a state court judgment against the debtor); and

        iii. *In re Total Woman Healthcare Ctr., P.C.*, No. 06-52000 RFH, 2006 WL 3708164, at *2 (Bankr. M.D. Ga. Dec. 14, 2006) (bankruptcy prompted by tax liabilities).

    b. Courts have also found that appointment of a PCO is redundant if there are other means of adequate oversight over the debtor – including government and private entities.

        i. *In re Mississippi Maternal-Fetal Medicine, P.A.*, No. 21-00091-NPO, 2021 WL 1941627, at *4 (Bankr. S.D. Miss. Feb. 18, 2021) (state licensing board and the continued care of the referring physician provided adequate oversight over the debtor's practice);

        ii. *In re Valley Health Sys.*, 381 B.R. at 761-65 (appointment of a PCO is redundant when a debtor is subject to substantial monitoring by a variety of entities);

        iii. *In re N. Shore Hematology-Oncology Assocs., P.C.*, 400 B.R. 7, 13 (Bankr. E.D.N.Y. 2008) (the New York State Department of Health and the Food and Drug Administration provided oversight over the debtor's operations, weighing against the appointment of a PCO); and

        iv. *In re Alternate Fam. Care*, 377 B.R at 759 ("Adding an ombudsman . . . would be a total duplication of the efforts of the various public and private entities already playing an oversight role.").

    c. Generally, appointment of a PCO is not necessary if a health care business is no longer operational because there is no need to represent patients or monitor and protect patient care.

        i. *In re Jennifer L. Ney Do Inc.*, No. 11-63563, 2011 WL 6032839, at *1 (Bankr. N.D. Ohio Dec. 5, 2011) (factors addressing level of care to patients and future operations are irrelevant when the debtor has closed its business and no longer provides health services to patients); and

ii. *In re Medical Assocs. of Pinellas*, 360 B.R. 356, 361 (Bankr. M.D. Fla. 2007) (court declined to appoint a PCO because the debtor had ceased operations and there was no longer a need to protect patients).

d. At least one court has considered the COVID-19 pandemic in determining that appointment of a PCO was not necessary.

i. *See In re Thomas Health Sys., Inc.*, No. 2:20-20007, 2020 WL 2026658, at *2 (Bankr. S.D.W. Va. Apr. 6, 2020) (The appointment of a PCO may "endanger patients during the pandemic, inasmuch as the ombudsman would be obliged to travel, visit patient rooms, and migrate between facilities at a time when personal contact should be minimized.").

D. What happens after the court orders appointment of a PCO?

1. The United States Trustee ("UST") shall appoint one disinterested person to serve as the PCO. 11 U.S.C. § 333(a)(2)(A).

2. If the debtor is a health care business that provides long-term care, the UST can choose between appointing:

a. the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the state in which the case is pending; or

b. another disinterested person. 11 U.S.C. § 333(a)(2)(A)-(B).

i. If the UST does not appoint the State Long-Term Care Ombudsman, then the court shall notify the individual serving in that position of the name and address of the ombudsman appointed. 11 U.S.C. § 333(a)(2)(C).

ii. The term "long-term care facility" includes skilled nursing facilities, intermediate care facilities, assisted living facilities, homes for the aged, and domiciliary care facilities. 11 U.S.C. § 101(27A).

3. The UST shall promptly file a notice of the appointment, including the name and address of the person appointed.

a. The notice of appointment should include a verified statement of the person appointed, setting forth the person's connections with the debtor, creditors, patients, any other interested party, their respective attorneys and accountants, the UST, and any person employed in the office of the UST. FED. R. BANKR. P. 2007.2(c).

b. Exception: If the appointee is a State Long-Term Care Ombudsman, a verified statement is not required. *Id.*

4. The court may terminate the PCO if it finds that appointment is no longer necessary to protect patients. FED. R. BANKR. P. 2007.2(d).

E. What are the duties of an appointed PCO?

1. The PCO must monitor the quality of patient care provided to all of the debtor's patients, to the extent necessary under the circumstances, including interviewing patients and physicians. 11 U.S.C. § 333(b)(1).

2. Within sixty (60) days of the appointment, the PCO must report to the court, at a hearing or in writing, regarding the quality of patient care. Thereafter, reporting must occur at least once every sixty (60) days. 11 U.S.C. § 333(b)(2).

    a. At least fourteen (14) days before making a report, the PCO shall give notice that it will make a report regarding the quality of patient care unless the court orders otherwise. FED. R. BANKR. P. 2015.1(a).

        i. The PCO shall:

            1) transmit the notice to the UST;

            2) post it conspicuously at the health care facility that is the subject of the report; and

            3) serve it on various interested parties including the debtor, trustee, and all patients. *Id.*

        ii. The notice shall state:

            1) the date and time when the PCO will make the report;

            2) the manner in which the PCO will make the report; and

            3) if the report is in writing, the name, address, telephone number, email address, and website, if any, of the person from whom a party may obtain a copy of the report at the debtor's expense. *Id.*

3. If the PCO determines the quality of patient care provided to the patients of the debtor is declining significantly or is otherwise being materially compromised, it must file a motion or written report, with notice to interested parties, immediately. 11 U.S.C. § 333(b)(3).

4. The PCO shall maintain the confidentiality of any patient information obtained. 11 U.S.C. § 333(c)(1).

    a. The PCO must seek court permission to review confidential patient records. *Id.*

        i. If the court approves such a review, it must impose restrictions on the PCO to protect the confidentiality of the records. *Id.*

ii. The PCO shall:

1) serve a motion to review confidential patient records on the patient and any family member or other contact person whose name and address have been given to the trustee or the debtor for the purpose of providing information regarding the patient's health care; and

2) transmit the motion to the UST subject to applicable nonbankruptcy law relating to patient privacy. FED. R. BANKR. P. 2015.1(b).

iii. Unless the court orders otherwise, any hearing on the motion must occur at least fourteen (14) days after service of the motion. *Id.*

F. What are some common reasons why a party might oppose appointment of a PCO?

1. If a PCO is appointed, the debtor's estate is responsible for the cost of the appointment. *See* 11 U.S.C. § 330(a)(1).

a. There are several ways a debtor can attempt to control cost; it can:

i. develop a budget;

ii. seek a financing or cash collateral order limiting the cost of services;

iii. try to limit the scope of work performed by the PCO through court order or other agreement; and

iv. propose a time limitation on the PCO's appointment. *Patient Care Ombudsman Why so Much Opposition?*, AM. BANKR. INST. J., Mar. 2006, at 22.

b. Although cost is relevant, some scholars have suggested that courts should give the cost-factor less weight than the other factors concerning potential harm and mitigation of harm.

i. Erin Masin, *The Patient Care Ombudsman: Taking Cost Out of Patient Care Considerations*, 26 Emory Bankr. Dev. J. 91 (2009) (criticizing cases that decided not to appoint a PCO on the basis of cost);

ii. Jerry Seelig & David Hoffman, *PCO Appointment: Whose Facts? The Case for Ombudsman Appointment*, AM. BANKR. INST. J., Mar. 2012, at 27 ("If patients are at risk, and the purpose of [the] statute is to protect patients, then financial analysis should play no role in determining a PCO appointment."); and

iii. *In re Flagship Franchises of Minnesota, LLC*, 484 B.R. 759, 765-66 (Bankr. D. Minn. 2013) (considering cost but giving it less weight than other factors).

2. PCO reports may give certain parties litigation advantages. *Patient Care Ombudsman Why so Much Opposition?*, AM. BANKR. INST. J., Mar. 2006, at 22.

    a. Interested parties may try to use PCO reports as a basis for motions to convert or to appoint a trustee or examiner. *Id.*

    b. A debtor can attempt to limit the use of PCO reports by seeking a protective order. *Id.*

G. If a court orders the appointment of a PCO, are there any benefits to PCO oversight?

1. The PCO can move a bankruptcy case along quickly and might increase efficiency as the PCO may serve as a valuable ally to the debtor in negotiations in court. *Id.*

2. The PCO serves as a contact for patients and family members –

    a. the PCO can provide comfort regarding the quality and monitoring of patient services; and

    b. the PCO can give patients a voice in the bankruptcy process. *Id.*

3. Since the PCO oversees patient care, the debtor can focus more of its attention on successfully restructuring and less time on patient care issues. *Id.*

4. The PCO may provide comfort to the debtor's employees –

    a. the PCO can assist in answering questions regarding patient care; and

    b. the oversight provided by the PCO can alleviate concerns held by doctors, nurses, and other staff regarding the quality of patient care. *Id.*

5. The PCO provides unbiased oversight over the debtor's operations, which helps ensure patient interests are adequately protected. *See* Jerry Seelig & David Hoffman, *PCO Appointment: Whose Facts? The Case for Ombudsman Appointment*, AM. BANKR. INST. J., Mar. 2012, at 26-27.

    a. Internal oversight is often flawed; and

    b. patients and staff benefit from the disinterestedness of a PCO. *Id.*

6. "The business end of a health care bankruptcy is driven by cost-containment, which may negatively impact patient safety[,]" so a disinterested, third-party is in the best position to ensure patients receive quality care delivered by competent personnel. *Id.* at 27.

# FTI Healthcare Industry Sector Outlook

FTI CONSULTING

December 2021

FTI CONSULTING

## Introduction

### The current state of play in the healthcare industry

Thank you for the opportunity to discuss some of our views currently facing the healthcare industry today. The FTI Consulting Healthcare practice believes the first half of 2021 will be a crucial period for all stakeholders in the industry given the recent election, continuing COVID impacts, and near-term debt maturities.

Over the past three years, we have been involved in over 450 healthcare engagements. In these engagements we have had the privilege of representing Companies, Secured Lenders, and Unsecured Creditors as they face and react to mergers and acquisitions, divestiture considerations, revenue cycle and billing management, regulatory and compliance changes, liquidity constraints and operational risk. In short, we have recent and direct experience working through both healthy and distressed situations which provides us with a deep understanding of the current environment and unique challenges facing the industry. We believe that our credentials and unique experience provide valuable insights to a range of situations in the healthcare space which we look forward to discussing with you today. The FTI Consulting Healthcare team brings the following strengths:

- Extensive experience building consensus among stakeholders and leading difficult negotiations, during which we have repeatedly and effectively used experience based quantitative support and analysis to successfully advocate for our Clients;
- Unique ability to leverage our healthcare industry specialists that allows us to quickly assess the situation, provide on-point analysis and recommendations and aggressively pursue our clients' interests;
- Ability to deliver professionals with relevant experience to immediately work on the engagement;
- Breadth and depth of firm-wide resources to be able to address any issue arising in the matter; and
- Ability to analyze and synthesize large amounts of borrower data with which lending groups can make timely informed restructuring decisions.

On behalf of the entire healthcare practice, thank you again for the opportunity to connect with you today. Please contact us at your convenience with any questions, clarifications or issues that you may have.

## Table of Contents





## Glossary

| | |
|---|---|
| **ACA** | The Affordable Care Act |
| **AKS** | Anti-Kickback Statute |
| **APM** | Alternative Payment Model |
| **ASC** | Ambulatory Surgical Center |
| **CMS** | Centers for Medicare and Medicaid |
| **COBRA** | Consolidated Omnibus Budget Reconciliation Act |
| **COVID** | COVID-19 Pandemic |
| **ED** | Emergency Department |
| **EHRs** | Electronic Health Records |
| **FFS** | Fee-for-Service |
| **HHS** | U.S. Department of Health & Human Services |
| **HOMG** | Hospital-owned Medical Group |
| **HOPD** | Hospital Outpatient Surgery Department |
| **LAN** | Learning Action Network |
| **MA** | Medicare Advantage |
| **MLR** | Medical Loss Ratio |
| **PBM** | Pharmacy Benefit Management |
| **PCP** | Primary Care Physicians |
| **PDGM** | The Patient-Driven Groupings Model |
| **PDPM** | Patient-driven payment model |
| **PPACA** | Patient Protection and Affordable Care Act |
| **PPM** | Physician Practice Management |
| **Stark** | Stark Physician Self-Referral Law |
| **RADV** | Risk Adjustment Data Validation |
| **REIT** | Real Estate Investment Trust |
| **VBA** | Value-based Arrangement |
| **VBID** | Value-based Insurance Design |
| **VBP** | Value-Based Purchasing |

# Executive Summary

## Selected Bios

**Rick Arrowsmith**

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Rick Arrowsmith specializes in turnaround and restructuring advisory, concentrated in sub-acute care, laboratory and healthcare real estate. Mr. Arrowsmith has close to 25 years of creditor workout experience.

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Tensie Axton specializes in developing and executing successful operational and financial strategies for businesses in various stages of their business cycle. Ms. Axton has more than 25 years of experience.

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Tim Dragelin has provided financial advisory services to all stakeholders, including borrowers, creditors and equity interests for more than 20 years.

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Narendra Ganti specializes in restructuring advisory and has over 20 years of experience advising debtors, lenders, creditors and other stakeholders.

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Wayne Gibson has 20 years of experience applying economic and financial modeling, data-intensive analysis, and complex claims analyses across numerous industries and in a variety of operational, dispute and compliance matters.

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Dave Katz is a member of the Senior Lender practice and has over 20 years of financial advisory and banking experience.

## Selected Bios

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Jan Naifeh has over 25 years of experience in working with clients during healthy growth periods as well as clients experiencing distress. She develops customized solutions and executes strategies on behalf of her clients.

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Charles Overstreet is the Global Segment Leader of FTI Consulting Health Solutions segment. Mr. Overstreet has exceptionally broad and varied experiences throughout the continuum of the healthcare industry.

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Adam Rauch has more than 10 years experience providing financial advisory services to companies, senior lenders and unsecured creditors' committees in the U.S. through both in- and out-of-court processes.

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George Serafin has 30+ years of experience and is FTI's Life Sciences Industry Leader responsible for the integrated delivery of services and solutions focused on assisting life sciences and healthcare clients with solving their most complex problems.





## FTI Consulting at a Glance

**FTI Consulting is an independent global advisory firm dedicated to helping organizations manage change, mitigate risk and resolve disputes.**

- **Global Reach**
- **Industry Experience**
- **Definitive Expertise**
- **Comprehensive Services**

| | | | |
|---|---|---|---|
| **$5.0B**<br>NYSE listed market capitalization[1] | **6,300 +**<br>Employees around the globe | **85**<br>85 cities around the globe | **16**<br>Operational experience in 16 industries |
| **FCN**<br>Publicly traded | **8/10**<br>Advisor to 8 of the world's top 10 bank holding companies | **96**<br>Advisor to 96 of the world's top 100 law firms | **29**<br>Countries |

Deal RANKED FIRM

**#1 Restructuring Adviser**
13 consecutive years

1. Number of total shares outstanding as of November 29, 2021, times the closing share price as of November 29, 2021.

## FTI Healthcare: How our Healthcare Experts Make the Critical Difference

**FTI Healthcare is dedicated to helping organizations manage change, mitigate risk, resolve disputes and improve performance.**

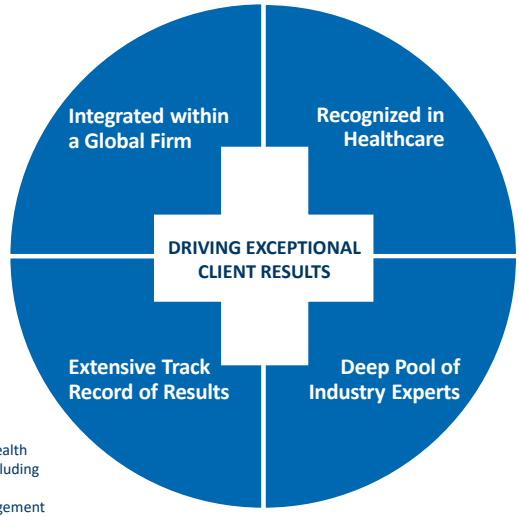
**Global Reach**
FTI Consulting has over 5,700 employees in offices across 82 cities and 27 countries
**53 of Fortune Global 100**
corporations are FTI clients

**Comprehensive Services**
Include Financial, Legal, Operational, Transactional, Political & Regulatory, and Reputational consulting

**450+**
FTI Healthcare clients served in the last three years

**Market Leading ROIs**
ROIs in the 3:1-10:1 range

**Transformational Services**
Comprehensive array of services for health system and physician organizations including performance improvement, strategy, transaction support and interim management




**Largest FTI Industry**

**Top 10 Management Consulting Firms**
For over 10 consecutive years
*Modern Healthcare* (2008-2019)

Named to **America's Best Management Consulting Firms**
*Forbes* (2016-2020)

**Experienced Leaders**
Leaders have 20+ years of healthcare industry experience

**Sample Industry Experts**
Healthcare CEOs, COO, CFOs, CMOs, PharmDs, MDs, RNs, Chief Restructuring Officers, Chief Implementation Officers, Interim Executives, Coders, Ancillary Department Leaders, Statisticians, Data Analysts and More

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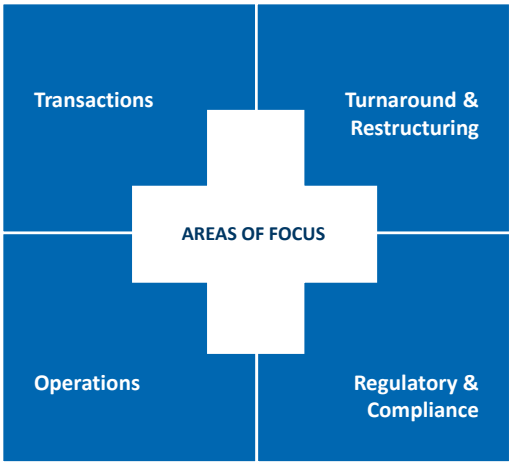
## Key Areas of Focus

**FTI Consulting specializes in a broad spectrum of services, providing assistance to clients throughout all phases of a company's financial health.**

**Transactions**
- ✓ 360° Due Diligence
  - — Financial and Tax
  - — Clinical and Regulatory Compliance
  - — Operational
- ✓ Merger Integration & Carve-outs
- ✓ Valuation Services
- ✓ Investment Banking

**Operations**
- ✓ Performance Transformation
- ✓ Labor Productivity & Process Improvement
- ✓ Revenue Optimization
- ✓ Provider Enterprise
- ✓ Quality & Clinical Delivery Optimization
- ✓ Non-labor Expense Management




**Turnaround & Restructuring**
- ✓ Business Plan Development & Execution
- ✓ Strategic Alternatives
- ✓ Liquidity Management
- ✓ Interim Management
- ✓ Bankruptcy & Insolvency Advisory

**Regulatory & Compliance**
- ✓ Risk Assessment
- ✓ Compliance Program Effectiveness
- ✓ Regulatory Disputes & Investigations
- ✓ Clinical Documentation, Coding & Billing Reviews
- ✓ Independent Review Organization (IRO) Services
- ✓ Business Dispute Advisory Services
- ✓ Strategic Communications

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EXECUTIVE SUMMARY

## Extensive On-Point Experience

**FTI has been retained in many of the largest and most complex process improvements, financial advisory and recapitalizations, working alongside companies and other constituents to maximize value. Additionally, FTI has significant operational expertise in addressing revenue constraint, operational challenges, and tightening liquidity in the healthcare industry.**

### On Point Experience

- **Healthcare Industry Specialists:** We have advised clients across the sector in various roles and understand key value drivers. We are actively engaged in multiple healthcare services matters which provide exposure to current market trends. FTI Consulting has deep expertise in performance improvement, revenue, billing and cash collection, staffing and operations, tax advisory, forensic analysis, and valuation.
- **Restructuring Expertise:** We have been involved in large and complex restructuring assignments across the healthcare spectrum from single site hospitals to nationwide healthcare franchises. Our expertise allows us to quickly assess the situation, provide on-point analysis and recommendations and aggressively pursue our clients' interests.
- **Due Diligence Reviews:** FTI has provided financial and operational due diligence reviews and services. These reviews included Quality of Earnings due diligence reports and revenue cycle and compliance assessments focused on validating the necessity of treatments, billing, reimbursement, claims testing and compliance, and mitigating any impact on revenue recognition.
- **Unmatched Credibility:** Engagement constituent groups know and respect FTI Consulting's team. Our professional reputation in the marketplace will supplement credibility in key negotiations with all parties involved in this situation.
- **Industry Relationships:** FTI Consulting has served companies, their boards, and their lenders, bondholders, equity investors and other case parties in a broad range of healthcare assignments, developing lasting business relationships with professionals throughout the industry.

### Extensive Healthcare Advisory

| | | | |
|---|---|---|---|
| CIENA HEALTHCARE: Financial Advisor to Syndicate of Secured Lenders | The Miami Center: Interim Regional President/Financial Advisor | MyMed: Financial Advisor to the Senior Lenders | Verity Health: Unsecured Creditors Committee |
| Promise Healthcare: Financial Advisor to the Company | Adeptus: Chief Restructuring Officer | Financial Advisor to the Bondholders | Forest Park Medical Center: CRO §363 Sale |
| Senior Care Centers: Unsecured Creditors Committee | MCCI: Financial Advisor to the Senior Lenders | neighbors: Chief Restructuring Officer and Interim CEO | Quorum Health: Financial Advisor to the Secured Lenders |
| Genesis: Financial Advisor to the Senior Lenders | Centennial: Financial Advisor to the Senior Lenders | Financial Advisor to the Senior Lenders | Financial Advisor to the Senior Lenders |
| Joerns Healthcare: Financial Advisor to the Senior Lenders | Financial Advisor to the Senior Lenders §363 Sale | Vanguard: Unsecured Creditors Committee | Financial Advisor to the Ad Hoc Senior Lenders |



EXECUTIVE SUMMARY

## Healthcare Sector Trends and Considerations

| | Current Trends | Future Considerations |
|---|---|---|
| **Deferred consumption of healthcare services** | ■ COVID has reduced patient volume across most sub-sectors due to care deferral and the moratorium on elective procedures. | ■ Short-term surge in demand is expected as vaccines become more readily available.<br>■ An aging population and other key drivers will cause patient volume growth in the long term. |
| **Increased costs related to COVID** | ■ Increased staffing and PPE costs have been experienced across all sectors. | ■ Increased costs related to infection control will likely continue beyond the pandemic. |
| **Stimulus support** | ■ Congress provided $178B in relief funding for providers, in addition to other programs aimed at bolstering liquidity during the pandemic. | ■ With relief funds shifting to other areas of the economy, utilization has yet to return to pre-pandemic levels and providers struggling prior to COVID have fewer options to remain afloat. |
| **Regulatory changes** | ■ The CARES Act had significant impacts to the healthcare industry including necessary funding, reimbursement waivers and a pause on the planned 2% reduction of Medicare program payments.<br>■ In April 2020, CMS announced it was allowing plans to provide mid-year benefit enhancements in response to the COVID outbreak. | ■ The Biden Administration is expected to release a package of healthcare reforms to be considered under the reconciliation process. While changes may materially impact some sectors, it is unlikely to cause major structural changes to the healthcare system prior to midterm elections.<br>■ The new administration has signed legislation enhancing the ACA subsidies and tax credits on a temporary basis.<br>■ Congress will likely pass drug pricing measures in the next 3-6 months. Anticipated targeted policies could disproportionately impact certain manufacturers. |
| **Personalized Care and the Patient Experience** | ■ Patients, as consumers of their healthcare interactions, are increasingly driving demand and accelerating the pace of innovation and change in the market. | ■ Digital health technology and innovation is promoting a more proactive and empowered patient population.<br>■ Precision-medicine continues to be a driving force within healthcare. |
| **Continuing increase in utilization of telehealth services** | ■ In response to the pandemic, CMS approved several reimbursable services for telehealth across the industry, increasing care access. | ■ While there is interest in expanding telehealth access permanently, increased scrutiny is likely given concerns regarding increased costs and fraud and curb regulatory flexibility granted during COVID may come under review. |
| **Ongoing market consolidation** | ■ Consolidation remains active within fragmented spaces such as PPM and home health. | ■ Major players will seek vertical integration in order to expand service offerings and lower costs. |

## Subsector Trends and Considerations

| | Current Trends | Future Considerations |
|---|---|---|
| **Payors and Health Plans** | ■ COVID caused consumers to defer elective and preventative healthcare services in 2020, leading to record earnings for Payors, however, Payors are anticipating lower earnings in 2021 and into 2022 as consumers catch up on deferred services.<br>■ Record profits during COVID are likely to lead to increased scrutiny on insurers, particularly on government-funded programs such as MA. This may fuel the push for cuts to payment rates. | ■ With the new administration, the ACA has seen renewed support and may seek to further advance coverage reforms such as a public option or lowering the age of Medicare eligibility.<br>■ Insurers will have to adjust to the push to value-based care from the traditional FFS model.<br>■ Increasing cost pressures are likely to continue to fuel the debate over the appropriate role for government in ensuring health coverage. |
| **Physician Groups** | ■ Physicians continue to experience downward reimbursement pressure from payors against escalating costs.<br>■ PPMs will continue to acquire independent physician practices, as physicians trade autonomy for higher perceived compensation and less administrative burden. | ■ Increased demand for telehealth services is likely to remain post-COVID.<br>■ The shift to value-based arrangements will continue.<br>■ Changes to the Stark Physician Self-Referral Law and Anti-Kickback Statute regulatory framework could provide more flexibility in structuring physician compensation – improving physician productivity and retention for PPMs. |
| **Behavioral Health** | ■ Mental health and substance abuse disorders worsened during COVID, as job losses led to increased isolation, depression, stress and alcohol/drug use, fueling growth in demand.<br>■ Increased demand for telehealth services is likely to remain post-COVID. | ■ As the de-stigmatization of mental illness continues to drive demand, payors will move to expand coverage and decrease cost of care.<br>■ The Biden Administration has proposed expanding reimbursement for telehealth for mental health services in the 2022 Medicare Physician Fee Schedule. |
| **Home Health** | ■ Providers have a new opportunity to participate in MA.<br>■ PDGM have caused a substantial increase in low-utilization payment adjustments (LUPA) episodes, reducing payment compared to that of a normal 30-day episode of care. | ■ As volumes return, given patients' deferral of treatments, patient needs will initially be more acute.<br>■ Transition to value-based reimbursement and highly coordinated care will benefit home care providers. Organizations can take steps to provide preventative care for patient risks and make treatments more efficient. |





## Subsector Trends and Considerations (Cont.)

| | Current Trends | Future Considerations |
|---|---|---|
| **Acute Care** | ■ Patient volumes and the number of elective procedures are still down relative to pre-COVID levels. Until COVID vaccines are fully distributed, the sector will face challenges to return to pre-COVID volumes.<br>■ Increased staffing and PPE costs will continue.<br>■ The use of telehealth has increased as the CMS added 80+ new services that can be delivered via telehealth. | ■ The economic fallout following the Cares Act infusion of liquidity may result in delayed effects of underlying stress and distress within the space.<br>■ Incentives for Medicaid expansion in the recent reconciliation legislation passed by Congress may lead to increased patient revenues for hospitals in non-expansion states. |
| **Post-Acute Care** | ■ Increased demand for post-acute care following hospital discharges is expected to continue as both the population and prevalence of chronic conditions grows.<br>■ Liquidity is expected to tighten further in 2021 as costs remain inflated (PPE and staffing).<br>■ $21B in stimulus funding for SNFs and PPP loans have only partially alleviated the estimated $41B bottom-line impact in 2020. Losses in 2021 are projected to be over $52B. | ■ Uncertainty regarding future stimulus and repayment of loans may negatively impact recovery in the post-acute sub-sector.<br>■ The Medicare Payment Advisory Commission is scrutinizing the role of private equity particularly in post-acute care, which may lead to tightened regulations. |
| **Senior Living** | ■ COVID has caused severe declines in occupancy, coupled with increased costs related to PPE and staffing requirements.<br>■ Strong competition for new residents will lead to an increased use of short-term pricing incentives to capture market share. | ■ Demand is projected to exceed available beds/units within the next five years, contributing to a positive long-term recovery.<br>■ The pandemic will lead to a heightened focus on infection control when investing in facilities. |
| **Life Sciences** | ■ Increased focus on health equity as part of access and affordability objectives<br>■ Personalized medicine, patient engagement and experience are core to companies' business strategies<br>■ Technology innovation continues to strongly influence product development and patient empowerment and engagement. | ■ Evolution to home-based care and adoption of necessary technologies (e.g., telehealth, remote patient monitoring, mobile apps, etc.)<br>■ Monetization of data<br>■ Companies will look to take advantage of accelerated regulatory pathways and health authority collaboration. |
| **Healthcare IT** | ■ The rise of telehealth across the industry has contributed to demand for underlying technological systems integration. | ■ The push to value-based care will require adequate information technology infrastructure support. |

# Market Trends and Observations

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## Healthcare Bankruptcy Activity

**There were 19 and 13 healthcare-related bankruptcies in 2020 and through 3Q21, respectively. The healthcare sector continues to have access to liquidity through government programs and other capital sources.**

**There were 19 healthcare bankruptcies with liabilities totaling $50M or more in 2020.**

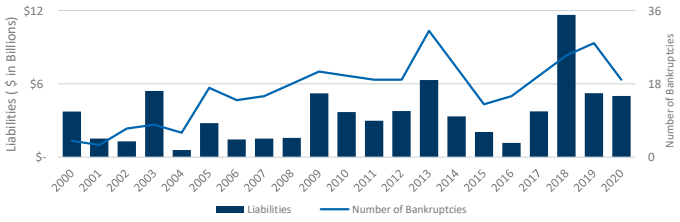
- Healthcare equipment and supplies companies saw an increase in filings compared to 2019, as the rest of the industry saw an 17% decrease.
- While overall filings were down, several pharmaceutical companies filed to wind down operations following involvement in opioid-related litigation.

**As government stimulus ends and patient volumes fail to rebound in 2021, cash-strapped companies will likely have to restructure.**

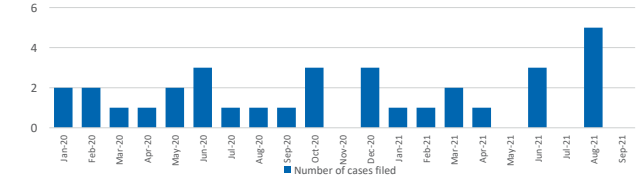
- The CARES Act included $100B to reimburse providers for expenses and lost revenues due to COVID and $180M for telehealth and rural health activities. Additional funds have been provided in subsequent bills.
- Congress is expected to enact legislation in 2021 to extend sequester relief for providers, effectively delaying the scheduled reinstatement of 2% across-the-board reductions in Medicare reimbursements.

**There have been 13 healthcare-related bankruptcies in 2021, year to date as of September.**

**Total Healthcare Bankruptcies with >$50M in Liabilities[1]**




**Total Monthly Healthcare Filings**




Sources: The Deal, Debtwire, Reorg

1. 2018 was skewed by one very large filing: HCR ManorCare, which had over $7B in liabilities.

# Recent Top Healthcare Bankruptcies

**Quorum Health Corporation and Akorn Inc. were the two largest bankruptcies in 2020, accounting for 53.4% of the total value of filings with $50M or more in liabilities.**

| Company | Sector | Liabilities ($ in Millions) |
|---|---|---|
| **2020** | | |
| Quorum Health Corp. | Acute Care | 1,262.3 |
| Akorn Inc. | Biotechnology/Pharmaceuticals | 1,051.8 |
| AAC Holdings Inc. (American Addiction Centers) | Behavioral Health | 517.4 |
| Vivus Inc. | Pharmaceuticals | 281.7 |
| TriVascular Sales LLC (Endologix) | Medical Devices | 281.4 |
| Benevis Corp. | Physician Group | 214.7 |
| Hygea Holdings Corp. | Physician Group | 212.2 |
| LVI Intermediate Holdings Inc. | Physician Group | 207.2 |
| Thomas Health System Inc. | Acute Care | 148.8 |
| LRGHealthcare | Acute Care | 128.0 |
| Rochester Drug Co-Operative, Inc. | Pharmaceuticals | 113.2 |
| REVA Medical Inc. | Medical Devices | 104.5 |
| MTPC LLC | Post-Acute Care | 100.0 |
| Unipharma LLC | Pharmaceuticals | 100.0 |
| Henry Ford Village Inc. | Post-Acute Care | 100.0 |
| Randolph Hospital Inc. | Acute Care | 55.4 |
| TM Healthcare Holdings LLC | Behavioral Health | 50.0 |
| **2021** | | |
| CMC II LLC (Consulate Health Care) | Post-Acute Care | 382.2 |
| Buckingham Senior Living Community, Inc. | Post-Acute Care | 300.0 |
| Amsterdam House Continuing Care Retirement Community, Inc | Post-Acute Care | 260.1 |
| Mercy Hospital & Medical Center | Acute Care | 202.1 |
| Community Intervention Services, Inc. | Behavioral Health | 106.8 |
| Prospect-Woodward Home | Post-Acute Care | 105.8 |
| Path Medical LLC | Physician Group | 86.5 |
| CP Holdings LLC | Post-Acute Care | 81.7 |
| Connections Community Support Programs, Inc. | Behavioral Health | 50.5 |
| California-Nevada Methodist Homes | Post-Acute Care | 50.0 |

Source: The Deal



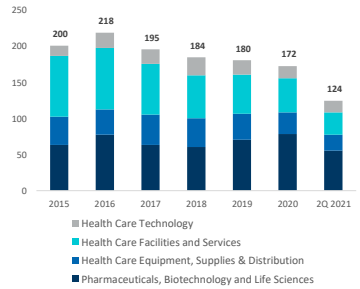


# Healthcare M&A

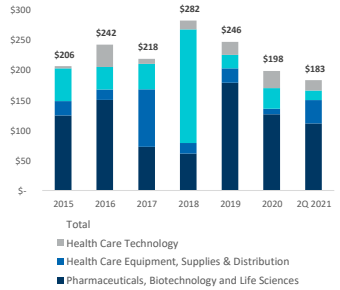
**Providers continue to seek consolidation in order to gain market share and take advantage of the economies of scale necessary to meet the goals of increased access to care, lower costs and improved quality of care.**

- In 2021, M&A activity significantly rebounded in the healthcare space following the outbreak of COVID and the resulting economic downturn in 2020.
- 4Q20 saw a resurgence of deal volume with 222 deals in December 2020. In 2020, there were, on average, 135 deals per month.
- Demand for physician groups increased following minimal activity in 2020, with 30 deals in 1Q21. Activity in eHealth, services and long-term care follow with the highest amount of activity by sector.
- Hospital activity saw a similar uptick in volume as deals in 4Q20 increased 127% over 3Q20.

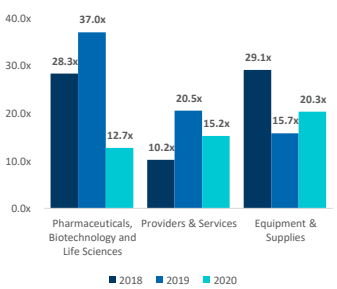
**U.S. Healthcare M&A Transaction Volume >$50M Through 2Q21** (# of Deals)



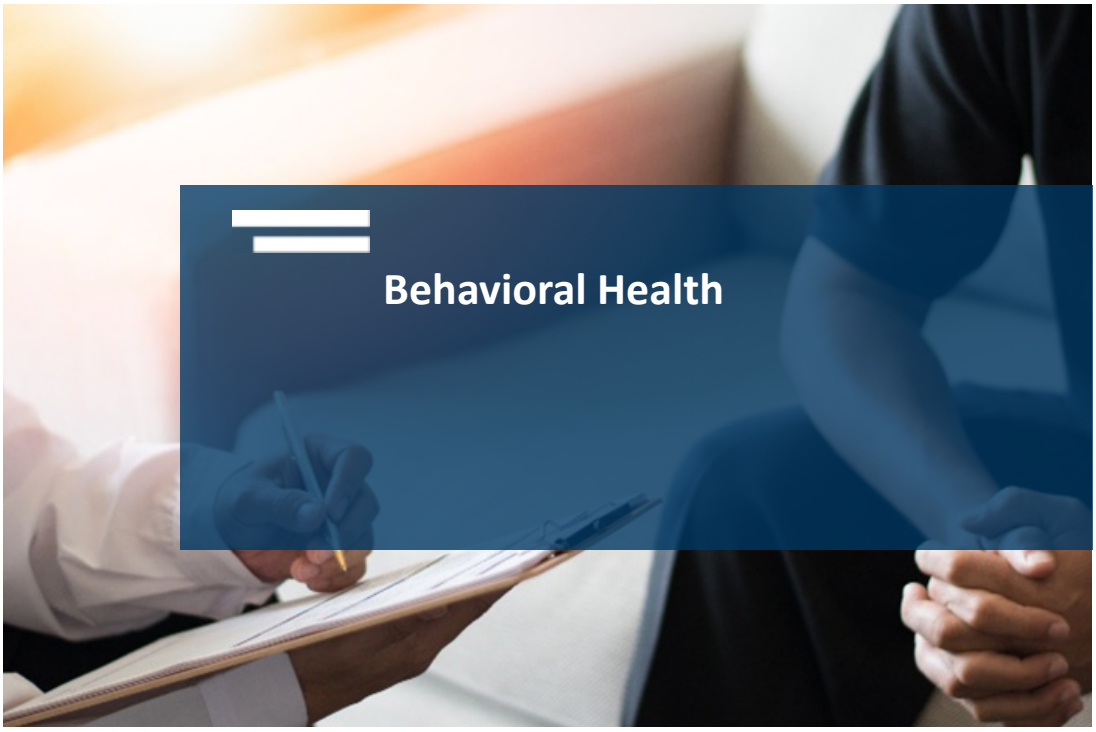

**U.S. Healthcare M&A Transaction Value >$50M Through 2Q21** ($ in Billions)




**Historical Average EV/EBITDA Multiples**




Sources: CapIQ, VMG Healthcare M&A Report 2020, Levin Associates Healthcare M&A

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## Service Line Overview

**Behavioral health can be categorized into three main service-line offerings.**

**Behavioral Health Care Continuum**

**Low-Intensity Care** → **High-Intensity Care**

### Outpatient

- Outpatient programs offer continuations of both inpatient and residential treatment regimens to assist patients in their transition back into society and help them continue the healing process.
- Primary offerings include medication management, group therapy and individual therapy.
- Attending regular sessions helps prevent patient relapse and provides them with safe outlets to discuss struggles they are experiencing.

### Inpatient

- Acute care for patients in need of stabilization or crisis resolution
- Primary offerings include:
  - Detoxification for individuals battling drug/alcohol addiction, safely removing toxins from the body for an increased likelihood of lasting rehabilitation.
  - Medication Management: Psychiatrists evaluate patients to set up and maintain a treatment regimen utilizing psychotropic medications.
  - Therapy: Confidential one-on-one or group settings provide outlets to share experiences and overcome hurdles.

### Residential Treatment

- Longer-term treatment options for a variety of patient needs – the primary means of care is psychotherapy, with medication used as a secondary form of treatment.
- Mental Rehabilitation: Treatment for anxiety, depression, eating disorders and schizophrenia, among others. Programs are designed to treat specific disorders.
- Substance Abuse Therapy: Individualized treatment options for those suffering from addiction to alcohol, amphetamines, cocaine, opioids and prescription drugs among others.
- Intellectual and Developmental Disability Services ("IDD"): Residential home care for children and adults in a supervised setting.

Sources: VMG Healthcare M&A Report: 2019 Trends and 2020 Expectations, IBIS World Reports

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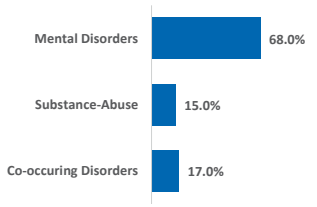
# Service Trends

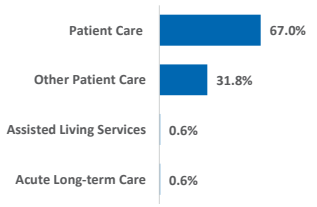
### Outpatient Revenue Segmentation




**Outpatient Rehabilitation Services** — Includes outpatient services relating to mental health, developmental and intellectual disabilities and substance abuse therapies.

- Industry demand has increased in the pandemic, with revenue increasing from $9.8B in 2021 to reach $10.0B in 2026.
- The total number of outpatient centers in the United States is estimated to grow from 94,836 in 2021 to 108,165 establishments by 2026.

### Inpatient Revenue Segmentation

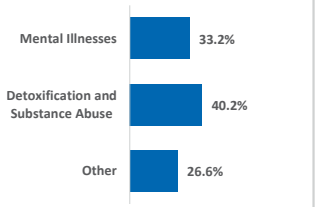



**Patient Care** — Include a wide variety of psychotic and neurotic disorders, such as dementia, psychosis, anxiety, delirium, schizophrenia, anorexia and stuttering.

**Other Patient Care** — Includes nonpsychotic and nonneurotic conditions and nonclinical revenue.

- Expanded public and private healthcare coverage and prevalence of mental illness are projected to bolster revenue at an annualized rate of 2.6%, to $26.6B in 2026.
- The total number of inpatient facilities in the United States is estimated to grow at an annualized rate of 2.2%, to 448 in 2026.

### Residential Revenue Segmentation




- Over the five years from 2021 to 2026, industry revenue is forecast to grow at an annualized rate of 1.7% to $20.8B.
- Currently, an estimated 45.3% of industry revenue is derived from Medicaid and Medicare.
- The total number of residential centers in the United States is estimated to grow from 8,602 to 9,427 operators by 2026.

Source: IBIS World Reports



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# Opportunity Summary

### Market Overview

**The behavioral health market is underserved. The pandemic has only increased the need and focus by local, state, federal and third-party payors.**

- The industry has benefited over the past five years due to growth in Medicare and Medicaid spending (annualized rate of 2.9%).
- The market is highly fragmented, with two top publicly traded players (Acadia and Universal Health Services) accounting for less than 25% of industry revenue in 2020.
- Consolidation, including some of the largest industry players, continues as companies seek cost reductions and increased market share.
- The opioid epidemic, increased access to care, and de-stigmatization of mental illness have driven an increase in demand, particularly for outpatient treatment programs.

### Opportunity

**Demand, changing staffing models, use of technology and expanding reimbursement present an opportunity for growth. The market is very fragmented and ripe for consolidation.**

- In a fragmented behavioral health landscape, platform deals will continue and there will be a focus on acquisitions and development of smaller behavioral health facilities, particularly in the outpatient space, as sponsors adopt a hybrid build-and-buy model of growth.
- Facilities that are able to track and show future outcomes are most successful. Payors and consumers will continue to look for the "best" treatment centers according to outcomes data.
- Growing investment in health IT including EHRs, decision support systems, telepsychiatry and imaging technologies, is expected to improve delivery of mental health and substance abuse care.

### Outlook

**Alcohol, tobacco and drug use continues to escalate and account for an estimated 25% of all deaths in the United States.**

- A growth rate of 3.2% is projected from 2021 to 2026 as government initiatives focused on mental health parity further contribute to demand for care.
- Private healthcare, namely employer-sponsored insurance (ESI), is responsible for 10.6% of medical reimbursements in the substance abuse disorder treatment industry.
- The number of people with private health insurance is projected to decline in the coming years. In 2021, out-of-pocket payments accounted for 4.7% of substance abuse disorder treatment industry revenue.

### Potential Targets

**While there is ample room for further consolidation, not all acquisition targets are created equal.**

- Facilities located close to referring doctors and highly populated cities are in a stronger position to attract clients.
- Success depends on the ability to establish and maintain close relationships with physicians, managed care companies, insurance companies, educational consultants and other referral sources.
- Companies that have formed trusted relationships with insurance companies and those that have already effectively navigated the transition to in-network status within a narrow network are better positioned to succeed.

Sources: FTI Consulting analysis, cms.gov, IBIS World (June 2020)

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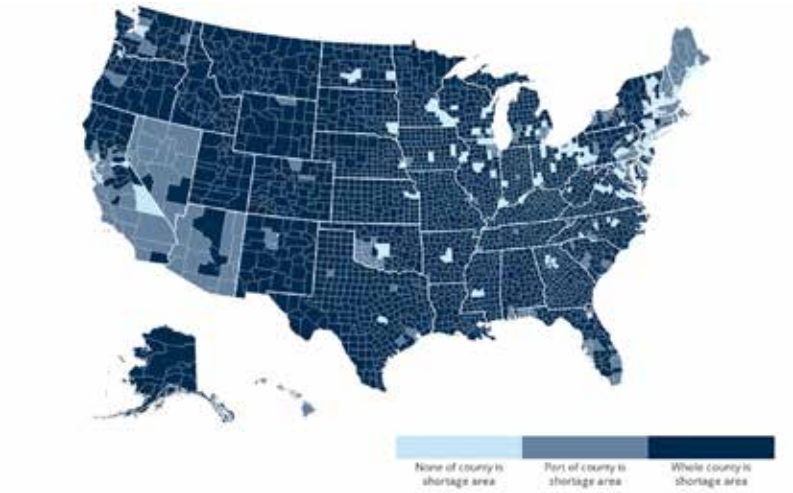
## Market Opportunities

**The map below illustrates states with health professional shortages areas ("HPSA"). Mental health HPSAs account for several population factors, including population-to-provider ratio, alcohol abuse prevalence, substance abuse prevalence and travel time to the nearest source of care ("NSC").**




Source: HRSA.gov



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## Opportunities/Tailwinds

**Reasons to consider an investment in behavioral health**

### Severely underserved market

- Mental health and substance abuse disorders worsened during COVID, as job losses led to increased isolation, depression, stress and alcohol/drug use.
- Approximately 58M U.S. citizens cope with a mental illness, substance abuse disorder or co-occurring conditions.
- Less than 43% of adults experiencing mental illness receive treatment in a given year.
- Of the 20M adults requiring treatment at a specialty facility annually, only around 2M receive treatment.
- De-stigmatization of mental illness has driven an increase in demand, particularly for outpatient treatment programs.

### Funding and governmental support

- In March 2021, the Biden Administration announced a plan that provides $2.5B in funding to address the mental illness and addiction crisis. SAMHSA will designate:
  - $1.5B to a Community Mental Health Services Block
  - $825.0M to Substance Abuse Prevention and Treatment Block Grant
  - SAMHSA awarded an additional $686M in CCBHC grants, Emergency Grants to address Mental and Substance Use Disorders During COVID-19 and supplements for the 2020 Emergency Response COVID-19 grant recipients.
- The new administration is expected to push through legislation expanding access to SUD treatment under Medicare and Medicaid.

### Opportunity to lower the cost of provision of care

- The ratio of monthly medical costs for patients with behavioral health comorbidities compared to those without is 2-3 times greater. Payors are recognizing this and increasingly funding services.
- New care models, including telehealth, can improve quality and access to care and cost-effectively address the shortage of behavioral health clinicians.
- Organizations that can adopt more highly leveraged care models (including psychiatric nurse practitioners, licensed clinical social workers and licensed mental health workers) may find success.
- Companies with a lower-cost provision of care in the behavioral health space will have a competitive advantage.

### Telehealth and technology

- The Coronavirus Preparedness and Response Supplemental Appropriations Act in May 2020 granted waivers permitting the use of telehealth to provide behavioral health services for the duration of the pandemic.
- The Biden Administration has proposed expanding reimbursement for telehealth for mental health services in the 2022 Medicare Physician Fee Schedule. Telehealth treatment for mental health care is expected remain available through December 31, 2023, under a proposed rule which is expected to be finalized.
- An effective telehealth platform improves patient access. However, with the ability for providers to see large patient volumes, the risk of fraudulent behavior increases.



Sources: FTI Consulting analysis, IBIS World Reports, VMG Healthcare M&A Report: 2019 Trends and 2020 Expectations, SAMHSA, Milliman and the American Psychiatric Association Study

# Opportunities/Tailwinds (Cont.)

## Reasons to consider an investment in behavioral health

### Highly fragmented industry with opportunity to improve efficiency and scale

- Private equity firms and strategic buyers with growing capital reserves and access to credit will continue to pursue platform-building acquisition strategies.
- CARES Act funding provided a temporary lifeline for many smaller providers. However, with reduced funding, there may be buying opportunities at lower multiples.
- Scale in terms of technology, contracting and recruitment/ training/retention could benefit a platform provider.
- Providers that can demonstrate quality and outcomes are poised to benefit.
- Outpatient therapies have relatively higher profit margins. Expanding the continuum of care offers an opportunity for growth and margin expansion.

### Autism is high-growth sector

- Autism Spectrum Disorder ("ASD") has become an attractive sector due to the increased funding from Congress and focus on applied behavioral analysis.
- An estimated one in 54 children are diagnosed with ASD by eight years of age.
- In September 2019, the Autism Collaboration, Accountability, Research, Education and Support Act of 2019 ("Autism CARES") was signed into law and will be in effect through 2024, providing more than $1.8B towards advancing the understanding of and treatment for autism.
- In March 2021, the American Rescue Plan was signed into law, including $3B in dedicated funds for special education, 12.6B for HBCS and $3B for Individuals with Disabilities Education Act (IDEA) programs.

### Ongoing opioid epidemic presents growing demand for services

- According to the CDC, between 1999 and 2017 more than 700,000 people died from drug overdoses.
- In response, the federal government increased funding for SAMHSA, reflecting a heightened level of demand for industry operators and supporting industry growth.
- In addition to its block grants, SAMHSA pledged $15M to test the efficacy of Assisted Outpatient Treatment ("AOT"). If proven effective, AOT could be expanded, further bolstering growth in the industry.

### Expansion of private health insurance and corporate coverages

- According to SAMHSA, private insurance covers 22% of all mental health expenditures in the Unite States.
- Private insurance payors and corporations, through better outcomes tracking, are seeing the benefits of expanding coverage, which should bolster demand for industry services.
- Mental illness and substance abuse translate to lost productivity for corporations. As such, employers are offering multidimensional benefits, from organized sessions with social workers and monthly therapy stipends to counseling referrals. Companies are also using awareness of mental health issues to retain and recruit workers.



Sources: FTI Consulting analysis, IBIS World Reports, VMG Healthcare M&A Report: 2019 Trends and 2020 Expectations, SAMHSA, Milliman and the American Psychiatric Association Study



# Challenges/ Headwinds

## Key obstacles to overcome in the behavioral health market

### Labor shortages and high turnover

- In 2021, wages represented 44.6% of industry revenue.
- Demand for specialized labor and increased minimum wage pressures lead to higher wages and labor shortages.
- The industry has a high employee turnover rate (averaging 40% annually).
- The increased need for behavioral health services post-pandemic may not be met due to shortage of an estimated 6,500 providers, limiting growth in a high-demand industry.

### Reimbursement pressures

- Commercial insurance is pressuring providers to go in-network, even withholding payment as a negotiating tactic. This puts pressure on working capital. Once in-network, providers require expertise and resources to negotiate fee schedules.
- The industry has seen an uptick in the proportion of Medicaid patients. Based on a sample of industry billing codes, Medicaid reimbursement rates ranged 26%-28% lower than commercial payors.
- A rise in the proportion of Medicaid patients may adversely affect profitability across the industry due to reimbursement pressures.

### Efficiency doesn't always come with scale

- The need for local/regional presence and good relationships with referral sources limits the ability to scale by adding new services or geographies.
- Inpatient substance abuse (detoxification) typically has high churn, low length of stay and high customer acquisition cost.
- The high administrative burden associated with managed Medicaid programs due to eligibility rules and authorization requirements requires a larger staffing footprint.

### Increasingly competitive environment

- Barriers to entry are increasing due to the regulatory environment, changing insurer policies and staffing requirements.
- There are a large number of nonprofits providing services, driving thin industry margins.
- The millennial generational cohort consists of over 80M people and is increasingly becoming larger than the baby boomer cohort as a consumer base. It is crucial that treatment centers shift marketing messages to appeal to this digitally connected group.

### Post-COVID Recovery

- Residential facilities were hit hard with coronavirus cases, creating fear among patients to attend these facilities. Unlike outpatient facilities, inpatient facilities could not treat patients using telehealth and suffered during COVID.
- While private insurance payors have been increasing mental health and substance abuse coverage, the pandemic had a significant negative impact on employment and insurance coverage, posing a near-term threat to the industry.



Sources: FTI Consulting analysis, onshift.com, IBIS World Reports, Health Resources and Services Administration

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# Industry at a Glance

## Snapshot

### Major Players

- Acadia Healthcare Company: ~ 18K beds
- Universal Health Services: ~ 23.7K beds
- American Addiction Centers
- Behavioral Health Group, Inc

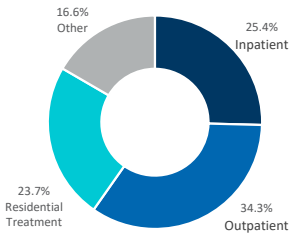
### Key Drivers

- Federal funding for Medicare and Medicaid
- Federal funding for social services
- Holders of private health insurance
- Per capita disposable income

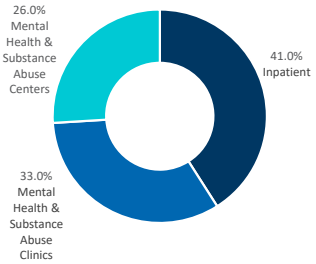
### Key Statistics

| 2020 Revenue | 2020 Profit | Wages |
|---|---|---|
| **$73.0B** | **$3.8B** | **$34.1B** |
| Annual Growth (2015-2020) **3.5%** | Projected Annual Growth (2020-2025) **2.9%** | Composed of Mental Health Centers, Mental Health Clinics, and Psychiatric Hospitals |

### Revenue by Service Line 2020




### Revenue by Segment 2020




Sources: IBIS World Reports for Psychiatric Hospitals in the US, Mental Health & Substance Abuse Clinics in the US, Mental Health & Substance Abuse Centers in the US



BEHAVIORAL HEALTH

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# Looking Forward: Strategic Growth Opportunities for Major Players

## UHS

- Offerings:
  - Inpatient
  - Partial Hospitalization
  - Outpatient
  - Residential Treatment
  - Specialty Programs
- Behavioral Care Centers: 300+ inpatient, outpatient, hospital and residential facilities
- Beds: Approximately 23,500
- Patients: 600K+/year
- 2020 Revenue: $11.56B
- 2020 EBITDA: $1.86B
- Largest facility-based behavioral health provider in the country

- A key element of UHS's growth strategy is expansion through the acquisition of additional hospitals in select markets.
- In recent years, UHS has focused its behavioral health segment efforts on partnerships with non-UHS acute care hospitals to help operate their behavioral health services. These arrangements include hospital purchases, leased beds and joint-venture operating agreements.
- As of February 25, 2021, UHS owned and/or operated 360 inpatient facilities and 39 outpatient and other facilities in 38 states.

## ACADIA

- Offerings:
  - Inpatient
  - Outpatient
  - Residential Treatment
  - Specialty Programs
- Employees: Approximately 42K
- Behavioral Care Centers: 589, including inpatient hospitals, outpatient facilities and residential facilities
- Beds: Approximately 18,000
- 2020 Revenue: $2.09B
- 2020 EBITDA: $644M
- Facilities/partnerships in the UK and Puerto Rico

- Acadia's primary business strategy is to acquire and develop behavioral healthcare facilities and expand its referral network.
- In 2019, Acadia acquired 11 facilities and added 585 beds, including 425 added to existing facilities and 160 added through the opening of two de novo facilities. In 2020, Acadia added approximately 600 beds.
- Acadia continues to hone its operating focus on the acute inpatient psychiatric segment.

## Encompass Health

- Offerings:
  - Inpatient Rehabilitation
  - Outpatient Care
  - Home Health
  - Hospice
- 137 inpatient rehabilitation hospitals
- 186,800 annual inpatient discharges
- Employees: 43K+
- 2020 Revenue: $4.6B
- 2020 EBITDA: $860M
- Largest owner and operator of inpatient rehab facilities
- Inpatient rehab accounts for approximately $3.5B of annual revenue

- Encompass continues to expand its portfolio of inpatient rehabilitation hospitals, home health agencies, and hospice agencies.
- Each year Encompass targets to add four to six new inpatient rehabilitation hospitals and $50M to $100M in home health and hospice acquisitions.
- In 2020, Encompass opened four new hospitals and expanded existing hospitals by 117 beds..
- At the end of 2020, Encompass had 137 hospitals, 241 home health locations and 82 hospice locations. Its nationwide footprint now spans 39 states and Puerto Rico.

Sources: Company websites, Company SEC filings


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HOME HEALTH

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## Service Line Overview

**Home health can be categorized into four main service-line offerings.**

### Skilled Home Health

- A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
- Primary offerings include:
  - Wound care for pressure sores or a surgical wound
  - Patient and caregiver education
  - Intravenous or nutrition therapy
  - Injections
  - Monitoring serious illness and unstable health status

### Personal Care Services

- Personal care services aim to help individuals who need assistance with the regimens of daily life and personal activities including bathing, dressing, moving around, using the toilet, eating and walking.
- Personal care services may also include companion care and homemaking services.

### Hospice

- When a patient has six months or less to live, the transition to hospice care is made.
- Hospice care is designed to provide pain management, symptom control, psychosocial support and spiritual care to patients and their families.
- Hospice care may also include palliative care to address symptoms, relieve pain and maximize quality of life.

### Therapy

- **Physical therapy** includes exercise to regain movement and strength to a body area and training on how to use special equipment or do daily activities, such as how to get in and out of a wheelchair or bathtub.
- **Speech-language therapy (pathology services)** includes exercises to regain and strengthen speech skills.
- **Occupational therapy** provides assistance in learning new ways to do usual daily activities.

Source: nia.nih.gov

HOME HEALTH

# Opportunity Summary

### Market Overview

**One of the leading subsectors for growth and activity within healthcare.**

- $95.9B market.
- Medicare and Medicaid represent 73.8% of industry revenue.
- The home health landscape is highly fragmented, with ~40,000 agencies across the United States.
- The top three players represent less than 10% of the market.

### Opportunity

**The home health industry has a positive outlook, with significant growth prospects and high likelihood of continued consolidation.**

- Annual growth rate is projected at 5.0% over the next five years.
- There is a likelihood of a long-term shift away from institutional care in the wake of COVID.
- Consolidation, strategic partnerships and JVs continue as companies seek service offering expansion, geographic coverage, cost reductions and market share.
- Headwinds exist due to continued reimbursement pressures from Medicare and Medicaid.

### Outlook

**High growth, number of small undercapitalized participants and ability to effect change through consolidation. Technology provides a significant opportunity for investment returns.**

- There is increased demand for specialization and broader service offerings from providers.
- MA is adding/expanding supplemental coverage for non-medical in-home care.
- Scale (through partnerships or M&A) should be sought to address the following key areas:
  - Strong technology, including productivity enhancements
  - Contract management
  - Recruitment, training and retention
  - Quality outcomes
  - Leadership
  - Specialization
  - Telehealth

### Potential Targets

**Focused individual market investment on a state-by-state basis will allow for market control.**

- Investments will likely be made in established state players without national reach that would benefit from additional scale and introduction of technology:
  - Florida
  - Texas
  - California
  - Michigan
  - Illinois
- Strategic assessment of targeted roll-ups should include: payor contracting consideration, provider number rationalization, employee training, HR benefits and retention programs, IT and RCM platform consolidation.

Sources: FTI Consulting analysis, IBIS World – "Home Care Providers in the US" – April 2021, Home Healthcare News



HOME HEALTH

# Opportunities/Tailwinds

## Change and disruption leading to investment opportunities

### Expansion of non-medical personal care reimbursement

- Beginning in 2020, CMS allowed MA plans to cover supplemental non-medical in-home support and services. Additionally, it expanded the definition of services that qualify for reimbursement.
- There exist new opportunities for home care providers to participate in MA, which now serves 34% of all Medicare beneficiaries, with 22M total enrollees.
- New patients who aren't utilizing traditional skilled home care present an untapped market opportunity.

### Focus on lower-cost outpatient care

- One year of home health aide service is nearly half the cost of one year in a private nursing home.
- The average hospital stay is decreasing, and many who are discharged need continued medical assistance at home.
  - In 1990, the average stay was nine days, dropping down to five days in 2017.

### Demand for increased specialization and expanded services

- Service needs have expanded, and more skilled caregivers are required (infusion, respiratory, occupational, speech and physical therapy).
- Physical rehabilitation and respiratory therapy are among the largest components of the broader home care service industry.
- There is an increased focus on chronic disease management, which is estimated to impact 150M in the United States, or six in 10 adults, with four in 10 having two or more chronic diseases.
- Care for dementia, heart disease and pulmonary disease is becoming more common.
- Possible care gaps include bariatric care and home dialysis.

### Use of new technologies

- Advances in technology are enabling more procedures to be performed in homes.
- Telemedicine now includes more advanced home and mobile health monitoring (e.g., vitals, teleretinal imaging, teleradiology, portal devices, cardiac monitoring).
- The use of electronic devices in patient charting and GPS in route management is increasing efficiency and profit opportunity for providers.
- Rural markets are underserved by home health providers. The use of technology and telehealth could expand the geographic reach of providers.

Sources: FTI Consulting analysis, IBIS World – "Home Care Providers in the US" – June 2020, Home Healthcare News

# Opportunities/Tailwinds (Cont.)

## Change and disruption leading to investment opportunities

### Increasing quality outcomes leads to reduced costs

- Studies show home health can lead to significant cost savings for payor/insurers.
- The Medicare house call demonstration program (Independence at Home) examined home-based primary care and found that its use resulted in an annual savings of $2,819 per beneficiary, increased quality of care, and decreased hospital and ED visits.
- A separate study showed that for patients released from the ED, those receiving home health care had lower hospital admissions/readmissions.

### Value-based care

- Transition to valued-based reimbursement and highly coordinated care greatly benefits home care.
- Recent changes should accelerate the needs of hospitals and health systems for experienced home health partners.
- Centers for Medicare & Medicaid Innovation is expanding the Value-Based Insurance Design model to test several wide-ranging updates to MA offerings, including a hospice carve-in set to take effect in 2021. Hospice care is currently not covered by MA plans.
- CMS introduced the VBID in seven states in 2017 and expanded it in 2018 and 2019. Language included in the Bipartisan Budget Act of 2018 requires VBID to include all 50 states and territories by 2020.
- Risk-bearing entities are looking to home health for post-acute cost and care management.

### Favorable demographics

- The 65+ population in the United States is expected to represent 23% of total US population by 2030 and nearly double to 95M by 2060.
- 52% of Americans aged 65+ require some form of long-term care.
- The U.S. population is living longer and recovering faster from surgeries, resulting in increased home care demand.
- Medicare beneficiaries, numbered 58M in 2018, are expected to total 80M by 2033.
- Over 10% of industry revenue is private health insurance, which is expected to increase.

Sources: FTI Consulting analysis, IBIS World – "Home Care Providers in the US" – June 2020, Home Healthcare News





# Challenges/Headwinds

## Key obstacles to overcome in home health

### Labor shortages and high turnover

- Wages are estimated to account for 57.5% of industry costs in 2021.
- 60% of home care providers identify labor shortages as among their top three concerns.
- Overall turnover rate is 65.7% and cost of training a new hire is ~$2,600.
- Onboarding, training and retention are the largest non-labor related operating expense in the space, averaging 3.0%-3.5% of revenue.
- Over the next five years to 2026, industry employment is projected to grow at an annualized rate of 4.8%, to 2M.
- Lack of specialized, skilled labor and the push for minimum wage hikes will result in higher wages for existing labor, placing negative pressure on profit margins.

### Reimbursement pressures

- Anticipated Medicare and Medicaid revenues represent 73.8% of industry revenue in 2021.
- Between 2014 and 2018, the Medicare home health benefit was cut by $730M. Medicaid has also been subject to federal reductions.
- CMS has pushed a "behavioral adjustment" of negative 8%, due to its belief that home health has a high level of waste and fraud. Legislation is being considered to prohibit assumption-based cuts from CMS.
- Given the highly fragmented market, home health does not have strong representation in Washington to fight CMS on reimbursement cuts.

### Move from PPS to PDGM payment model

- PDGM went live January 1, 2020 for all episodes beginning after that date.
- Under the prior Requests for Anticipated Payment (RAP) plan, 60% of a 60-day care period was received upfront, before care delivery. CMS plans to reduce RAPs to 20% in 2020 for existing agencies and eliminate them by 2021.
- Under PDGM, agencies get 20% of payment upfront on a 30-day care period.
- Without access to RAPs, many freestanding home health agencies with tight margins will go out of business or change ownership.
- PDGM reduces PT and OT therapy thresholds, causing most home health providers to scale back therapy services.

### Varying state requirements

- Some U.S. states have licensing requirements while others do not.
- Licensing and accreditation may make it costlier and more time-consuming to enter certain states (e.g., California is not a licensure state for non-medical or custodial care; Florida requires different levels of service licensing).

Sources: FTI Consulting analysis, IBIS World – "Home Care Providers in the US" – April 2021, Home Healthcare News

HOME HEALTH

## Challenges/Headwinds (Cont.)

### Key obstacles to overcome in home health

**Digital Disruption**

- The 21st Century Cures Act passed in 2016 requires that states implement electronic visit verification for all home health visits by 2023 (specific to providers reimbursed by Medicaid).
- There is a strong focus on data collection and analysis of data to demonstrate home health benefits such as cost savings and improvement/maintenance of seniors' health to satisfy payors and providers.
- Small firms may struggle, having limited software capabilities and capital to invest in infrastructure.
- The increased use of technology in the field is also a significant change for many nurses and service providers.

**Fraud**

- Fraud and improper payments are a major issue in the home health space.
- In fiscal year 2018, Medicare paid an estimated $3.2B in improper payments for home health services.
- Home health providers may be required to provide surety bonds in the future, in accordance with recommendations from the Office of the Inspector General to CMS.

**Concentration**

- Employees of relatively small regional and local operators provide most of the care.
- Centralizing care and decreasing costs may pose as greater challenges due to the concentration of providers at a local level.
- Home health providers will need to tailor patient intake at both the local and national level to their company's footprint.

Sources: FTI Consulting analysis, IBIS World – "Home Care Providers in the US" – June 2020, Home Healthcare News



HOME HEALTH

## United States - Industry At a Glance

### Snapshot

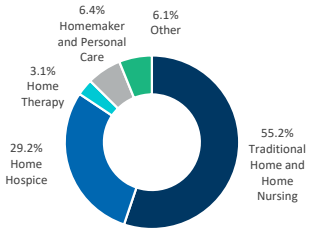
**Largest home health industry players**

| | |
|---|---|
| **Kindred Healthcare** | **2.9%** |
| **Lincare Holdings Inc.** | **2.6%** |
| **Amedisys, Inc** | **2.2%** |
| Interim Healthcare | 0.5% |

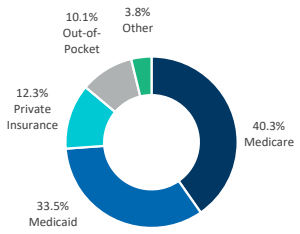
**Key Statistics**

| 2021 Revenue | 2021 Profit | Wages |
|---|---|---|
| **$95.9B** | **$5.5B** | **$55.1B** |
| Annual Growth (2016-2021) **1.0%** | Projected Annual Growth (2021-2026) **5.0%** | Businesses in the Industry **431K+** |

**2021 Products and Services Segmentation**




**2021 Major Market Segmentation**




Sources: IBIS World – "Home Care Providers in the US" – April 2021; LexisNexis Risk Solutions (2019)

HOME HEALTH

## Industry Regulatory Changes

**CY 2020**

- The PDGM took effect January 1, 2020, shortening the unit of payment from a 60- to a 30-day episode of care with new case mix methodology. Therapy thresholds were eliminated as a payment driver.
- A negative 8% "behavioral adjustment" was imposed by CMS.
- OASIS data collection and the Quality Reporting Program will result in reduced costs for home health agencies.
- CMS permits cost of remote patient monitoring to be reported as allowable cost on the Medicare cost report.
- MA began covering non-medical in-home care in 2019; because of the late CMS announcement, just 3% of MA plans offered these services in 2019, according to an AARP analysis.
- MA plans are able to offer expanded telehealth coverage.

**CY 2021**

- A new home infusion therapy benefit begins in 2021 and will cover services related to the administration of drugs through infusion pumps, training, and remote monitoring of services.
- There is a MA carve-in demonstration for hospice in 2021. MedPAC believes this would promote integrated, coordinated care, consistent with the goals of the MA program.
- CMS' new proposed payment rule for 2021 would give home health agencies an estimated 2.6% rate increase, equating to about $540M more for providers in 2022. However, this does not cover projected inflation and will put additional margin pressure on agencies to operate more efficiently.

**CY 2022**

- PDGM will phase out RAP payments.
- The home health VBP Model is designed to shift from volume-based payments to focus on quality of care. The home health VBP program includes:
  - Payment +/- of 3% in 2018
  - 5% in 2019
  - 6% in 2020
  - 7% in 2021
  - Maximum 8% adjustment in 2022 when all states will be transitioned
- HHAs payments will be adjusted depending on the quality of performance.



HOME HEALTH

## U.S. Healthcare M&A Activity – Select Recent Transactions

**Providers and services led transaction volume in 2019 and 2020.**

- The market continues to experience very high multiples, even more so YTD in 2020.
- PE and strategic buyers are looking to take advantage of roll-up opportunity and projected 4.9% CAGR.
- The space is dominated by independent providers, leading to little to no brand overlap in many regions of the country.
- Consolidation among existing care providers is crucial to establishing economies of scale and local/state/federal influence.
- Larger providers are well positioned to take market share from smaller agencies that cannot withstand cash flow pressures of PDPM (estimates of up to 30% of smaller providers could close or change ownership).

### Scale and roll-ups continue

- In April 2020, Amedisys announced plans to acquire AseraCare Hospice for $235M. In 2019, Amedisys completed the acquisition of three hospice companies: Integrated Compassionate Care Hospice (Feb-19), RoseRock Healthcare (Apr-19) and Asana Hospice (Jan-20), making Amedisys the fourth-largest hospice provider in the United States.
- Encompass acquired Alacare Home Health & Hospice in Apr-19 for $220M.
- Addus HomeCare purchased Hospice Partners of America, a multistate provider of hospice services for $130M.
- Care Advantage acquired Team Nurse, a provider of both non-medical and medical home health care services in Dec-19. Care Advantage made four acquisitions total in 2019, with the Team Nurse deal one of its biggest.

### Specialization and differentiation

- Ascension Health and PE firm TowerBrook Capital Partners agreed to acquire Hospice Compassus from Audax and Formation Capital for $1B in Oct-19. Compassus operates more than 125 community-based hospice, palliative and home health care services locations in 30 states.

### JVs / Partnerships

- LHC announced numerous new and expansion JVs related to expanding its U.S. footprint. LHC is aiming to tri-locate home health, hospice and personal care services in one area. During that process, LHC typically focuses on home health first, then hospice, then community-based services.
- Encompass acquired two inpatient rehab facilities through JVs.
- In July 2020, Bayada Home Health Care announced plans to form a JV with Universal Health Services Inc. (NYSE: UHS), one of the largest providers of hospital and health care services in the country. The JV with Bayada will enable UHS to "significantly expand" its home health care services.



Source: S&P Capital IQ Data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ACUTE CARE

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## Service Line

**Acute care providers are generally facilities where a patient receives active but short-term treatment for a severe injury or episode of an illness. Care can be provided in any of the following settings:**

### Trauma Care & Acute Care Surgery

- Treatment of individuals with acute surgical needs, such as life-threatening injuries, acute appendicitis or strangulated hernias.

### Emergency Care

- Treatment of individuals with acute, life- or limb-threatening medical or surgical needs, such as acute myocardial infarctions or acute cerebrovascular accidents, or evaluation of patients with abdominal pain.

### Urgent Care

- Ambulatory care in a facility delivering medical care outside a hospital emergency department, usually on an unscheduled, walk-in basis.
  - Examples include evaluation of an injured ankle or of fever in a child.

### Short-term Stabilization

- Treatment of individuals with acute needs before delivery of definitive treatment.
  - Examples include administering intravenous fluids to a critically injured patient before transfer to an operating room

### Prehospital Care

- Care provided in the community until the patient arrives at a formal health-care facility capable of giving definitive care.
  - Examples include delivery of care by ambulance personnel or evaluation of acute health problems by local health-care providers.

### Critical Care

- The specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units.
  - Examples are patients with severe respiratory problems requiring endotracheal intubation and patients with seizures caused by cerebral malaria.

Source: National Institutes of Health National Library of Medicine

ACUTE CARE

# Opportunity Summary

### Market Overview

**Hospitals have struggled over the past five years. While increased access to insurance and growing demand from the elderly population have supported steady revenue growth, these factors did not outweigh the financial impact of COVID.**

- The industry has seen overall revenue decline at an annualized rate of 1.5% to $938.2B from 2015 to 2020, including a decline of 17.9% in 2020 alone.
- While the industry has benefited from the expansion of Medicaid under the PPACA and has seen a greater number of patients seeking care, government insurance plans have lowered reimbursement rates.

### Opportunity

**Increasing demand and changes to the reimbursement landscape create hurdles and opportunities for growth for acute care providers.**

- Patient populations in need of more care are growing at a rate faster than that of the workforce. As a result, hospitals are seeking new ways to attract physicians and nurses – including increasing salaries for new hires and retaining temporary and contract employees.
- The Health Care Payment and Learning Action Network ("LAN") released aspirational goals surrounding the adoption of alternative payment models ("APMs"). While survey responses indicate clinicians believe APMs will result in better quality of care and more affordable care, adoption has slowed amongst providers.

### Outlook

**Revenue for the hospitals industry is expected to gradually return to typical growth rates over the next five years.**

- The industry's projected annualized growth rate of 2.4% will bring total revenue to $1.1T by 2025.
- Projected growth is largely attributed to an increase in federal funding for government health insurance (annualized rate of 4.2%) and rising demand associated with an aging population (annualized rate of 3.1%).
- Return to normalized volumes of elective procedures that were deferred during COVID will assist growth in the industry.

### Potential Targets

**While the hospital and specialty hospital industries remain fairly fragmented with low market share concentration, there is potential for future consolidation.**

- No provider accounts for more than 5% of the hospital industry revenue. The four largest companies combined are estimated to account for just 11.1% of revenue in 2020.
- Several standalone facilities and smaller hospitals have sought out capital or economies of scale as they have experienced drops in volume or reimbursement in recent years.
- Consolidations over the last five years have caused a decline in the total number of operators (annualized rate of 2.8%).

Sources: FTI Consulting analysis, cms.gov, IBIS World Reports, LAN



ACUTE CARE

# Opportunities/Tailwinds

## Reasons to consider an investment in acute care

### Significant funding and governmental support

- As of December 2020, $178B was allocated to the Provider Relief Fund via the CARES Act. An estimated $26B remains – per the Consolidated Appropriations Act, and 85% of remaining funds must be made available to providers to help cover additional losses or expenses due to COVID.
- Health care providers that participate in traditional Medicare were eligible for loans through the Medicare Accelerated and Advance Payment Programs in addition to the Provider Relief Fund. About $80B in loans went to hospitals in March 2020.
- While the new Biden administration has focused much of its attention on pandemic relief, it is expected that drug pricing legislation and efforts to expand healthcare coverage are on the agenda.

### Increased demand from the aging population

- While elderly patients have largely avoided hospitals and deferred any non-emergent care in 2020, it is expected volume and demand for services will return to the pre-COVID trend by late 2021.
- The cohort of adults aged 65 and older positively affects hospital revenue, as the per capita healthcare spending in this age group is three to five times higher than that of people under the age of 65.

### High utilization of telehealth

- The rapid expansion of telehealth during the pandemic was critical for healthcare organizations across the United States to be able to continue delivering services. An effective telehealth platform has proven to expand access, improve outcomes and reduce costs.
- In addition to previously allowable telehealth services, CMS added 80+ new services, including inpatient and emergency department visits.
- Other favorable changes included increased coverage for telephone and digital-based services and enhanced reimbursement rates to existing services.
- While it is expected these reactive measures will be pared back after the pandemic, utilization and patient satisfaction rates could be key to a more permanent adoption in the near future.

Sources: FTI Consulting analysis, IBIS World Reports, American Hospital Association, U.S. Census Bureau, Bank of America Health Policy Updates

ACUTE CARE

## Opportunities/Tailwinds (Cont.)

### Reasons to consider an investment in acute care

**Transitioning from FFS to value-based care**

- CMS' Hospital VBP Program aims to reward acute care hospitals with incentive payments for the quality of care provided in the inpatient hospital setting.
- Currently, less than 20% of Medicare spending is value-based. Over the next five years, the VBP aims to have nearly 100% of Medicare reimbursements tied to value-based contracts.
- In addition, the LAN's goal is to have 50% of both Medicaid and commercial reimbursement tied to an APM.
- To date, payers have been quicker to adopt APMs than providers.

**Capitalize on the EHR Incentive Program**

- The Medicare and Medicaid EHR Incentive Program is available for certain acute care hospitals with at least 10% Medicaid, CAHs and cancer hospitals.
- Eligible-hospitals can receive as much as $11M in funding.
- Hospitals eligible to participate in the program include subsection D hospitals paid under the hospital inpatient PPS, critical access hospitals, and MA hospitals.

**Redefining location of care**

- In November 2020, CMS expanded its Hospital Without Walls program by introducing the Acute Hospital Care at Home program. The program allows additional regulatory flexibility for hospitals to treat patients requiring acute inpatient admission in their homes and other non-hospital locations.
- Participating hospitals admit patients from the ED and inpatient beds to their homes when it is determined suitable for the patient.
- To participate, hospitals must apply for a waiver and adhere to CMS' screening and safety protocols.

Sources: FTI Consulting analysis, IBIS World Reports, American Hospital Association U.S. Census Bureau, Bank of America Health Policy Updates



ACUTE CARE

## Challenges/Headwinds

### Key obstacles to overcome in the acute care market

**Overcoming COVID impact on revenue and volume**

- In March 2020, CMS announced that nearly all elective procedures and non-essential medical, surgical and dental procedures must be delayed due to the ongoing pandemic.
- Hospitals have been feeling the effects of declining revenue for close to a year. In 2020 alone, it is estimated that hospitals lost more than $320B in revenue nationwide.
- In November 2020, hospital and health system operating margins fell 8.3% compared to the prior year, including CARES Act funding. Without CARES Act funding, operating margins dropped 11.6%. Bond rating services such as Moody's are expecting an increase in technical defaults in 2021 resulting from a failure to meet covenants such as debt service coverage ratios.

**Increasingly competitive environment**

- In the past five years, the number of new facilities that deliver healthcare services, including physician-run outpatient surgery centers, specialty hospitals and diagnostics centers, has grown significantly.
- Independent competitors often have lower costs because of their smaller size and simpler infrastructure.
- Historically, hospitals use the income from high-margin operations to finance certain unprofitable services and procedures. Increased competition has forced hospitals to use other strategies to decrease costs.

**Nursing shortages have hindered recovery efforts**

- The national registered nurse (RN) vacancy rate reached 9.9% in 2020, and more than one-third of hospitals have vacancy rates exceeding 10.0%
- To meet the climbing staffing needs, institutions have been seeking help from supplemental staffing agencies. Travel nurse rates have increased substantially beyond the historical 25%-50% premium.
- Reducing reliance on temporary labor and creating "stickiness" with their staff nurses has become a top priority for senior executives of many organizations

**Anticipated physician shortage**

- The US is expected to see an estimated shortage up to 139,000 physicians, including shortfalls in both primary and specialty care, by 2033, in part due to a cap on funding for residency training programs.
- The gap between the country's increasing health care demands and the supply of doctors to adequately respond has become more evident as the US continues to combat COVID.
- More than two of five currently active physicians will be 65 or older within the next decade. The anticipated shifts in retirement patterns over that time could have large implications for the supply of physicians to meet health care needs.



Sources: FTI Consulting analysis, IBIS World Reports, American Hospitals Association, Associate of American Medical Colleges, U.S. Chamber of Commerce

ACUTE CARE

# Challenges/Headwinds

## Key obstacles to overcome in the acute care market

### Increased labor and wage costs

- Hospitals have had to increase spending on labor and medical supplies used to control the spread of the coronavirus – specifically wage costs are estimated to account for 35.6% of industry revenue in 2020, up from 33.6% in 2015.
- Potential change in federal labor laws, including the proposed Employee Free Choice Act, may increase the likelihood of employee unionization attempts and lead to the adoption of mandatory nurse-patient ratios, driving wages up even further.

### Threats of rural hospital closures

- From 2010 to early 2020, there were 124 closures of rural hospitals. An additional 430 rural hospitals are at risk of closure – accounting for 21% of the country's rural hospitals.
- Rural hospitals struggle with the vast amount of uncompensated and under-compensated care due to high rates of uninsured, Medicaid and Medicare patients.

### Complying with hospital price transparency regulations

- In January 2021, hospital price transparency requirements took effect. The rule requires hospitals to publish five types of charges: (1) gross charges, (2) discounted cash price, (3) payer-specific negotiated charges, (4) de-identified minimum negotiated rates, and (5) de-identified maximum negotiated rates.
- Hospitals that fail to comply with the rule will receive a penalty of $300 per hospital per day or $109,500 per hospital per year.
- The rule has been criticized for several reasons:
  - Price information does not include out-of-pocket costs.
  - Prices cannot be calculated, as they are dependent on a function of complex algorithms.
  - The rule could lead to collusion among providers.
  - It creates a burdensome cost of compliance.

### Overcoming operational challenges

- The pandemic has imposed additional complexities on workforce management. For example:
  - Managing off-site employees, keeping them engaged and mitigating impact on patient experience.
  - Clinical staff burnout, out-migration and union issues.
- The initial shock of COVID forced hospital management into a reactive mode. As they slowly move into a post-COVID world, management is preparing for the following:
  - Recapturing patients and accelerating screening/testing in order to make up for past delays in preventative and diagnostic care.
  - A shift in supply chain and laboratory operations related to volume increases.



Sources: FTI Consulting analysis, IBIS World Reports, American Hospitals Association, Associate of American Medical Colleges, U.S. Chamber of Commerce

ACUTE CARE

# United States - Industry at a Glance

## Snapshot

**Industry Players (No Major Players)**

**Not-for-profit**

- CommonSpirit Health (22K beds, F2020 revenue of $30B)
- Ascension Health (27K beds, F2020 revenue of $25B)

**For-profit**

- HCA Healthcare Inc. (49K beds, F2020 revenue of $52B)
- Tenet Healthcare Corp. (16K beds, F2020 revenue of $15B)
- Community Health Systems Inc. (20K beds, F2020 revenue of $12B)

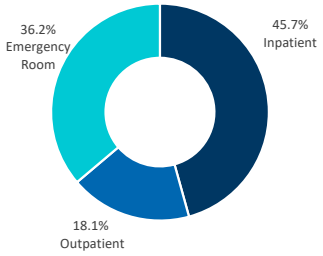
**Key Drivers**

- Total health expenditure
- Federal funding for Medicare and Medicaid
- Number of people with private health insurance
- Number of adults aged 65+
- Per capita disposable income

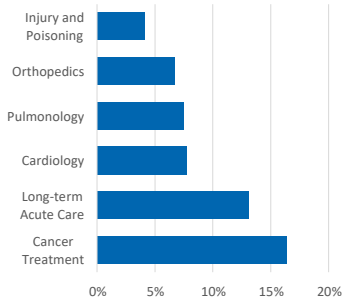
## Key Statistics

| 2020 Revenue | 2020 Profit | Wages |
|---|---|---|
| $938.2B | $71.3B | $333.7B |
| Annual Growth (2015-2020) | Projected Annual Growth (2020-2025) | Projected Annual Growth (2020-2025) |
| -1.5% | 2.4% | 1.7% |

## Revenue by Service Line 2020




## Revenue by Segment 2020



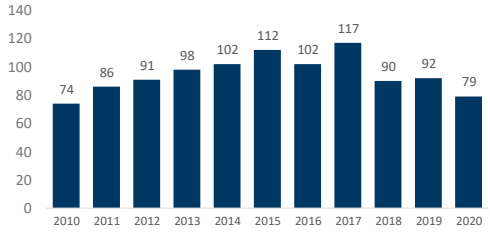

Sources: IBIS World Reports for Hospitals in the US, Specialty Hospitals in the US; Company reports

ACUTE CARE

## 2020 M&A Overview

- Divestures continued in 2020 with public for-profit health systems divesting a considerable amount of hospital assets to decrease debt.
- Deal activity started 2020 at a very good pace; however, it slowed in 2H20 as hospitals had to shift their focus to the operational challenges brought on by COVID.
- Contract alignment continues to be a major consideration in hospital-to-hospital transactions. Hospital mergers within a single state saw average reimbursement rates increase by 6%-10%, in part due to underdeveloped contract management by one or both parties.[1]

**ACH Total Deal Count (2010 – 2020)**




**Notable transactions announced in 2020**

**Prisma Health**

- Exemplifying single-state transactions, on March 5, 2020, Prisma Health announced an agreement to acquire South Carolina-based health systems KershawHealth and Providence Health from LifePoint Health, a portfolio company of Apollo Global Management. The two health systems include three hospitals with 529 beds. The transaction is still pending regulatory approval.

**CHS**

- CHS continues to sell non-core systems in an effort to reduce debt.
- In April 2020, CHS signed definitive agreements to sell three hospitals in Texas with a combined total of 590 beds. All three deals closed in October.
- CHS completed the sale of the 84-bed St. Cloud Regional Medical Center in Florida to Orlando Health in July 2020.

Source: Kaufman Hall, "2020 M&A in Review"
1. There has not been a significant change in reimbursements observed when hospitals merge across state lines.

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## Post-Acute Care and Senior Living Service Types

**Post-Acute Care ("PAC") serves a wide spectrum of individuals primarily discharged from acute-care hospitals with complex medical issues. Senior Living ("SL") serves a range of senior citizens, from those in need of home maintenance and hospitality support to those in need of full nursing care.**

POST-ACUTE

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### Long-Term Acute Care Facility ("LTCH" or "LTAC")

- LTACs provide hospital-level medical and rehabilitative care to individuals with clinically complex problems, such as multiple acute or chronic conditions, for extended periods.
- To qualify as an LTAC for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average inpatient length of stay greater than 25 days.

### Inpatient Rehabilitation Facility ("IRF")

- IRFs promote obtaining optimum levels of physical, cognitive, emotional, psychological, social and economic usefulness.
- The category includes services provided in inpatient and outpatient settings, ranging from comprehensive programs in specialized hospital settings to therapies offered in units of hospitals, nursing facilities, or ambulatory centers.

### Skilled Nursing Facility ("SNF")

- SNFs contain licensed nursing beds for patients that require continuous care.
- Care offerings include short-term stays and longer-term stays for the elderly.

### Independent Living ("IL"), Assisted Living ("AL"), and Memory Care ("MC")

- IL – Designed for seniors who pay for some services, such as housekeeping and meals, but require minimal, if any, assistance with daily activities.
- AL – Serves seniors who need assistance with daily activities but do not require continuous skilled nursing care.
- MC – Designed for residents with significant cognitive impairment.

### Continuous Care Retirement Communities ("CCRC")

- CCRCs, also referred to as Life Plan Communities, provide IL/AL/MC and skilled nursing services to seniors.
- In order to qualify as a CCRC, the different service levels must be provided in a single facility.
- While some CCRCs offer rental agreements, many charge an upfront entrance fee ("EF") that may be refundable in part or in full. EF contracts typically provide IL residents with access to and discounts on long-term care as they move through the care continuum from IL to AL, MC and SNF.

Sources: FTI Consulting internal research, National Investment Center for Seniors Housing & Care Investment Guide (Sixth Edition), American Seniors Housing Association





## Industry Overview

**PAC and SL predominately comprise low-margin, privately held and middle-market companies that provide medical care and/or residency to aging individuals.**

- **PAC/SL have been some of the hardest subsectors hit by COVID, with severe declines in occupancy coupled with increased costs related to PPE and staffing requirements.**
- Over 186,000 COVID deaths (26% of all U.S. deaths occurred among residents and staff of nursing homes and other long-term care facilities.
  - Highly restrictive visitation policies and the closing of social gathering areas amplified families' concerns, leading to plummeting occupancy rates in 2020 that have yet to fully recover. Families increasingly turned to home health instead.
  - Reduction in elective or non-essential procedures also lowered hospital patient referrals to both free-standing SNFs and those within CCRC properties.
  - Lower occupancy coupled with increased costs related to PPE and staffing for COVID safety led many operators to request rent abatement or deferrals from landlords to preserve liquidity.
  - For SNFs, $13B in stimulus funding and $8B in PPP loans provided in 2020 only partially alleviated the estimated $41B bottom-line impact that year. The recent $1.9B stimulus bill specifically allocated another $450M to nursing homes. However, SNF losses in 2021 are projected to be over $52B. In September 2021, HHS announced another $25.5B available under Phase 4 of the Provider Relief Fund.
- **An increase in the U.S. aging population and in prevalence of chronic disease is expected to fuel significant industry growth in the next 10-15 years.**
- **The industry is highly fragmented with over 16,000 hospital providers and more than 29,000 senior living properties. The four largest SNF and IL/AL/MC operators represent 8% and 10% of total beds and units, respectively.**
- **Expense growth continues to outpace reimbursement growth.**
  - Sector challenges such as staffing shortages, increases in healthcare costs and high labor-intensive structures put continual pressure on operating margins, which can range from an average of 25% for free-standing IRFs down to below zero for SNFs.
  - Technology, shift in payor mix, and increased competition have driven rates down. Specifically, there has been an ongoing trend of Medicaid and Managed Care taking larger shares of payor mix at the expense of Medicare and private pay, which have better margins.
    - SNF: (1) Reimbursement has been flat to down, resulting in continuation of lower average daily rates; (2) The ongoing trend of tying reimbursements to quality of care and generally tightening reimbursements will likely continue in the long-run.
    - Recent changes to therapy reimbursement impacts IRF.
- **Capital and Investment**
  - Investment in PAC/SL includes both private equity and REITs. As of 2019, publicly traded REITs owned 11.6% of units in senior housing and 6.5% in nursing care properties (an estimated $49B market value). Nearly $5.3B has been invested in nursing homes by private equity.
  - Tax exempt bonds are the primary source of capital for the estimated 30% of operators that are nonprofits, with over $42B in municipal bonds issued for senior housing (of which 80% is invested in CCRCs).



Sources: FTI Consulting analysis, AARP, The American Health Care Association/National Center for Assisted Living (AHCA/NCAL), Skilled Nursing News, American Hospital Association

# Industry Outlook

**While the long-term market outlook is optimistic in PAC/SL, near-term pressures are expected to remain in place until occupancy returns to pre-COVID levels.**

- **Liquidity is expected to tighten further over the next 12 months as costs remain inflated and stimulus funding ends. HHS began recoupment of Medicare Accelerated and Advance Payments in April and 50% of payroll tax deferrals come due in December 2021.**
  - In addition, staffing shortages are exacerbated by burnout and expected to remain a long-term issues across all PAC service types.
  - Rent deferrals/abatements for SNFs continues through 2021 as REITs/landlords aim to bridge to a more normalized environment.
- **The longer-term market outlook is favorable as PAC/SL is viewed as essential to the continuum of care and demand is projected to exceed available beds/units within the next five years.**
- **An increased reliance on data and trend towards a consumer-driven market are expected.**
  - Growth in both complementary and disruptive technology has increased, particularly focused on achieving greater operating efficiencies and improved outcomes.
  - In 2019, federal guidelines were established mandating that hospitals provide detailed information to patients about post-acute providers.
  - Data sharing and privacy have also become highly scrutinized issues among healthcare providers.
  - The tracking and use of this data are becoming increasingly important to maintaining occupancy levels, as healthcare becomes more consumer-driven.
  - The cost of implementing these new technologies is likely to be high, further straining liquidity in the short term while providing opportunity to reduce costs in the medium to long term.
- **As occupancy is slow to rebound, industry experts differ as to whether the shift to home health will be permanent.**
  - Prior to the pandemic, home health providers estimated that 10%-15% of SNF patients could be safely cared for at home as opposed to in a facility after an acute-care discharge.
  - Home health providers point to increased direct referrals from physicians and to studies indicating patients' preference for being treated at home after a hospital stay.
  - However, the reality is that many SNF patients (particularly long-stay Medicaid) require 24/7, hands-on care that is not feasible with in-home care.

Sources: Skilled Nursing News, IBIS, Home Health Care News





# Opportunities and Targets

**While the long-term market outlook is optimistic in PAC/SL, near-term pressures are expected to remain in place until occupancy returns to pre-COVID levels.**

- **Although transaction activity within senior housing and skilled nursing is down YOY as of 2Q21, price per unit is up 28% in senior housing, indicating activity in the market for higher quality properties.**
  - SNF price per unit is down 8% YOY, highlighting opportunities to acquire either smaller, distressed operators unable to maintain positive cash flow or large, underperforming portfolios being offloaded by REITs.
  - A 2020 survey of senior housing investors reported that their existing properties are older and are more geared toward middle-market customers who may have utilized part of their "nest egg" during the pandemic.
- **In CBRE's 1H21 survey, active adult communities emerged as the top investment interest (31%), followed by Assisted Living (28%) and Independent Living (23%).**
  - Overall, cap rates showed compression in 1H21 versus 2H20 of -13 bps, a stark reversal of the +31 bps change observed from 1H20 to 2H20.
- **Distressed senior housing operators struggling to ride out the pandemic have yet to fuel M&A activity in 2021.**
  - Distressed sales peaked in Q3 2020 at 2.1% of total volume, but seniors housing represented only 1.2% of distressed loans for all commercial real estate as of 1Q21, according to JLL.
- **In the longer term, investments in new construction will also be required, driven by aging inventory and anticipated insufficient supply.**
  - Supply shortages from pandemic-driven construction delays appear to magnify that demand.
  - As a percentage of existing supply, senior housing units under construction dropped from peak levels of 7.0% in Q4 2019 to 4.7% in Q1 2021.
- **Investors will be assessing acquisition targets in several areas, particularly quality of care and safety measures.**
  - States with higher Medicaid reimbursement rates, favorable demographics, less Certificate of Need restrictions and other advantages (such as upper payment limit rules) are likely to be a focus of senior housing investors and generate higher price per bed.
  - Potential SNF investment targets in the Southeast and Mid-Atlantic have more favorable demographics than those on the West Coast (i.e., population density combined with higher chronic disease rate).
  - Greater consideration will be given to the physical layout of facilities, including more open areas, fewer touch points and improved HVAC systems.
  - SNF, IRF and LTAC facilities with an ability to track outcomes, such as readmit rates, will be able to provide transparency and build trust in the market that will attract patients and aid operators (with high quality ratings) to regain lost occupancy more rapidly.
  - Strong marketing, communications and community outreach programs are critical in senior housing in order to attract patients/residents post-COVID.

Sources: FTI Consulting analysis, AARP, The American Health Care Association/National Center for Assisted Living (AHCA/NCAL), Senior Housing News

# Opportunities/Tailwinds

## Reasons to consider an investment in the PAC and SL market

### An aging population

- The 65 and older population will increase by 16.2 M over the next 10 years, driving demand for senior living communities.
- By 2030, the 65+ population will compose 21 percent of the total population, up from 17 percent in 2020.
- Roughly 8.4 M U.S. residents will have Alzheimer's by 2030, up from 4.7 M in 2020, placing greater focus on memory care options.

### Recovery in the post-COVID environment

- The distribution of vaccines has allowed senior living properties to resume communal activities and normal visitation, making them more attractive to prospective residents.
- An increase in elective procedures and senior living services requiring a higher level of care (AL/MC/SNF) has also improved occupancy.
- Adopting digital-friendly features such as virtual tours and live broadcasts will increase the ability of senior living to market to potential out-of-market residents.

### Increased demand for post-acute care following hospital discharges

- From 2Q19 to 1Q20, over 25% of discharges from hospitals were coded for post-acute care.
- Of Americans over 60 years old, 80% suffer from at least one chronic disease.
- LTACs' ability during the pandemic to deliver necessary hospital-level services to a more clinically complex population could have lasting implications for their role within the healthcare continuum.

### Portfolio diversification benefits

- The combination of real estate, hospitality and needs-driven services gives senior housing properties unique diversification attributes for investors.
- In the 2008-2009 real estate market downturn, senior housing property investment returns and rent growth outperformed other commercial property types.
- In the past 10 years, the healthcare REIT sector index has been the third best performing sector behind industrial and apartments, with an annualized return of 10.1%.



Sources: FTI Consulting analysis, National Investment Center for Seniors Housing & Care Investment Guide (Sixth Edition), American Action Forum, McKnight's Senior Living Home Care Daily News, Home Health Care News

POST-ACUTE CARE AND SENIOR LIVING

# Challenges/Headwinds

## Key obstacles to overcome in the PAC and SL market

### Labor shortages and increasing wage rates

- Tight labor markets in 2019 put upward pressure on wage rates, typically the largest expense of an operator.
- Shortages of qualified personnel, such as nurses and therapists, particularly in non-urban settings, have also posed a significant challenge to PAC operators.
- The more complex the care type, the more challenging it is to attract and retain the necessary staff for a facility.
- The University of California and others estimate that an additional 1.0M to 2.5M long-term care workers will be needed by 2030.
- A survey by Activated Insights found that 34% of senior housing professionals reported feeling "burnout" during the first two months of 2021 (vs. 17% during same period in 2020).

### Low staff vaccine acceptance

- Low vaccine acceptance rates by staff, particularly in nursing homes, are limiting the industry's ability to rebound fully from the effects of COVID.
- The CDC estimates that only 65% of nursing home staff members have been vaccinated as opposed to 85% of residents.

### Ongoing PPE and safety protocol-related costs post-COVID

- Expenses related to staffing, PPE, and routine testing are estimated at $30B per year for 2020 and 2021.
- Sustained PPE costs could result in an estimated 1%-2% margin decrease in senior living based on current trends.
- Stimulus payments to support PPE and safety-related costs are unlikely to continue beyond 2021.

### Repayment of loans and uncertainty regarding future stimulus

- HHS estimates that long-term providers received $21B of stimulus. Much of senior housing was ineligible, given the predominance of private pay.
- The Cares Act also temporarily loosened discharge requirements by hospitals to IRF and LTAC facilities, a reversal of which would negatively impact PAC.
- Although Phase 4 of the Provider Relief Fund makes available another $25.5B, uncertainty remains around further stimulus to offset the continued headwinds and repayment of 2020 funding.
  - Repayment of employer payroll tax deferrals
  - Recoupments of Medicare Accelerated and Advance Payments



Sources: FTI Consulting analysis, National Investment Center for Seniors Housing & Care Investment Guide (Sixth Edition), American Action Forum, McKnight's Senior Living Home Care Daily News, Home Health Care News

# Challenges/Headwinds (Cont.)

## Key obstacles to overcome in the PAC and SL market

### CMS reimbursement policy changes

- In April 2021, CMS disclosed a 5% spending increase had occurred in 2020 as a result of PDPM, a program designed to be budget neutral.
- PDPM pay rate changes have been delayed until 2022 but will have a material impact on operators once implemented.
- Financial incentives are increasingly being tied to improved outcomes, payer mix and margins through relationships with hospitals and insurers.
- PDPM increases reimbursement for more complex patients, but CMS' push toward a uniform payment model could shift referrals toward IRFs long-term if SNFs are unable to attract qualified staff and care for these patients.

### Competitive pricing within senior living to drive occupancy

- Strong competition for new residents within senior living is anticipated, potentially leading to increased use of short-term and long-term pricing incentives to capture market share.
- Short-term incentives should be prioritized to avoid long-term erosion of margins.
- Prospective CCRC residents may opt for lower refundable entrance fee contracts, which will create short-term liquidity issues as refunds on older, higher-refundable EF contracts need to be paid. A lower-refundable contract's EF is typically lower than a higher-refundable contract's EF for an equivalent unit.

### Aged housing inventory

- More than 32% of the property inventory in the NIC Map Primary Markets is at least 25 years old.
- Investors are being required to evaluate appropriate levels of CapEx to retain useful life in properties.
- Rising construction costs, longer construction schedules and changing regulatory environments may deter new construction investment and shift investors towards reinvestment in existing assets or acquisition of failed developments instead.

### Transition to home health services

- Home health has been one of the few bright spots in companies that have seen sizable declines in revenue in the senior living and skilled nursing segments due to COVID. Amedisys, one of the largest home health companies in the U.S., reported a 5% growth in home health volume in 4Q20. The company projects an 8% increase in home care volume in 2021.
- In 2019, CMS expanded MA to home care providers. However, less than 4% of plans elected to offer home care benefits. This number rose to ~21% nationwide due to COVID, as the pandemic led to an increase in funding of MA and other federal payment opportunities for home care providers.



Sources: FTI Consulting analysis, National Investment Center for Seniors Housing & Care Investment Guide (Sixth Edition), American Action Forum, McKnight's Senior Living Home Care Daily News, Home Health Care News



# Post-Acute Care and Senior Living at a Glance

## Snapshot

**Major Players (by Key Service)**

**IRF**
- Kindred Healthcare; UPMC Rehabilitation Institute

**LTAC**
- Encompass Health Corp. (~9K beds)[2]; Select Medical Corporation (~4K beds)

**SNF**
- Genesis Healthcare (~42K beds); The Ensign Group (~25K beds); ProMedica Senior Care (~16K beds); The Evangelical Lutheran Good Samaritan Society (~16K beds)

**IL/AL/MC**
- Brookdale Senior Living (~68K units); Holiday Retirement (~32K units); National Senior Campuses (~21K units); Ascension Living (~8K units)

**CCRC**
- Life Care Services LLC (~37K units); Erickson Living (~24K units)

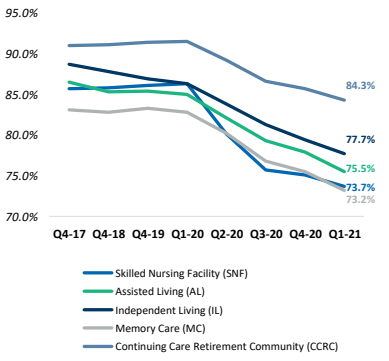
## Key Statistics

| 2020 Revenue | 2020 Profit | Wages |
|---|---|---|
| $129.8B | $11.8B | $56.5B |

| Annual Growth (2015-2020) | Projected Annual Growth (2020-2025) | Profit Margin |
|---|---|---|
| 0.5% | 2.5% | 9.1% |

| | # Investment Grade Properties | # Beds/ Units | Average Length of Stay |
|---|---|---|---|
| SNF | 10,300 | 1,300K | 146 days[3] |
| IL/AL/ MC | 12,300[4] | 1,200K | 22 months |
| CCRC | 1,900 | 600K | EF 62 months Rental 35 months[5] |
| LTAC | 365 | 26K | 25 days |
| IRF | 1,172 | *n/a* | 13 days |

*[3] FY 2019 national SNF industry benchmark per HMP Metrics Database*
*[4] Number of properties as of 4Q19 per National Investment Center for Senior Housing & Care Investment Guide Sixth Edition ("NIC Investment Guide")*
*[5] Per the NIC Investment Guide, as of 4Q19, the CCRC average length of stay is 62 months for entrance-fee residents and 35 months for rental residents*




Sources: SEC Filings, National Investment Center for Senior Housing & Care Investment Guide (Sixth Edition), HMP Metrics Database, MedPac March 2020 Report to the Congress, American Healthcare Association National Center for Assisted Living, Definitive Healthcare

FTI CONSULTING

# Industry Overview

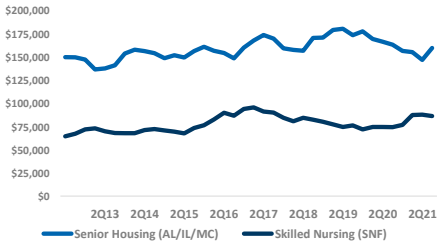
## Recent SNF & Senior Housing M&A Activity as of 2Q21

**In the 12-month period from 3Q20 to 2Q21, transaction volume for Senior Housing and SNF totaled $11.8B, which represents a decline of 20% compared to the previous TTM period.**

- Senior Housing and SNF transaction volumes reached $7.8B and $4.0B in 3Q21, respectively. Senior housing volume declined 28% and SNF increased 2% YOY.
- 2Q21 price per unit among Senior Housing transactions increased 47.2% year-over-year to roughly $187K/unit. The 2Q21 price per bed among SNF transactions decreased 8.1% year-over-year to roughly $81K/bed.
- The top five acquirers accounted for 47% of total deal size in the TTM period. Major transactions announced in 3Q21 include:
  - Welltower announced the acquisition of Holiday Retirement's 86 IL communities for $1.58 billion, or $152,000 per unit.
  - Harrison Street to purchase 24 properties operated by Oakmont Senior Living for $1.2 billion
  - DigitalBridge Group will sell a 300-property portfolio, including 174 SNFs, for $3.2B to Highgate Capital Investments and Aurora Health Network
- Several large-scale healthcare REIT mergers were also announced in 3Q21,
  - Ventas's $2.3B acquisition of New Senior Investment Group and
  - American Healthcare to merge with Griffin-American Healthcare for a combined $4.2B healthcare real estate assets portfolio

| Summary of M&A Activity | Senior Housing | | Skilled Nursing | | Total | |
|---|---|---|---|---|---|---|
| *($USD millions, except per unit data)* | Actual | *YoY Δ%* | Actual | *YoY Δ%* | Actual | *YoY Δ%* |
| **Q2 2021** | | | | | | |
| Volume | $ 2,011 | *157.9%* | $ 991 | *92.2%* | $ 3,002 | *131.8%* |
| # of Properties | 120 | *140.0%* | 91 | *93.6%* | 211 | *117.5%* |
| Total Units or Beds | 11,492 | *112.4%* | 12,087 | *98.7%* | 23,579 | *105.2%* |
| Price per Unit or Bed | $ 186,947 | *47.2%* | $ 80,852 | *(8.1)%* | $ 136,152 | *25.1%* |
| Avg. Cap Rate | - | - | - | - | - | - |
| **TTM** | | | | | | |
| Volume | $ 7,773 | *(28.2)%* | $ 4,036 | *1.6%* | $ 11,809 | *(20.2)%* |
| # of Properties | 455 | *(20.6)%* | 365 | *(13.7)%* | 820 | *(17.7)%* |
| Total Units or Beds | 45,857 | *(28.1)%* | 44,066 | *(14.4)%* | 89,923 | *(22.0)%* |
| Price per Unit or Bed | $ 159,687 | *(2.1)%* | $ 86,241 | *16.1%* | $ 123,412 | *6.4%* |
| Avg. Cap Rate | *6.6%* | *0.6%* | *9.0%* | *0.9%* | *6.7%* | *0.6%* |

### TTM Avg. Senior Housing and Skilled Nursing Price per Unit or Bed




### TTM Top 5 Buyers & Sellers

| *($USD millions)* | | | Total Deal Size | # Properties | Avg. Price |
|---|---|---|---|---|---|
| | **Buyer Name** | **Type** | | | |
| 1. | Harrison Street RE Cap | REIT (LON:AEWU) | $ 867.0 | 23 | $ 37.7 |
| 2. | Brookfield AM | Strategic (Private) | 715.0 | 34 | 21.0 |
| 3. | AEW | Investment Firm (Private) | 692.0 | 10 | 69.2 |
| 4. | Merrill Gardens | Investment Firm (Private) | 692.0 | 10 | 69.2 |
| 5. | Omega Healthcare | REIT (NYSE:OHI) | 543.0 | 27 | 20.1 |
| | **Total Top 5 Buyers** | | **$ 3,509.0** | **104** | **$ 33.7** |
| | **Seller Name** | **Type** | | | |
| 1. | Healthpeak Properties Inc | REIT (NYSE:PEAK) | $ 3,452.0 | 154 | $ 22.4 |
| 2. | Welltower | REIT (NYSE:WELL) | 982.0 | 28 | 35.1 |
| 3. | Columbia Pacific | Investment Firm (Private) | 568.0 | 28 | 20.3 |
| 4. | Formation Capital | Private Operator | 366.0 | 36 | 10.2 |
| 5. | Greystone Healthcare MGMT | Investment Firm (Private) | 341.0 | 18 | 18.9 |
| | **Total Top 5 Sellers** | | **$ 5,709.0** | **264** | **$ 21.6** |

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Source: National Investment Center for Seniors Housing & Care Q1 2021 Real Capital Analytics Report

# Provider Relief Fund Reporting and Repayment

On June 11, 2021, the Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA) released revised reporting requirements for recipients of Provider Relief Fund (PRF) payments. The announcement included an extension of the amount of time recipients will have to report information and is intended to reduce the burden of reporting. It also extended the deadline for expending those PRF payments received after June 30, 2020. The revised reporting requirements are applicable to payments that exceed $10,000, in aggregate, during a single Payment Received Period.

**The revised requirements issued on June 11, 2021 can be found here.**

Important changes included in the revisions include:

1) The period of availability of funds is based on the date the payment is received (rather than requiring all payments be used by June 30, 2021, regardless of when they were received).
2) Recipients are required to report for each Payment Received Period in which they received one or more payments exceeding, in the aggregate, $10,000 (rather than $10,000 cumulatively across all PRF payments).
3) Recipients will have a 90-day period to complete reporting (rather than a 30-day reporting period).
4) The PRF Reporting Portal will open for providers to start submitting information on **July 1, 2021.**

In January 2021, HHS opened registration for the Provider Relief Fund Reporting Portal. HRSA encourages recipients to establish a Provider Relief Fund Reporting Portal account now. They can do so by registering here. Registering now will facilitate the receipt of program updates closer to the time of the official opening of the portal for reporting.

A synopsis of anticipated frequently asked questions is found below:

## ***Terms and Conditions***

**Is there a set period of time during which recipients must use the funds to cover allowable expenses or lost revenues attributable to COVID-19?**

Yes. Provider Relief Fund recipients must use payments only for eligible expenses, (including services rendered), and lost revenues attributable to coronavirus before the deadline that

corresponds to the Payment Received Period. The date is based on the date when the payment was received. Funds will be available for use for at least 12 months and for a maximum of 18 months. The payment is considered received on the deposit date for automated clearing house (ACH) payments or the check cashed date. Recipients must follow their basis of accounting (e.g., cash, accrual, or modified accrual) to determine expenses.

| | **Payment Received Period** | **Deadline to Use Funds** |
|---|---|---|
| Period 1 | April 10, 2020 to June 30, 2020 | June 30, 2021 |
| Period 2 | July 1, 2020 to December 31, 2020 | December 31, 2021 |
| Period 3 | January 1, 2021 to June 30, 2021 | June 30, 2022 |
| Period 4 | July 1, 2021 to December 31, 2021 | December 31, 2022 |

Recipients may use payments for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. It should be noted that HHS expects it would be highly unusual for providers to have incurred eligible expenses prior to January 1, 2020.

Recipients are subject to audit and HHS reserves the right to audit Provider Relief Fund recipients now or in the future. HHS is authorized to collect any Provider Relief Fund amounts that have not been supported by documented expenses or losses attributable to coronavirus. In addition, HHS is authorized to collect any Provider Relief Funds not used in a manner consistent with program requirements under applicable law.

All payment recipients must attest to the Terms and Conditions, which require the submission of documentation to substantiate that these funds were used for health care-related expenses or lost revenues attributable to coronavirus.

**To accept a payment, must the recipient have already incurred eligible expenses and losses higher than the Provider Relief Fund payment received?**

No. Recipients do not need to be able to prove that prior and/or future lost revenues and expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment at the time they accept such a payment.

Recipients must report on the use of Provider Relief Fund payments in accordance with legal and program requirements in the relevant Reporting Time Period. Payments may be used for eligible expenses incurred prior to receipt of those payments (i.e., pre-award costs) so long as they are to prevent, prepare for, and respond to coronavirus. Duplication of expenses and lost revenues is not permitted.

**What should recipients do if they have remaining Provider Relief Fund money that they cannot expend on permissible expenses or losses by the relevant deadline?**

Remaining Provider Relief Fund moneys received that cannot be used for permissible expenses or losses by the relevant deadline will be returned to HHS.

Deadlines to use funds correspond to the date the payment was received, as outlined in the Post-Payment Notice of Reporting Requirements. The Provider Relief Fund Terms and Conditions and legal requirements authorize HHS to audit Provider Relief Fund recipients now, or in the future, to ensure that program requirements are met.

HHS is authorized to recoup any Provider Relief Fund amounts that were made in error or exceed lost revenue or expenses due to COVID-19, or in cases of noncompliance with the Terms and Conditions.

**How does a Reporting Entity determine whether an expense is eligible for reimbursement through the Provider Relief Fund?**

To be considered an allowable expense under the Provider Relief Fund, the expense must be used to prevent, prepare for, and respond to coronavirus. Provider Relief Fund payments may also be used for lost revenues attributable to the coronavirus.

Recipients of funds are required to maintain adequate documentation to substantiate funds were used for health care-related expenses or lost revenues attributable to coronavirus, and that those expenses or losses were not reimbursed from other sources. The burden of proof is on the fund recipients to ensure that adequate documentation is maintained.

## ***Use of Funds***

**How do I determine if expenses should be considered "expenses attributable to coronavirus not reimbursed by other sources?"**

Expenses attributable to coronavirus may include items such as supplies, equipment, information technology, facilities, personnel, and other health care-related costs/expenses for the period of availability. The classification of items into categories should align with how Provider Relief Fund payment recipients maintain their records.

Recipients must identify the expenses attributable to coronavirus, and then any offset amounts received through other sources, such as direct patient billing, commercial insurance, Medicare/Medicaid/Children's Health Insurance Program (CHIP); other funds received from the federal government, including the Federal Emergency Management Agency (FEMA); the Provider Relief Fund COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured (Uninsured Program);the COVID-19 Coverage Assistance Fund (CAF); and the Small Business Administration (SBA) and Department of the Treasury's Paycheck Protection Program (PPP).

Provider Relief Fund payments may be applied to the remaining expenses or costs, after netting other funds received or obligated to be received which offset those expenses. The Provider Relief Fund permits reimbursement of marginal increased expenses related to coronavirus provided those expenses have not been reimbursed from other sources or that other sources are not obligated to reimburse.

## ***Supporting Data***

**What documentation is required for reporting?**

Supporting worksheets will be available to assist Reporting Entities with completion of reports. In addition, Reporting Entities who are using a portion of their funds for lost revenues may be required to upload supporting documentation when reporting on their calculation of lost

revenues. The documentation required is dependent upon which method of calculating lost revenues providers select.

## ***Miscellaneous***

**Who is required to report when the portal opens?**

A Reporting Entity must report only when they have retained over $10,000 in aggregated Provider Relief Fund payments received during a single Payment Received Period.

**What are the required timelines for reporting?**

Provider Relief Fund recipients are required to report in each Payment Received Period in which they received one or more payments exceeding $10,000, in aggregate, as indicated below. Reporting must be completed and submitted to HRSA by the last date of the relevant Reporting Time Period. Provider Relief Fund recipients that do not report within the respective Reporting Time Period are out of compliance with payment Terms and Conditions and funds may be subject to recoupment.

| | **Payment Received Period** | **Deadline to Use Funds** |
|---|---|---|
| Period 1 | April 10, 2020 to June 30, 2020 | June 30, 2021 |
| Period 2 | July 1, 2020 to December 31, 2020 | December 31, 2021 |
| Period 3 | January 1, 2021 to June 30, 2021 | June 30, 2022 |
| Period 4 | July 1, 2021 to December 31, 2021 | December 31, 2022 |

**What is the process to return unused funds?**

When the first reporting period begins, providers will be able to return unused funds through the Reporting Portal.

**Are providers that received payments under Phase 3 of the General Distribution limited to using these funds to cover coronavirus-related losses or expenses experienced during the first two quarters of calendar year 2020?**

No. The Terms and Conditions require payment recipients to certify that funds will only be used to prevent, prepare for, and respond to coronavirus, and will only reimburse the recipient for health care-related expenses or lost revenues that are attributable to coronavirus. While HHS collected information on the losses and expenses associated with the first two quarters of 2020 for the purposes of making additional General Distribution payments to those with demonstrated financial need, the Terms and Conditions do not place limits on which quarters these funds must be applied to cover eligible losses or expenses.

# Phase 4 General Distribution Payments

In December 2021, HRSA began releasing Provider Relief Fund Phase 4 General Distribution payments to providers and suppliers based on changes in operating revenues and expenses from July 1, 2020 to March 31, 2021. Phase 4 payments also include new elements specifically focused on equity, including reimbursing smaller providers for their changes in operating revenues and expenses at a higher rate compared to larger providers, and bonus payments based on the amount of services providers furnish to Medicaid/Children's Health Insurance Program (CHIP) and Medicare beneficiaries.

Each row represents the number of providers qualified to receive a payment in each state/territory and the total payments distributed. The dataset will be updated as additional payments are released. The data does not reflect recipients' attestation status, returned payments, or unclaimed funds.

Phase 4 General Distribution December 2021

| State | Total Providers (#) | Total Payment ($) |
|---|---|---|
| TOTAL | 69,051 | $8,721,483,229.00 |
| Alabama | 918 | $112,799,049 |
| Alaska | 233 | $24,475,730 |
| American Samoa | 19 | $517,940 |
| Arizona | 1021 | $106,137,292 |
| Arkansas | 620 | $83,771,905 |
| California | 9377 | $894,260,598 |
| Colorado | 1208 | $132,251,498 |
| Connecticut | 933 | $138,080,400 |
| Delaware | 169 | $20,757,455 |
| District of Columbia | 131 | $16,403,053 |
| Federated States of Micronesia | 11 | $174,595 |
| Florida | 3805 | $453,946,147 |
| Georgia | 1857 | $233,778,719 |
| Guam | 13 | $936,892 |
| Hawaii | 391 | $36,994,939 |
| Idaho | 329 | $30,010,110 |

| | | |
|---|---|---|
| Illinois | 2747 | $349,581,930 |
| Indiana | 907 | $164,227,667 |
| Iowa | 789 | $85,954,720 |
| Kansas | 721 | $111,482,742 |
| Kentucky | 897 | $115,613,510 |
| Louisiana | 1240 | $137,492,831 |
| Maine | 315 | $60,691,173 |
| Marshall Islands | 1 | $13,928 |
| Maryland | 1723 | $191,711,521 |
| Massachusetts | 1583 | $222,524,552 |
| Michigan | 2151 | $274,415,440 |
| Minnesota | 1299 | $147,666,606 |
| Mississippi | 616 | $80,726,688 |
| Missouri | 1263 | $175,151,184 |
| Montana | 286 | $25,647,522 |
| Nebraska | 501 | $63,772,677 |
| Nevada | 561 | $39,824,869 |
| New Hampshire | 262 | $41,187,846 |
| New Jersey | 2145 | $276,239,302 |
| New Mexico | 283 | $30,168,525 |
| New York | 4858 | $756,002,073 |
| North Carolina | 1622 | $180,357,826 |
| North Dakota | 141 | $12,801,850 |
| Northern Mariana Islands | 3 | $2,447,679 |
| Ohio | 2609 | $398,472,528 |
| Oklahoma | 755 | $112,955,722 |
| Oregon | 851 | $92,877,165 |
| Palau | 4 | $888,873 |
| Pennsylvania | 2700 | $440,434,043 |
| Puerto Rico | 530 | $49,905,911 |
| Rhode Island | 255 | $43,004,560 |
| South Carolina | 715 | $92,879,114 |
| South Dakota | 220 | $27,351,062 |

| | | |
|---|---|---|
| Tennessee | 1713 | $306,726,088 |
| Texas | 5673 | $642,731,720 |
| Utah | 312 | $31,131,869 |
| Vermont | 142 | $19,661,713 |
| Virgin Islands | 9 | $437,382 |
| Virginia | 1646 | $163,144,491 |
| Washington | 1390 | $229,920,882 |
| West Virginia | 391 | $59,449,272 |
| Wisconsin | 1067 | $164,656,519 |
| Wyoming | 120 | $13,853,329 |

*Date Last Reviewed: December 2021*

Call-to-Action

- PRF Reporting Portal
- HRSA COVID-19 Coverage Assistance Fund
- HRSA COVID-19 Uninsured Program

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**Provider Support Line**

(866) 569-3522; for TTY dial 711

Hours of operation are 8 a.m. to 10 p.m. Central Time, Monday through Friday.

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**FOR IMMEDIATE RELEASE**
**December 14, 2021**

**Contact: HHS Press Office**
**202-690-6343**
**media@hhs.gov (mailto:media@hhs.gov)**

# HHS Is Releasing $9 Billion in Provider Relief Fund Payments to Support Health Care Providers Affected by the COVID-19 Pandemic

Today, the U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), announced the distribution of approximately $9 billion in Provider Relief Fund (PRF) Phase 4 payments to health care providers who have experienced revenue losses and expenses related to the COVID-19 pandemic. The average payment being announced today for small providers is $58,000, for medium providers is $289,000, and for large providers is $1.7 million. More than 69,000 providers in all 50 states, Washington, D.C., and eight territories will receive Phase 4 payments. Payments will start to be made later this week.

The PRF Phase 4 payments, in addition to the $8.5 billion in American Rescue Plan (ARP) Rural payments to providers and suppliers who serve rural Medicaid, Children's Health Insurance Program (CHIP), and Medicare beneficiaries, are part of the $25.5 billion the Biden-Harris Administration is releasing to health care providers to recruit and retain staff, purchase masks and other supplies, modernize facilities, or other activities needed to respond to COVID-19.

“As we continue to fight the pandemic, the Biden-Harris Administration remains committed to supporting our health care providers on the front lines,” said Health and Human Services Secretary Xavier Becerra. “This vital funding will ensure critical health care services are delivered to communities across the country – including to those who are disproportionately impacted by the pandemic and medically-underserved. We will continue to make health care accessible for everyone who needs it and reach people where they are.”

As part of the Biden-Harris Administration's commitment to greater transparency regarding the PRF, HRSA publicly released the Phase 4 payment methodology in September (https://www.hrsa.gov/provider-relief/future-payments/phase-4-arp-rural/payment-methodology), making it available to providers during the application period. Approximately 75% of Phase 4 funding is being distributed based on expenses and decreased revenues from July 1, 2020 to March 31, 2021. HRSA is reimbursing a higher percentage of losses and expenses for smaller providers – which generally entered into the COVID-19 pandemic on worse financial footing, have historically operated on slimmer financial margins, and typically care for vulnerable populations – as compared to larger providers.

Consistent with the Biden-Harris Administration's dedication to health equity and supporting the most vulnerable communities, HRSA is distributing 25% of Phase 4 funding as "bonus" payments based on the amount and type of services provided to Medicare, Medicaid, or CHIP patients. Similar to the American Rescue Plan (ARP) Rural payments announced last month (/about/news/2021/11/23/biden-admin-begins-distributing-arp-prf-support-to-providers-impacted-by-pandemic.html), HRSA is using Medicare reimbursement rates in calculating these payments to mitigate disparities due to varying Medicaid reimbursement rates.

Additionally, HHS has updated the Terms and Conditions for Phase 4 and ARP Rural payments to ensure relief funds are being used to address the financial impact of COVID-19. Recipients whose payment(s) exceed $10,000 are required to notify HHS of a merger with or acquisition of any other healthcare provider. Providers who report a merger or acquisition may be more likely to be audited to ensure compliant use of funds.

HRSA is currently reviewing the remaining Phase 4 applications and will make the remainder of Phase 4 payments in 2022.

"While we have made over half a million relief payments to health care providers throughout this pandemic, we know that many continue to face COVID-19 related financial challenges," said Acting HRSA Administrator Diana Espinosa. "HRSA is committed to providing as much support as we can through the Provider Relief Fund to health care providers as they continue responding to and recovering from this crisis."

View a state-by-state breakdown of the Phase 4 payments (http://www.hrsa.gov/provider-relief/data/general-distribution/phase-4-general-distribution-payments) announced today.

As providers agree to the terms and conditions of Phase 4 payments, it will be reflected on the public dataset (https://data.cdc.gov/Administrative/Provider-Relief-Fund-General-Allocation/kh8y-3es6).

For additional information, visit www.hrsa.gov/provider-relief (http://www.hrsa.gov/provider-relief).

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Note: All HHS press releases, fact sheets and other news materials are available at https://www.hhs.gov/news (/news) .

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Last revised: December 14, 2021

**HHS Headquarters**

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**News alert**

# Changes to Nursing Home Visitation COVID-19 (Revised) and COVID-19 Survey Activities

Nov 12, 2021 Nursing facilities



The Centers for Medicare & Medicaid Services (CMS) is continuing to promote health and safety and address the impacts of the COVID-19 public health emergency (PHE) on nursing home residents and their families by issuing memos that revise guidance for nursing home visitation and address the backlog of complaint and recertification surveys.

The first memo, Nursing Home Visitation - COVID-19 (Revised), issues revised visitation guidance in nursing homes. Together with infection prevention safeguards, including the recent staff vaccination regulation, this guidance will promote resident health and ensure continued safety as facilities continue to open. Early in the pandemic, visitation restrictions were implemented to mitigate the risk of visitors introducing COVID-19 to the nursing home. Today's guidance update reflects that, while visitors, residents, or their representatives should be made aware of the risks associated with visiting loved ones, visitation should now be allowed for all residents at all times. CMS has consistently updated its visitation guidance through the COVID-19 PHE, and this update represents our most comprehensive action to

bring residents and loved ones closer together. CMS continues to strongly encourage that everyone get vaccinated against COVID-19.

The second memo, Changes to COVID-19 Survey Activities, includes steps to assist State Survey Agencies (SAs) to address the backlog of facility complaint and recertification surveys. This backlog was the result of the temporary suspension and reprioritization of survey activity nationwide in the early days of the pandemic as CMS and states focused their efforts on infection prevention and control and controlling the spread of COVID-19. In recent months, states have made strong concerted efforts to resume recertification surveys, and we want that to continue.

Steps to assist SAs include:

- Revising the criteria for conducting COVID-19 Focused Infection Control (FIC) Surveys;
- Guidance for resuming recertification surveys; and
- Temporary guidance and minor flexibilities related to complaint investigations.

In addition, CMS is increasing oversight in nursing homes to provide a more focused review of quality-of-life and quality-of-care concerns. For example, the memorandum instructs surveyors to specifically review and focus additional attention to the competency of nursing staff, the use of any potentially inappropriate antipsychotic medications, and other areas of care, such as unplanned weight loss, loss of function/mobility, depression, abuse/neglect, or pressure ulcers.

To view the Nursing Home Visitation COVID-19 (Revised) memo, please visit: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/nursing-home-visitation-covid-19-revised.

To view the Changes to COVID-19 Survey Activities and Increased Oversight in Nursing Homes memo, please visit: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/changes-covid-19-survey-activities-and-increased-oversight-nursing-homes.

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Fiscal Year (FY) 2022 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) Rates Final Rule (CMS-1752-F)
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# Special Report | Nursing Facilities Have Received Billions of Dollars in Direct Financial and Non-Financial Support During Coronavirus Pandemic

**MARCH 17, 2021**



The coronavirus pandemic has taken an enormous toll on nursing home residents and staff. Since the beginning of the pandemic and as of the end of February 2021, nursing facilities have reported that at least 640,271 residents and 552,660 staff members have had confirmed cases of COVID-19 and that at least 130,174 residents and 1,623 staff members have died of the virus.[1] These numbers are likely underreported, since the Centers for Medicare & Medicaid Services (CMS) did not require facilities to report COVID-19 cases and deaths until May 2020.[2] Nevertheless, the reported deaths account for more than one-third of coronavirus deaths in the United States and, in nine states, nursing facility residents and staff account for more than half of all deaths,[3] although residents account for less than .05% of the country's population.[4]

During the pandemic, the federal government waived many longstanding resident protections and facility reporting requirements.[5] Accountability and oversight were severely limited, as CMS waived virtually all standard and complaint surveys[6] and barred long-term care ombudsmen and families from visiting.

What also changed during the pandemic was the large influx of public funds sent to facilities. During the coronavirus pandemic, nursing homes have received billions of additional dollars and non-monetary support from all levels of government in addition to reimbursement for care through the Medicare and Medicaid programs. The Federal Government has given, or in some cases, loaned facilities (with many loans forgiven) hundreds of millions of additional dollars through multiple programs. Most of these federal payments have been made without regard to facilities' performance. Many states have also increased Medicaid rates across-the-board or paid higher rates for COVID-19-positive residents or established COVID-19-only facilities and paid them high rates. In addition, the Federal and State Governments have provided indirect financial support to nursing facilities, supplying personal protective equipment, tests and testing equipment, multiple training opportunities, the National Guard, and "strike teams" to help facilities in crisis situations during the pandemic. Despite these billions of dollars, the nursing home industry continues to ask for more financial support,[7] even as patients leaving the hospital are choosing home care over facility care for their post-hospital recovery[8] and nursing facilities' occupancy rates decline to an unsustainable 70%.[9]

Concerns have been raised about nursing facilities that have received extensive COVID financial assistance, although sanctioned for fraud or poor care.

This Report highlights some of the key federal and state programs, both direct financial payments and indirect financial support, and describes some of the concerns raised about nursing home chains and individual facilities that have received extensive financial support.

**Federal Money**

Billions of federal dollars include at least the following:

**Provider Relief Fund.** The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted March 27, 2020,[10] created a $175 billion Provider Relief Fund. Approximately $21 billion of the $175 billion was earmarked for nursing facilities.[11] CMS described the distribution of Provider Relief Funds in three phases.[12] Only the third-phase distribution was based on so-called performance. Although the CARES Act requires facilities to spend money awarded under the Provider Relief Fund on "health care related expenses or lost revenues that are attributable to coronavirus,"[13] Seema Verma, then-CMS Administrator, said, as she announced the initial payout of $1.5 billion to skilled nursing facilities (SNFs) in April 2020, that the federal money comes with "'no strings attached.'"[14]

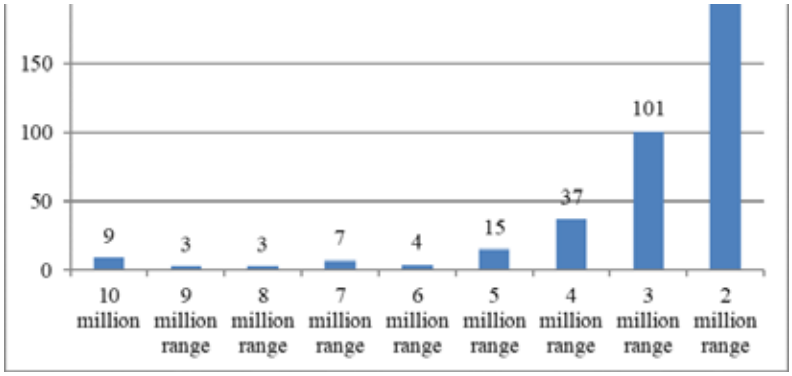
- Phase One: On May 22, 2020, HHS announced that all certified skilled nursing facilities (SNFs) with six or more certified beds were eligible to receive $50,000 per facility plus $2,500 per bed.[15] More than 13,000 certified SNFs received a total of $4.9 billion. *The Washington Post* estimated in August that "the average distribution was $315,000, with some larger facilities receiving $3 million or more."[16]
- Phase Two: On July 22, 2020, CMS announced $5 billion from the Provider Relief Fund "to build nursing home skills and enhance nursing homes' response to COVID-19, including enhanced infection control."[17] The money, available for Medicare-certified facilities and state veterans' homes, could be used for "hiring additional staff, implementing infection control 'mentorship' programs with subject matter experts, increasing testing, and providing additional services, such as technology so residents can connect with their families."[18] The $5 billion was distributed in two phases, $2.5 billion in August 2020[19] and $2 billion in Phase Three.
- Phase Three: On September 3, 2020, CMS announced that it would distribute $2 billion in "performance-based incentive payments" to nursing facilities.[20] To qualify, a facility was required to meet two criteria: (1) a COVID-19 infections rate that is below the rate of infection in the county in which it is located and (2) a COVID-19 death rate that falls below a nationally established performance threshold for mortality among nursing home residents infected with COVID-19. Performance-based payments were made on October 28 ($333 million to more than 10,000 facilities)[21] and on December 7 ($523 million to more than 9,000 facilities).[22]

**Paycheck Protection Program**. This program, created as part of the CARES Act and extended by the Consolidated Appropriation Act, 2021,[23] provides loans to businesses to keep workers employed during the pandemic.[24] The Small Business Administration (SBA) administers the program. Loans of up to $10 million may be forgiven if "employee and compensation levels are maintained," "loan proceeds are spent on payroll costs and other eligible expenses;" and "at least 60 percent of the proceeds are spent on payroll costs."[25] Businesses can receive multiple PPP loans.[26]

SBA data, reported by *FederalPay*, indicate that, as of March 1, 2021, 10,293 nursing facilities (as reported by December 1, 2020) received PPP loans totaling $5.7 billion.[27] The average PPP loan is $550,701.

Using SBA data, *ProPublica* identified nursing facilities and organizations receiving PPP loans.[28] The Center for Medicare Advocacy calculated that 389 nursing facilities and organizations received at least two million dollars in PPP loans, totaling more than $1 billion, as of March 1, 2021.

**Nursing Facilities Receiving $2 Million or More from the Paycheck Protection Program**




**Other Medicare Funding Issues**

The reimbursement system that went into effect for Medicare coverage of SNF care on October 1, 2019 – the Patient Driven Payment Model – was intended to be budget-neutral but has in fact "provided $200 more per day than the system it replaced."[29] The CARES Act suspended the 2 percent sequestration (automatic reduction) in Medicare reimbursement rates for providers for the period May 1, 2020 through December 31, 2020.[30] The Consolidated Appropriations Act, 2021 extended the sequestration relief for three additional months.[31]

**Medicare Accelerated and Advance Payment Program**[32]

CMS expanded its Medicare accelerated and advance payment program for all Medicare providers in order to expedite payments and provide emergency funding and address cash flow issues.[33]

**Other Federal Programs (Not Limited to Nursing Facilities)**

Nursing facilities are eligible for other loans, such as Economic Injury Disaster Loans.[34]

**Other Programs**

LeadingAge New York identified "COVID-19 Financial Assistance Opportunities for Not-for-Profit Providers (Version 10.6.20)."[35]

**Medicaid**

CMS described flexibilities that enable states to modify their Medicaid payment rates and methodologies, including increasing payments to facilities, targeting payment increases to COVID-19 residents, and amending state plans through the Medicaid Disaster Relief State Plan Amendment template (created in March 2020).[36] The National Governors Association (NGA) reported that 23 states provided additional payments to nursing facilities and 10 states increased staff payments and other employee incentives.[37] LeadingAge described 23 states' and the District of Columbia's use of Medicaid to increase reimbursement for facilities during the pandemic.[38]

- **Some states increased Medicaid reimbursement across-the-board**, by either specific percentages (such as 10%, in California and Oregon) or dollar increases (such as $20 per day, in Kansas, or $40 per day, in Montana).[39] Connecticut increased Medicaid payments by "another $31.2 million" in December 2020.[40] Washington submitted a State Plan Amendment in April 2020 to increase Medicaid rates by an average of $5.17 per day on May 1, 2020 and by $7.40 per day on July 1, 2020.[41]
- **Some states focused Medicaid reimbursement on staff salaries.** On April 15, 2020, Arkansas announced that CMS had approved its request to use Medicaid to fund the temporary increase of wages for direct care workers, including $125 per week for designated staff (including nursing staff) who worked 20-39 hours per week and $250 per week for designated staff working 40+ hours per week.[42] For staff working with COVID-19-positive residents, weekly wages

increased more, $125 for staff working one-19 hours per week, $250 for staff working 20-39 hours per week, and $500 for staff working 40+ hours per week.[43]

- **Some states paid higher reimbursement for residents who tested positive for COVID-19.** Kentucky announced that it would pay a per diem add-on of $270 for each COVID-19- positive resident.[44] *Politico* reported that California, Massachusetts, Michigan, and New Mexico paid incentive payments to facilities accepting COVID-19-positive patients from hospitals.[45]
- **Some states created coronavirus-only facilities and paid higher rates** ("double or more") for care of their residents.[46] Ohio, for example, pays as much as $984 per day for a resident in isolation centers who needs a ventilator.[47] Some coronavirus-only facilities had poor records for quality of care.[48] New Mexico named as its coronavirus-only facility Canyon Transitional Rehabilitation Center, a one-star facility owned by Genesis HealthCare that was cited for "a complete lack of infection control, massive staff shortages and staff incompetence."[49] The facility was eligible for payments of $600 per patient per day, in addition to Medicare payments for the residents.[50]

**Federal and States Non-Monetary Support**

Nursing homes also received large amounts of non-monetary support during the pandemic. This support includes personal protective equipment (PPE), tests and testing equipment,[51] training, assistance from the National Guard, and strike teams.

- **PPE:** In May 2020, the Federal Emergency Management Agency (FEMA) sent a 14-day supply of PPE to 15,000 nursing homes nationwide. The supplies included more than 7.1 million surgical masks; almost 32.3 million gloves; more than 922,000 goggles/eye protection, and almost 9.7 million gowns.[52] States also provided PPE to facilities. For example, Georgia provided facilities with "industrial foggers, disinfectant solution" as well as "hundreds of thousands of face shields, masks, gloves and gowns."[53]
- **Tests:** In July 2020, the federal government announced that it would send point-of-care antigen tests to all nursing facilities that were certified to perform the tests.[54] States also sent tests and testing equipment to facilities. In May, Delaware's Governor announced a plan for universal testing of all residents and staff in long-term care facilities and said that the state would provide all facilities with "tests, testing supplies, training, and support."[55]
- **Training:** The Federal Government has provided a considerable amount of training to nursing facilities, focusing on infection control.

  On August 25, 2020, CMS provided "CMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management" in order "to equip both frontline caregivers and their management with the knowledge they need to stop the spread of coronavirus disease 2019 (COVID-19) in their nursing homes."[56] A new National Nursing Home COVID Action Network was created under an Agency for Healthcare Research and Quality contract to provide "free training and mentorship to nursing homes across the country to increase the implementation of evidence-based infection prevention and safety practices to protect residents and staff."[57]
- The American Rescue Plan includes $200 million to Quality Improvement Organizations to provide support for infection control and vaccination uptake.[58]
- **National Guard:** The CMS "Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes" (Feb. 2021 edition[59] and earlier monthly editions) described activities of the National Guard in at least 18 states.[60] Tasks performed by the National Guard included disinfecting nursing facilities, conducting COVID-19 testing, staffing facilities, training and assisting in infection control, assisting with data collection, and providing ancillary services.
- **Strike Teams:** Maryland was the first state to use strike teams. The teams were "made up of National Guard, state and local health departments and hospital systems" and their purpose was to "provide emergency care, supplies and equipment to assist overburdened nursing homes and extended care facilities" that experienced a coronavirus outbreak.[61] The CMS Toolkits describe infection control "strike teams" used by states to test residents and staff for COVID-19, provide nurses and aides to achieve staffing stability, assist staff with implementation of infection control protocols, provide "initial triage, site assessment" and other functions for facilities on request, and go into facilities with outbreaks, among other functions.[62] The National Governors Association reported that 28 states had dedicated support teams for nursing facilities.[63]

  CMS also deployed federal Task Force Strike Teams "to provide onsite technical assistance and education to nursing homes experiencing outbreaks."[64]

The American Rescue Plan includes $250 million for Strike Teams.[65]

**COVID-19 Money for Poor Performing Facilities**

Concerns have been raised about multi-state nursing home chains that have received federal and state money during the pandemic, despite the poor care they provide and the legal actions brought against them for defrauding the Government. Concerns have also been raised about COVID-19 payments and loans made to individual facilities, despite their poor records for care and their high rates of COVID-19 cases and deaths.

*The Washington Post* reported in August, "More than a dozen companies that received federal funding have settled civil lawsuits in recent years with the Justice Department, which alleged improper Medicare billing, forged documents, substandard care and other abuses."[66] A dozen companies, nearly all operating under corporate integrity agreements with the HHS Office of Inspector General, repaid the Government more than $260 million. Nevertheless, companies that have been sued for Medicare fraud in recent years "received more than $300 million in relief payments."[67]

*The Washington Post* described large payments to a sample of such chains:

- In April 2020, Saber Healthcare and related entities agreed to pay $10 million to resolve allegations under the False Claims Act that nine of Saber's facilities in North Carolina, Ohio, Pennsylvania, and Virginia, submitted false and inflated claims to Medicare.[68] *The Washington Post* reports that Saber Healthcare received more than $45 million in pandemic funding.[69]

- Brius Healthcare Services, California's largest operator with 81 nursing facilities and a record of "police scrutiny, lawsuits, stiff regulatory fines and state and federal investigations that have uncovered numerous alleged violations,"[70] received more than $35 million in federal relief funds.[71]

- Life Care Centers of America, a privately-held company with more than 200 nursing facilities, is currently under a five-year Corporate Integrity Agreement (signed 2016) with the HHS Inspector General for overbilling Medicare.[72] The company's nursing facility in Kirkland, Washington was the site of the first COVID-19 outbreak in February 2020. Life Care Centers of America received $19,269,489 from the Provider Relief Fund on October 27, 2020,[73] and, according to *The Washington Post* in August 2020, $48 million in relief payments.[74]

The *Miami Herald* reports that 24 Florida facilities under common ownership – more than one-third of which are on the state's Watch List of troubled facilities – received funding totaling between $48 million and $78 million from CARES Act funds, a combination of "competitive federal coronavirus relief funds" and increased federal reimbursement.[75]

*The New York Times* reported that Genesis Healthcare, the country's largest operator of nursing homes, "received more than $300 million in government grants and loans" during the pandemic, as of May 2020.[76] These funds included at least a $180 million CARES Act grants, $27 million in state money, and $158 million in advance Medicare payments from the Federal Government.[77] In a February 10, 2021 letter to Senator Elizabeth Warren, Genesis identified additional COVID funding that the company has received: $416.9 million in state and federal grants as well as $247.8 million in loans or advances subject to recoupment or repayment ($199.1 million in CARES Act Provider Relief Funds, $54.5 million in federal grants for infection control, $28.5 under the Quality Incentive Payment Program, $153.2 million in advance payments under the Medicare Accelerated and Advanced Payment Program, $92.2 million in payroll tax deferrals, $11.1 million in temporary suspension of Medicare sequestration, state relief totaling $123.7 million, and a state loan total totaling $2.3 million).[78]

*Business Insider* reported that 200 "of the US's worst-performing nursing homes received millions of dollars from the Paycheck Protection Program."[79] It cited individual facilities that were fined for poor care, but that nevertheless received PPP payments that dwarfed their fines.

For example, Kingston Healthcare Center, a California nursing facility, has a poor record for care. Following a coronavirus outbreak in April and May, the state sent a strike team to the facility so that it could continue operating. In October 2020, the California Occupational Safety and Health Administration fined the facility $92,500, later reduced to $17,315, for failing to protect workers from coronavirus.[80] Kingston Healthcare Center, one of six California facilities designated a Special Focus

Facility.[81] was cited with 17 deficiencies as of November 2020, [82] including one immediate jeopardy.[83] As of November 2020, 71 staff and 112 residents, 19 of whom died, had tested posted for coronavirus. Despite this record, the California nursing facility received $1,628,800 in PPP loans,[84] almost triple the $550,701 average that nursing facilities nationwide received in PPP loans.[85]

Andbe Home, a Kansas nursing facility, was in the news when all 63 of its residents, and 55 of its 70 staff members, tested positive for COVID-19 and at least 10 residents died.[86] In October, CMS cited immediate jeopardy, imposed federal fines of $14,860, and moved to terminate the facility's participation in the Medicare program. Nevertheless, AARP reported in November that the facility had received more than $300,000 in funding from the Provider Relief Fund.[87]

**Conclusion**

During the coronavirus pandemic, nursing homes have received billions of dollars in direct and indirect financial support, although, as the discussion of payments to Genesis Healthcare shows, the actual dollar amounts received by individual corporations (and facilities) change and are difficult to track. Nevertheless, the nursing home industry continues to ask for more assistance.[88] The American Health Care Association claims that at least 1,600 nursing homes could close in 2021 without more aid.[89] As AARP asked, "Nursing Homes Are Getting Billions in COVID Aid – Where Is It Going?"[90] That question needs to be answered before the nursing home industry is given more public dollars.

*March 22, 2021 – T. Edelman, M. Edelman*

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May 2015 | Issue Brief

# Reading the Stars: Nursing Home Quality Star Ratings, Nationally and by State

Cristina Boccuti, Giselle Casillas, Tricia Neuman

## Executive Summary

About 1.3 million people receive care each day in over 15,500 nursing homes in the United States that are certified by either Medicaid or Medicare or both. The federal government requires nursing homes to meet minimum standards as a condition of Medicare and Medicaid payment. Over the years, serious concerns have been raised about the quality of nursing home care and the adequacy of oversight and enforcement.[1] Nursing home provisions in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) were enacted to help address these concerns. Nonetheless, reports of quality problems in nursing homes persist, such as low staffing levels, new pressure ulcers (bedsores), and documented fire hazards.[2] These are serious issues given the frailty and vulnerability of nursing home residents.

In 2008, the Centers for Medicare and Medicaid Services (CMS) launched the Five-Star Quality Rating System on its *Nursing Home Compare* website to provide summary information to help consumers choose a nursing home in their area. CMS recently modified the methodology of these ratings, began posting more information about nursing home deficiencies from state health inspections, and is planning future steps to increase the star ratings' reliability, as required by certain provisions in The Affordable Care Act (ACA) and the Improving Medicare Post-Acute Care Transformation Act (IMPACT). This issue brief presents national and state-level analysis of nursing homes quality scores based on these five-star ratings and discusses relevant policy considerations.

### Key Findings

- More than one-third of nursing homes certified by Medicare or Medicaid have relatively low overall star ratings of 1 or 2 stars, accounting for 39 percent of all nursing home residents. Conversely, 45 percent of nursing homes have overall ratings of 4 or 5 stars, accounting for 41 percent of all nursing home residents.
- For-profit nursing homes, which are more prevalent, tend to have lower star ratings than non-profit nursing homes. Smaller nursing homes (with fewer beds) tend to have higher star ratings than larger nursing homes.
- Ratings tend to be higher for measures that are self-reported (quality measures and staffing levels) than for measures derived from state health inspections.
- In 11 states, at least 40 percent of nursing homes in the state have relatively low ratings (1 or 2 stars). In 22 states and the District of Columbia, at least 50 percent of the nursing homes in the state have relatively high overall ratings (4 or 5 stars).
- States that have higher proportions of low-income seniors tend to have lower-rated nursing homes.

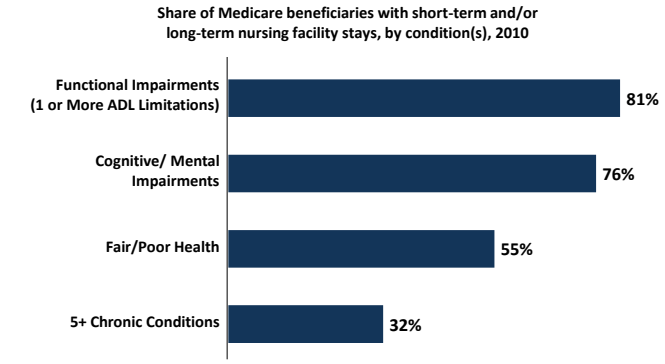
# Background

## THE PEOPLE LIVING IN NURSING HOMES

Nursing home quality is a serious issue, particularly in light of the vulnerability of the people who are living in them. Nursing home residents tend to have significant limitations, including functional and/or cognitive limitations and multiple chronic conditions. While Medicaid is the primary payer for over 60 percent of nursing facility residents, the vast majority of people living in nursing homes are Medicare beneficiaries.[3] Some are short-stay residents and are admitted for Medicare-covered skilled nursing care following a hospitalization before returning home or continuing to stay for non-Medicare covered services in the same or different facility.[4] Others are long-stay residents, often with dementia, who reside in nursing homes because they or their family are unable to care for them in their own homes. Together, Medicare and Medicaid payments account for more than half (52 percent) of all expenditures on nursing home care, including care in skilled nursing facilities, nursing homes, and continuing care retirement communities.[5]

Figure 1

**Medicare beneficiaries with stays in nursing facilities have significant functional and/or cognitive limitations and health problems**




Note: ADL is activity of daily living. Analysis includes Medicare beneficiaries who stayed in a skilled nursing facility or a long-term care facility during the year.
Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2010 Cost and Use file.

Among Medicare beneficiaries who spent time in a long-term care facility or a skilled nursing facility, 81 percent are limited in their ability to perform activities of daily living, such as eating and bathing, 76 percent have cognitive or mental impairments, 55 percent are in fair/poor health and 32 percent have five or more chronic conditions, according to analysis of the 2010 Medicare Current Beneficiary Survey (**Figure 1**). Nearly two-thirds have incomes of less than $20,000. Women and people ages 85 and older account for a disproportionate share of nursing home residents.

## Nursing Home Characteristics

Nationwide, just over 15,500 nursing homes are certified to provide care to Medicare or Medicaid beneficiaries (**Table 1**). The vast majority (92 percent) are certified for both programs. Among these nursing homes, most (70 percent) are for-profit, about a quarter (24 percent) are non-profit and a very small share are government-owned (6 percent). On average, nursing homes have 106 beds, with 19 percent having fewer than 60 beds and almost 30 percent having more than 120. Among the nursing homes certified by Medicare or Medicaid, 10 percent are part of Continuing Care Retirement Communities (CCRCs), which typically offers housing options with a full range of assistance levels. Most nursing homes (95 percent) are freestanding facilities, while 5 percent are housed within a hospital.

**Table 1. Nursing Homes Certified by Medicare and/or Medicaid in the US, 2015**

| | |
|---|---|
| Number of Nursing Homes | 15,505 |
| Number of Nursing Home Residents | 1,366,044 |
| **Characteristic** | **Percent of Nursing Homes** |
| **Certification** | |
| Medicare only | 5% |
| Medicaid only | 3% |
| Medicare and Medicaid | 92% |
| **Tax status** | |
| For-profit | 70% |
| Non-Profit | 24% |
| Government | 6% |
| **Size** | |
| < 60 beds | 19% |
| 60 - 120 beds | 52% |
| > 120 beds | 29% |
| **CCRC affiliation** | |
| CCRC | 10% |
| Not affiliated with CCRC | 90% |
| **In-hospital Status** | |
| Freestanding | 95% |
| Within a Hospital | 5% |

NOTE: CCRC is continuing Care Retirement Community. Analysis Includes only nursing homes certified by Medicare and/or Medicaid.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015.

## Recurrent Problem: Reports of Poor Quality Care in Nursing Homes

Serious concerns about the quality of care in nursing homes have been reported for decades. In 1986, an Institute of Medicine (IOM) report identified several problem areas with nursing home care, including staffing capacity, training, and supervision and made several recommendations regarding oversight and regulation to enhance nursing home standards, particularly those that received federal and state funding.[6] Subsequently, Congress enacted landmark legislation in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) that, among other provisions, established new minimum requirements for nursing homes eligible to receive Medicare or Medicaid payment, and put in place added enforcement systems.[7] To carry out these provisions, the federal government contracts with states to inspect nursing homes, but states may place additional conditions on nursing homes to meet state licensing requirements. For example, some states require a registered nurse (RN) to be on duty 24 hours a day for nursing homes with 100 or more residents—higher than the federal minimum standard which requires an RN on duty for at least at least 8 consecutive hours per day, 7 days per week, regardless of the number of residents in the nursing home.[8]

In some respects, the quality of care in nursing homes has improved since OBRA 87—such as lower use of physical restraints—but nursing home deficiencies and citations continue to be prevalent.[9] Over the past decade, multiple studies, including those conducted by the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) have found that significant proportions of patients are in nursing homes cited with deficiencies that are serious enough to cause harm or immediate jeopardy.[10] Recent media reports have also described circumstances that raise significant concerns about the quality of care in nursing homes.[11]

## Nursing home Compare and the Five-Star Quality Rating System

To help consumers and their families find a nursing home and to encourage nursing homes to achieve higher quality through public reporting of nursing home performance, CMS launched its *Nursing Home Compare* website in 1998. In 2008, CMS modified the website to provide more user-friendly star ratings based on quality scores for all Medicare- and Medicaid-certified nursing homes. While the ratings provided additional means for consumers to compare nursing homes, some have criticized the heavy reliance on self-reported data.[12] In February 2015, CMS modified its star rating system to begin to address some of these concerns, and is planning additional changes in the future.

The current CMS Five-Star Quality Rating System calculates an overall star rating—with one star being the lowest possible score and five being the highest—based on performance in three types of measures, each of which also has its own five-star rating. These three domains are: 1) state health inspections; 2) staffing ratios; and 3) quality measures. We summarize these domains below and briefly describe how CMS derives a score for each. For more detailed information on the methodology used to calculate individual components and overall quality measures, see *Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide.*[13]

- **State Health Inspection measures** are based on state health inspection reports which provide multiple types of information on nursing home deficiencies identified during annual inspections, including the number and severity of problems, revisits needed to document that deficiencies were corrected, and actions taken by nursing homes to investigate complaints. CMS weights deficiencies that cause "immediate jeopardy to resident health or safety" more heavily when determining each nursing home's score, particularly when the infractions are widespread and not isolated incidents. Examples of these types of infractions include: failure to prevent or treat residents' pressure ulcers (bedsores that, if infected, can lead to sepsis and pain); failure to maintain food storage in areas free of pests including rodents and roaches; environmental hazards, such as electrical fires; and failure to follow up on head injuries and fractures among residents.

  To help control for variation among states that results from differences in state practices, such as state licensing requirements, the star ratings for State Health Inspections are based on the ranked performance of facilities within a state. That is to say, the star ratings are curved, wherein 5-star ratings are reserved for the 10 percent of nursing homes that received the highest score on the State Health Inspection measure, and 1-star ratings are reserved for the 20 percent of nursing homes that scored the lowest. The remaining 70 percent of nursing homes are evenly assigned 2, 3, and 4 stars. In every state, therefore, 20 percent of nursing homes receive a rating of 1 star.

- **Staffing measures** incorporate information reported by nursing homes on the ratio of nurses to residents, as measured by nurse hours per resident days. This measure adjusts for patient care needs (based on patient acuity levels) at each nursing home and includes calculations of both RN hours per resident days and total nurse hours (including additional types of nurses, such as certified nurse aids) per resident days. To receive a 5-star rating in staffing, a nursing home must have staffing levels that equate to 5 stars for *both* RNs and total nurses. A nursing home with fewer than 3 hours of total nursing staff per resident days and fewer than 16 minutes of RN time per resident days (both adjusted for patient care needs) would be assigned 1 star in the Staffing star rating.[14]

- **Quality measures** are calculated using the Minimum Data Set (MDS)—an assessment instrument that nursing homes use to document the function and health status of their patients. (The MDS is used for a number of purposes, including determining Medicare payment for patients receiving skilled nursing facility care). Currently, the star ratings incorporate 11 selected measures from the MDS, some of which apply to short-stay patients and the others to long-stay patients. Examples of these measures include the percent of residents with new or worsened pressure sores, the percent of residents who self-report moderate to severe pain, and the percent of residents who experienced falls with major injury. For the total quality score, each of the 11 selected measures is calculated separately to adjust for differences in prevalence, with each measure given equal weight.

- **Overall star ratings** are a composite of the three measure domains, with the State Health Inspection score forming the core of the Overall star rating. Several algorithms apply to the Overall star rating calculation with the general goal of preventing nursing homes from receiving high Overall star ratings if they received low ratings in one or more individual categories. For example, if a nursing home received only 1 star in its State Health Inspection measure, then its maximum Overall star rating is capped at 2 stars. Also, if a nursing home receives only 1 star in the Quality measures category, its Overall rating is reduced by 1 star.

## CHANGES TO THE STAR RATING SYSTEM

The current Five-Star Quality Rating System, described above, incorporates methodological changes that CMS implemented in February 2015. The impetus for changing the methodology for determining star ratings stemmed from a number of factors. One consideration was the high proportion of nursing homes in the 4- and 5-star ranges. Before the new methodology was implemented, 78 percent of nursing homes scored 4 or 5 stars in the Quality measures category and 54 percent of all nursing homes had 4 or 5 stars overall.[15] With relatively large shares of nursing homes in the 4-and 5-star rating group, questions arose as to consumers' ability to assess the relative performance among nursing homes in their area. In response, CMS rebased its measurement system by increasing the number of points necessary to earn a Quality measure star rating of two or more stars and by changing the scoring method for the staffing measures. CMS also incorporated two new indicators into the Quality measures category regarding the use of antipsychotic medication (one measure for short-stay residents and one for long-stay residents) in response to multiple research studies showing the risks associated with overuse of antipsychotic medication use in nursing homes.

CMS officials anticipate making additional changes to improve the validity of the star rating system in the future. One slated change—required by provisions in the ACA—will be to incorporate staffing data collected quarterly from electronic systems used for payroll reporting, rather than rely exclusively on self-reported staffing levels. The goal of using the electronic payroll data sources is to obtain more information, with greater accuracy, on total staffing hours and staffing turnover. In 2015, CMS also instituted special unannounced, on-site inspections of a nationwide sample of nursing homes to validate self-reported quality data, in addition to the recertification surveys that are conducted at least every 15 months for every nursing home.[16]

# Methods

This issue brief presents data based on an analysis of the Nursing Home Compare database, which is publicly available on the CMS website and updated monthly. This analysis uses data from the February 2015 release. The Nursing Home Compare database provides individual nursing home information on over 15,000 nursing homes certified by Medicare or Medicaid, such as each nursing home's name, location, size, and number of recorded deficiencies and fines. This analysis does not include data on facilities that do not receive payment from Medicare or Medicaid, which may include many independent and assisted living facilities. The database used in this analysis provides star ratings for each nursing home in the domains described earlier in this paper (quality, staffing, and state health inspection) and a composite rating. Of these three domains, the state health inspections are the only measures that do not rely on self-reported data—data supplied by the nursing home.

This analysis also uses the 2012-2014 Current Population Survey for state-level estimates of the percent of people age 65 and older living with incomes less than 200 percent of poverty to examine the extent to which star ratings vary by the percent of seniors with low incomes living in each state. Notably, this analysis does not assess the validity or reliability of the CMS Five-Star Quality Rating System; rather it simply shows how the ratings vary nationally and by state, and by nursing home characteristics. Also, because the overall star ratings incorporate scores that are curved (assigned based on rankings, rather than raw scores) within each state—particularly the State Health Inspection measure, which is weighted more heavily—it is not entirely possible to draw comparisons between states.

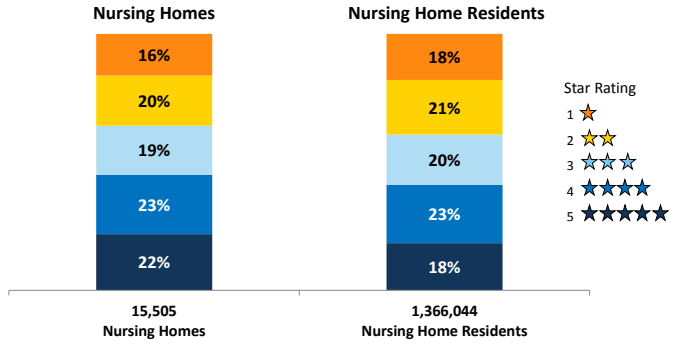
# Findings: National and State-Level Snapshot of Nursing Homes by Star Ratings

## National Findings

- **More than one-third (36 percent) of nursing homes certified by Medicare or Medicaid have overall ratings of 1 or 2 stars (Figure 2).** Almost two in five nursing home residents (39 percent) live in these 1- and 2-star nursing homes. A larger share of nursing homes—45 percent—have overall ratings of 4 or 5 stars, accounting for 41 percent of all nursing home residents.

Figure 2

**More than one-third of all US nursing homes have overall ratings of 1 or 2 stars, accounting for 39% of all nursing home residents**



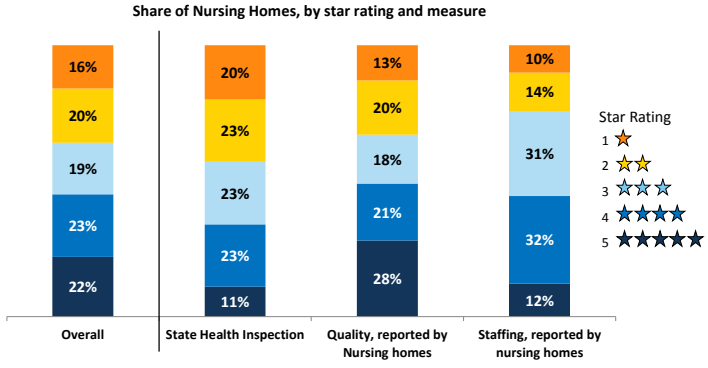

NOTE: Analysis is based on the overall composite star rating score for nursing homes. Analysis includes only nursing homes certified by either Medicare or Medicaid and excludes nursing homes with unavailable star ratings.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

- **Scores tend to be higher on measures that are reported by nursing homes (quality and staffing) than those derived from the State Health Inspection reports (Figure 3).** For example, almost half (49 percent) of all nursing homes scored 4 or 5 stars in the self-reported Quality measures category and 44 percent scored 4 or 5 stars in the self-reported Staffing measures category, in contrast to 34 percent in the State Health Inspections

category. Conversely, 43 percent of nursing homes had a relatively low score—1 or 2 stars—on the State Health Inspection measures, while 33 percent received 1 or 2 stars for the Quality measures and 24 percent received 1 or 2 stars on the Staffing measures. Notably, just 12 percent of nursing homes received a 5-star rating for the self-reported Staffing measures. As described earlier, the State Health Inspection measures incorporate a curve in the star ratings, which means nursing homes are assigned star ratings based on their ranked score in the state.

Figure 3

**Star ratings tend to be higher for nursing homes' self-reported measures, compared with State Health Inspection scores**

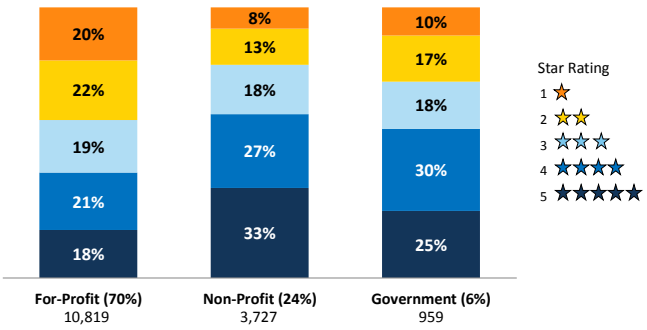



NOTE: The "Overall" measure is a composite score, based on facility performance in the other three measures. Analysis includes only nursing homes certified by either Medicare or Medicaid and excludes nursing homes with unavailable star ratings.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

- **For-profit facilities, which comprise 70 percent of all nursing homes in the U.S., tend to have lower overall star ratings than non-profit nursing homes (Figure 4).** Forty-two percent of for-profit nursing homes received a relatively low overall score (1 or 2 stars), double the rate observed among non-profit nursing homes. One in five for-profit nursing homes received only 1 star, the lowest possible rating, as compared to less than one in ten non-profit nursing homes. This finding is consistent with previous studies conducted by other researchers and GAO which have found greater numbers of deficiencies, including ones that involve actual harm or immediate jeopardy to residents, among for-profit nursing homes compared with non-profit nursing homes.[17]
  - Non-profit nursing homes, which comprise about a quarter of all Medicare-and Medicaid-certified nursing homes, tend to have higher overall star ratings. One-third of all non-profit homes (33 percent) received the highest possible overall score with 5 stars—a substantially higher rate than among for-profit homes (18 percent). Non-profit nursing homes include both corporate and religiously affiliated entities; further analysis (not shown) reveals little differences in the overall scores between different types of non-profit nursing homes certified by Medicare and/or Medicaid.

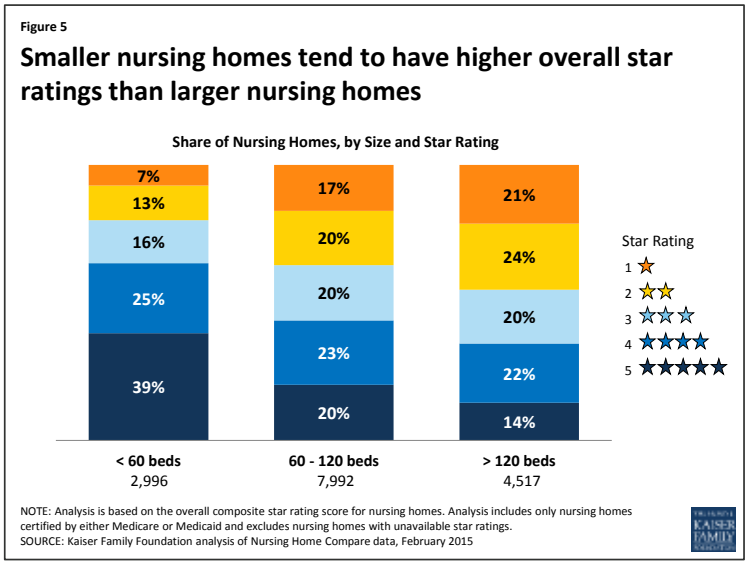
Figure 4

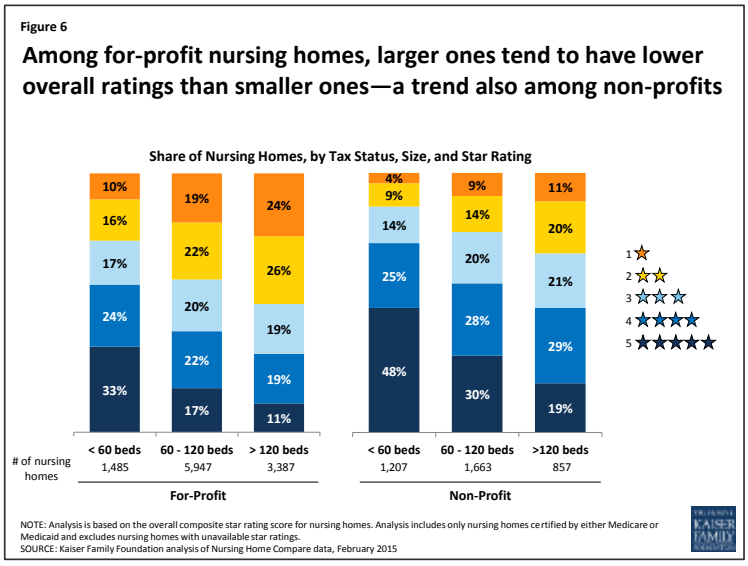
**For-profit nursing homes, which are much more prevalent, tend to have lower overall star ratings than non-profit nursing homes**




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

- **Smaller nursing homes, with fewer beds, tend to have higher overall star ratings than larger nursing homes (Figure 5).** Among nursing homes with fewer than 60 beds, 39 percent received the highest possible overall rating—5 stars—compared to 14 percent of nursing homes with more than 120 beds. GAO has also documented higher rates of deficiencies among relatively large nursing homes.[18] This trend is holds true for for-profit and non-profit nursing homes **(Figure 6).**



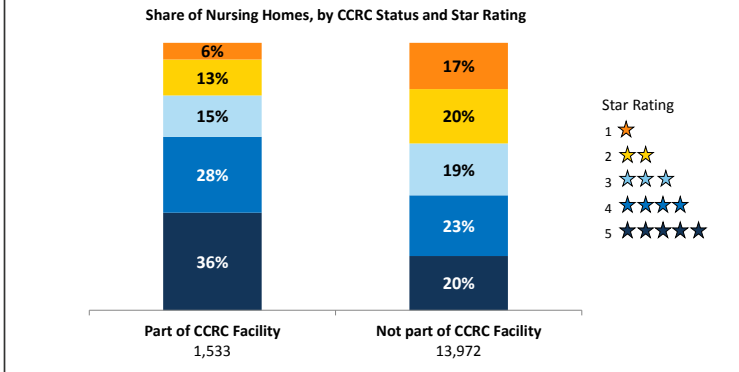

  - One of the factors influencing lower overall ratings among larger nursing homes with more residents could be their lower scores, on average, on staffing ratio measures. This suggests that smaller nursing homes may have more nursing staff hours per patient than larger homes. For example, in nursing homes with more than 120 beds, 14 percent received only one star on the staffing measure, compared with 4 percent among nursing homes with fewer than 60 beds (not shown).

  - There are no federal minimum standards linking the size of nursing homes (by the number of beds or residents) to nurse staffing requirements.[19] Regardless of size, nursing homes must have one registered nurse (RN) on duty for at least 8 consecutive hours per day, 7 days per week, and maintain 24-hour nursing coverage (either from an RN, or a licensed practical nurse (LPN)—a certification level which requires less academic training than an RN).[20] Some states, however, have established minimum licensing requirements that are linked to the size of nursing homes.[21]

- **Nursing homes that are part of a continuing care retirement community (CCRC) tend to have higher overall star ratings than nursing homes unaffiliated with a CCRC (Figure 7).** Ten percent of all nursing homes certified by Medicare or Medicaid are affiliated with a CCRC. Among them, 64 percent received 4 or 5 star ratings—higher than the 43 percent among nursing homes that are not affiliated with a CCRC. Further analysis finds that 69 percent of CCRC-affiliated nursing homes are non-profits (not shown), which is considerably higher than the 24 percent observed across all nursing homes. Also, CCRC-affiliated nursing homes, with an average bed size of 88 (not shown), tend to be smaller compared with the average across all nursing homes—106 beds.

Figure 7

**Nursing homes that are part of a continuing care retirement community tend to have higher overall star ratings**




NOTE: Analysis is based on the overall composite star rating score. CCRC is Continuing Care Retirement Community. 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

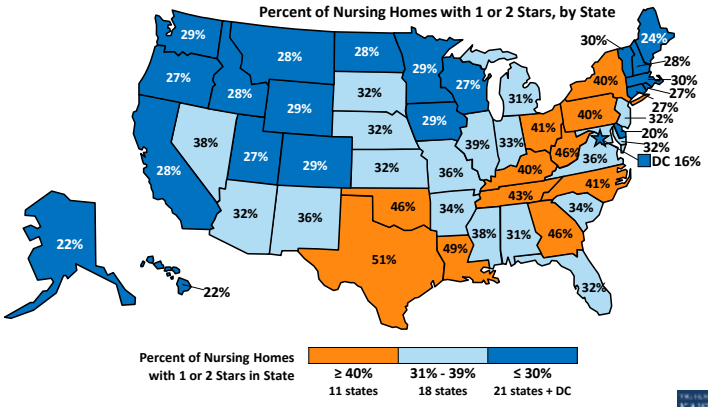
## State-Level Findings

CMS contracts with states to inspect nursing homes as part of the federal role to certify that nursing homes are eligible for Medicare and Medicaid payment and to enforce federal minimum quality standards, but states may place additional conditions on nursing homes to meet state licensing requirements. These differences and variations in state inspection protocols were considered in determining the star rating methodology. Specifically, the star ratings for the State Health Inspection measure—which is weighted more heavily in the overall composite measure—is curved based on the ranked performance of all nursing homes within a state. Therefore, differences between states in the overall ratings primarily reflect differences in the two domains that rely on self-reported data (quality measures and staffing data). As a result, drawing comparisons between states, based on star ratings, is problematic in some ways. With this caveat, the findings presented below provide analysis of star ratings of nursing homes, by state. Further state-level analysis of nursing home characteristics and star ratings for each set of measures is provided in the Appendix.

- **In 11 states, at least 40 percent of all nursing homes have relatively low overall ratings—either 1 or 2 stars (Figure 8).** In Texas, for example, more than half (51 percent) of nursing homes received only 1 or 2 stars, followed by Louisiana (49 percent), Georgia, Oklahoma, and West Virginia (all 46 percent). In nine states, more than 20 percent of the state's nursing homes have the lowest possible rating—1 star **(Appendix Table 2)**. These states are Texas, Louisiana, Oklahoma, Kentucky, Tennessee, New Mexico, West Virginia, Ohio, and Georgia.

Figure 8

**In 11 states, at least 40% of nursing homes have relatively low overall ratings (either 1 or 2 stars)**



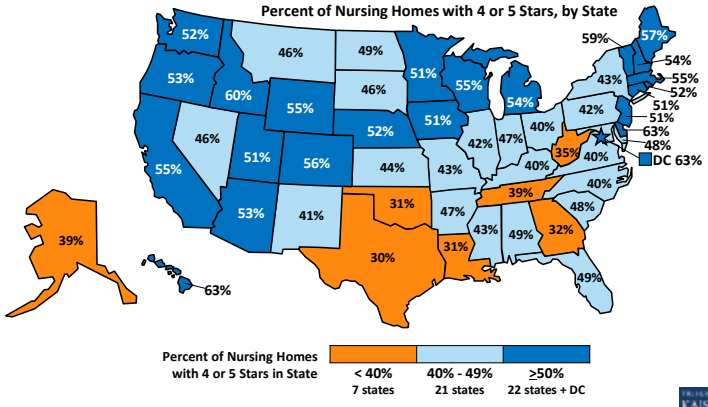

NOTE: Analysis is based on the overall composite star rating and includes only nursing homes certified by either Medicare or Medicaid.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

  - Looking at the individual ratings for staffing and quality specifically, the three states with the highest percentages of 1-star ratings on the Staffing measures are Texas, Louisiana, and Georgia. More than 30 percent of nursing homes in these three states received 1 star on the Staffing measures—well above the national rate of 10 percent **(Appendix Table 5)**. The three states with the highest percentages of nursing homes with 1-star ratings on the Quality measures are Oklahoma, Kentucky, and Mississippi **(Appendix Table 4)**.

- **In 22 states and the District of Columbia, at least half of the nursing homes in the state have relatively high overall ratings—either 4 or 5 stars (Figure 9).** Further, in seven states and the District of Columbia, more than 30 percent of all nursing homes have the highest possible overall rating—5 stars **(Appendix Table 2)**. These are: the District of Columbia, Hawaii, Delaware, California, New Hampshire, Vermont, Idaho, and Rhode Island.[22] For most of these seven states, the percentage of small nursing homes in these states is higher than the national rate—19 percent **(Appendix 1)**.

Figure 9

**In 22 states and DC, at least half of the nursing homes have relatively high overall ratings (either 4 or 5 stars)**

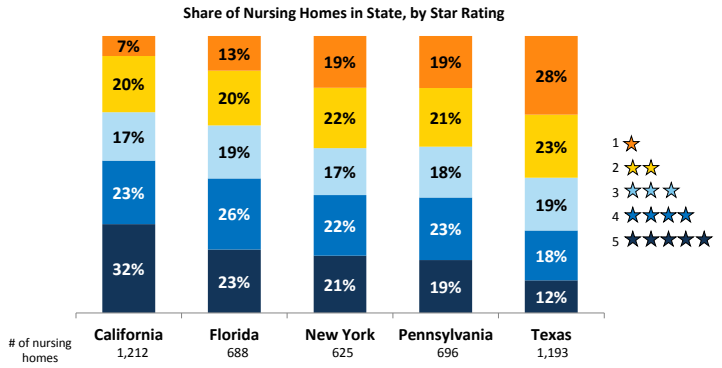



NOTE: Analysis is based on the overall composite star rating and includes only nursing homes certified by either Medicare or Medicaid.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

- **Among the five states with the largest number of people age 65 and older, the share of nursing homes with the best possible rating (5-stars) ranges from 32 percent in California to just 12 percent in Texas (Figure 10).** Conversely, the share of nursing homes with the lowest possible rating (1 star) ranges from 28 percent in Texas to 7 percent in California. About 40 percent of nursing homes in New York and Pennsylvania have relatively low ratings, of 1 or 2-stars.

Figure 10

**Among the 5 states with the most seniors, California has the smallest share of low-rated nursing homes; Texas, the largest**



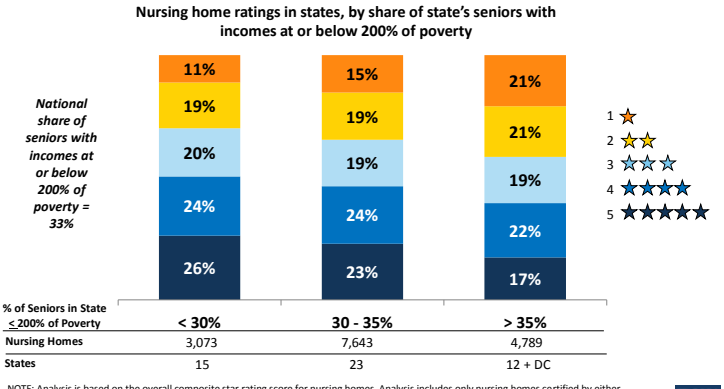

NOTE: Analysis is based on the overall composite star rating score for nursing homes. Analysis includes only nursing homes certified by either Medicare or Medicaid and excludes nursing homes with unavailable star ratings.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

  - Among these five states, Texas and California have the highest share of for-profit nursing homes (86 percent and 84 percent respectively), while Pennsylvania and New York have the lowest shares (55 percent and 56 percent respectively) **(Appendix Table 1)**. Also among these five states, New York and Pennsylvania have the highest share of relatively large nursing homes with more than 120 beds (62 percent and 43 percent respectively), while California and Florida have the lowest shares (23 percent and 25 percent respectively).

- **In states that have a relatively larger percent of low-income seniors living in the state, nursing homes tend to have lower overall ratings (Figure 11).** Among the 12 states and the District of Columbia where more than 35 percent of seniors have incomes below twice the poverty rate (concentrated mostly in the South), 42 percent of nursing homes have a 1- or 2-star overall rating. In contrast, in the 15 states with less than 30 percent of seniors living below twice the poverty level, 30 percent of nursing homes have 1- or 2-star ratings, and half are rated with 4 or 5 stars. **(Appendix Table 6)**. Because data on the incomes of each nursing home's residents are not provided in the Nursing Home Compare dataset, these findings are based on poverty rates among seniors in each state. Further research could examine factors associated with low-star ratings in states with greater percentages of seniors in poverty, such as Medicaid payment rates, and whether lower income nursing home residents are more likely than higher income residents to be a low-rated nursing home.[23]

Figure 11

**Nursing homes in states with greater shares of low-income seniors tend to have lower overall ratings**

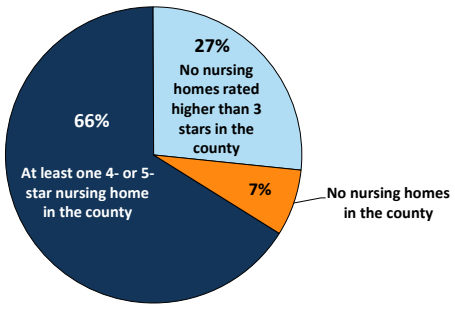



NOTE: Analysis is based on the overall composite star rating score for nursing homes. Analysis includes only nursing homes certified by either Medicare or Medicaid and excludes nursing homes with unavailable star ratings.
SOURCE: Kaiser Family Foundation analysis of: Nursing Home Compare data, February 2015 and Current Population Survey, 2011-2013 Annual Social and Economic Supplement.

- **Two-thirds of all counties in the U.S. have at least one Medicare- or Medicaid-certified nursing home with a 4- or 5- star rating (Figure 12).** The presence of a 4- or 5-star nursing home in two-thirds of all counties does not necessarily imply that all people in these counties have access to a bed in a highly rated nursing home because these nursing homes may not have an available bed. Also, patients and families may place a high priority on being in a nursing home close to family members. Additionally, prospective nursing home residents and their families may not rely on the *Nursing Home Compare* website to search for and select a nursing home. These factors may help explain that while 92 percent of nursing home residents live in counties with at least one 4- or 5- star nursing home (not shown), only 41 percent of nursing home residents are in a 4- or 5- star nursing home (Figure 2).

Figure 12

**Two-thirds of U.S. counties have at least one nursing home with an overall rating of 4 or 5 stars**




3,143 counties in the U.S.

NOTE: Analysis is based on the overall composite star rating score. The total number of counties in the US is derived from the Census 2010 FIPS Codes for Counties and County Equivalent Entities file for the 50 states and DC. Analysis excludes nursing homes with unavailable overall star ratings and includes only nursing homes certified by either Medicare or Medicaid.
SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015

One-third of counties (34 percent) have no 4- or 5-star nursing homes, including counties in which all nursing homes are rated with fewer than 3 stars (27 percent) and counties with no Medicare- or Medicaid-certified nursing homes at all (7 percent). Eight percent of nursing home residents live in counties with no 4- or 5-star nursing homes.

## Discussion

The nursing home population includes some of the oldest, frailest, more medically compromised and cognitively impaired people covered by Medicare or Medicaid. Nursing home residents—both short-term and longer term residents—are particularly at risk because they are often unable to care for themselves, and dependent on others to get by on a day-to-day basis. Medicare and Medicaid, which together account for more than half of all nursing home revenue, require facilities to meet minimum federal standards to help safeguard the health and safety of nursing home residents. Further, CMS has developed and improved the *Nursing Home Compare* website to provide consumers with both detailed and summary information on nursing home quality. Nonetheless, researchers, reporters and advocates have continued to identify serious quality concerns among some of the nation's nursing homes, including those that relate to inadequate staffing, high rates of preventable conditions, such as pressure ulcers (bedsores), and fire safety hazards. A recent study, for example, found that almost one in five nursing homes had deficiencies that caused harm or immediate jeopardy to residents.[24]

Our analysis, based on this data, finds that nearly half of the nursing homes certified by Medicare or Medicaid have 4- or 5- star ratings. But, more than one-third of the nursing homes have relatively low ratings of 1 or 2 stars, accounting for almost 40 percent of all nursing home residents in Medicare- or Medicaid-certified nursing homes. For-profit nursing homes, which are more prevalent, tend to have lower star ratings than non-

profit nursing homes. Nursing homes with a relatively large number of beds tend to have lower star ratings than smaller nursing homes (with fewer beds). Nursing homes affiliated with CCRCs, which are disproportionately non-profits, tend to have higher ratings than those that are not affiliated with a CCRC.

The analysis also finds that nursing home star ratings vary within and across states. In 22 states, at least half of the nursing homes have relatively high ratings with 4 or 5 stars. But in 11 states, at least 40 percent of nursing homes have ratings of only 1 or 2 stars. In 9 states, more than 20 percent of nursing homes have the worst possible star rating—1 star.

While many nursing homes have relatively high quality ratings with 4 or 5 stars, low ratings in others give rise to questions that warrant serious consideration. What more can CMS do to improve the quality of nursing home care? Should CMS consider linking payments to the Five-Star Quality Rating System (or improvements in these quality ratings) as the agency has done for Medicare Advantage plans? Imposing and enforcing higher standards (e.g., with respect to staffing levels) could improve the quality of care for residents, but also have cost implications for nursing homes and payers. What options are available to residents living in areas with nursing homes with just one or two stars, or in areas where nursing homes with higher ratings have no available beds?

The role of nursing homes may evolve in the future, as part of broader changes in health care delivery. Some suggest that nursing homes could provide more complex levels of care to their residents, as part of a broader effort to reduce the rate of preventable hospitalizations among Medicare patients.[25] Others caution that many nursing homes may not be well-equipped to care for patients with complex medical needs, given concerns about staffing levels and other issues. Previous research has shown that limited on-site capacity and other factors may be associated with the relatively high rates of preventable hospitalizations and emergency room visits among nursing home residents.[26] Given the substantial needs and vulnerabilities of nursing home residents and the significant investment by Medicare and Medicaid in nursing home care, the quality of care provided in nursing homes is likely to remain an issue for policymakers and families in the years to come.

# Appendix

| Appendix Table 1: Distribution of Medicare- and Medicaid-Certified Nursing Homes, by Tax Status and Size, Nationally and by State, 2015 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | | Tax Status | | | Size (bed count) | | |
| | Number of Nursing Homes | Number of Nursing Home Residents | For-Profit | Non-Profit | Govern-ment | Fewer than 60 beds | 60-120 beds | More than 120 beds |
| **National** | **15,505** | **1,366,044** | **70%** | **24%** | **6%** | **19%** | **52%** | **29%** |
| Alabama | 226 | 22,748 | 81% | 13% | 6% | 8% | 50% | 42% |
| Alaska | 18 | 624 | 6% | 56% | 39% | 78% | 22% | n/a |
| Arizona | 145 | 11,478 | 79% | 19% | 1% | 13% | 50% | 37% |
| Arkansas | 227 | 17,588 | 85% | 12% | 4% | 2% | 72% | 26% |
| California | 1,212 | 102,370 | 84% | 13% | 3% | 28% | 48% | 23% |
| Colorado | 212 | 16,309 | 76% | 16% | 8% | 21% | 58% | 21% |
| Connecticut | 229 | 24,178 | 79% | 20% | 1% | 9% | 50% | 41% |
| Delaware | 46 | 4,284 | 67% | 24% | 9% | 15% | 52% | 33% |
| District of Columbia | 19 | 2,521 | 47% | 53% | 0% | 21% | 32% | 47% |
| Florida | 688 | 73,467 | 73% | 25% | 2% | 8% | 67% | 25% |
| Georgia | 355 | 33,923 | 66% | 28% | 6% | 8% | 61% | 32% |
| Hawaii | 46 | 3,661 | 48% | 28% | 24% | 37% | 41% | 22% |
| Idaho | 78 | 3,896 | 73% | 13% | 14% | 35% | 55% | 10% |
| Illinois | 755 | 72,277 | 72% | 25% | 3% | 15% | 45% | 40% |
| Indiana | 516 | 38,954 | 44% | 24% | 32% | 18% | 58% | 25% |
| Iowa | 438 | 24,775 | 54% | 43% | 4% | 42% | 51% | 7% |
| Kansas | 335 | 18,198 | 52% | 35% | 13% | 53% | 41% | 7% |
| Kentucky | 281 | 23,253 | 74% | 24% | 2% | 18% | 60% | 22% |
| Louisiana | 280 | 25,861 | 81% | 15% | 5% | 6% | 43% | 51% |
| Maine | 103 | 6,171 | 71% | 28% | 1% | 45% | 50% | 6% |
| Maryland | 227 | 24,445 | 70% | 27% | 2% | 14% | 38% | 48% |
| Massachusetts | 413 | 41,014 | 72% | 27% | 1% | 13% | 39% | 48% |
| Michigan | 429 | 39,353 | 72% | 20% | 8% | 16% | 51% | 33% |
| Minnesota | 376 | 26,622 | 30% | 62% | 9% | 43% | 45% | 13% |
| Mississippi | 203 | 16,140 | 77% | 10% | 13% | 11% | 73% | 16% |
| Missouri | 509 | 38,280 | 76% | 18% | 6% | 11% | 67% | 22% |
| Montana | 82 | 4,560 | 46% | 35% | 18% | 37% | 49% | 15% |
| Nebraska | 214 | 11,938 | 49% | 29% | 22% | 44% | 44% | 11% |
| Nevada | 52 | 4,830 | 75% | 13% | 12% | 25% | 37% | 38% |
| New Hampshire | 76 | 6,780 | 61% | 25% | 14% | 22% | 55% | 22% |
| New Jersey | 361 | 45,207 | 72% | 24% | 4% | 9% | 36% | 55% |
| New Mexico | 70 | 5,420 | 70% | 23% | 7% | 20% | 66% | 14% |
| New York | 625 | 104,411 | 56% | 38% | 6% | 8% | 30% | 62% |
| North Carolina | 416 | 36,933 | 80% | 18% | 3% | 11% | 62% | 27% |
| North Dakota | 80 | 5,603 | 3% | 95% | 3% | 53% | 33% | 15% |
| Ohio | 941 | 76,261 | 79% | 19% | 2% | 21% | 57% | 22% |
| Oklahoma | 305 | 18,772 | 86% | 12% | 2% | 17% | 66% | 17% |
| Oregon | 135 | 7,257 | 81% | 16% | 3% | 26% | 59% | 16% |
| Pennsylvania | 696 | 79,430 | 55% | 41% | 4% | 17% | 40% | 43% |
| Rhode Island | 84 | 8,014 | 77% | 23% | 0% | 20% | 44% | 36% |
| South Carolina | 188 | 16,754 | 77% | 18% | 6% | 21% | 46% | 32% |
| South Dakota | 109 | 6,331 | 35% | 61% | 5% | 61% | 34% | 5% |
| Tennessee | 317 | 28,835 | 79% | 16% | 5% | 12% | 48% | 40% |
| Texas | 1,193 | 93,208 | 86% | 10% | 4% | 10% | 58% | 32% |
| Utah | 99 | 5,569 | 82% | 12% | 6% | 34% | 48% | 17% |
| Vermont | 37 | 2,685 | 65% | 32% | 3% | 32% | 41% | 27% |
| Virginia | 286 | 28,440 | 69% | 27% | 3% | 13% | 56% | 31% |
| Washington | 221 | 17,128 | 72% | 22% | 6% | 23% | 52% | 25% |
| West Virginia | 126 | 9,539 | 75% | 19% | 6% | 18% | 69% | 13% |
| Wisconsin | 388 | 27,409 | 53% | 34% | 14% | 31% | 50% | 20% |
| Wyoming | 38 | 2,340 | 42% | 16% | 42% | 37% | 50% | 13% |
| NOTES: Analysis includes only nursing homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). Percents may not total to 100 due to rounding. | | | | | | | | |
| SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015 | | | | | | | | |

| Appendix Table 2: Distrbution of Nursing Homes, by Overall Star Rating, Nationally and by State, February 2015 | | | | | | |
|---|---|---|---|---|---|---|
| | | Overall Star Rating | | | | |
| State | Number of Nursing Homes | 1 star | 2 stars | 3 stars | 4 stars | 5 stars |
| **National** | **15,505** | **16%** | **20%** | **22%** | **23%** | **19%** |
| Alabama | 226 | 10% | 21% | 20% | 27% | 22% |
| Alaska | 18 | 6% | 17% | 39% | 11% | 28% |
| Arizona | 145 | 11% | 21% | 14% | 26% | 27% |
| Arkansas | 227 | 15% | 19% | 19% | 26% | 20% |
| California | 1,212 | 7% | 20% | 17% | 23% | 32% |
| Colorado | 212 | 10% | 18% | 16% | 26% | 30% |
| Connecticut | 229 | 12% | 15% | 22% | 22% | 29% |
| Delaware | 46 | 11% | 9% | 17% | 30% | 33% |
| District of Columbia | 19 | 5% | 11% | 21% | 11% | 53% |
| Florida | 688 | 13% | 20% | 19% | 26% | 23% |
| Georgia | 355 | 21% | 25% | 22% | 16% | 15% |
| Hawaii | 46 | 2% | 20% | 15% | 24% | 39% |
| Idaho | 78 | 5% | 23% | 12% | 29% | 31% |
| Illinois | 755 | 19% | 20% | 19% | 21% | 21% |
| Indiana | 516 | 15% | 18% | 20% | 25% | 21% |
| Iowa | 438 | 14% | 15% | 21% | 26% | 25% |
| Kansas | 335 | 13% | 19% | 24% | 22% | 22% |
| Kentucky | 281 | 25% | 15% | 20% | 24% | 16% |
| Louisiana | 280 | 27% | 22% | 20% | 21% | 10% |
| Maine | 103 | 6% | 18% | 18% | 36% | 21% |
| Maryland | 227 | 12% | 20% | 20% | 22% | 26% |
| Massachusetts | 413 | 11% | 18% | 15% | 29% | 26% |
| Michigan | 429 | 12% | 18% | 15% | 26% | 28% |
| Minnesota | 376 | 9% | 20% | 20% | 25% | 26% |
| Mississippi | 203 | 20% | 19% | 18% | 23% | 21% |
| Missouri | 509 | 16% | 20% | 22% | 21% | 22% |
| Montana | 82 | 10% | 18% | 26% | 24% | 22% |
| Nebraska | 214 | 14% | 17% | 16% | 23% | 29% |
| Nevada | 52 | 19% | 19% | 15% | 21% | 25% |
| New Hampshire | 76 | 9% | 18% | 18% | 22% | 32% |
| New Jersey | 361 | 10% | 22% | 17% | 24% | 27% |
| New Mexico | 70 | 23% | 13% | 23% | 21% | 20% |
| New York | 625 | 19% | 22% | 17% | 22% | 21% |
| North Carolina | 416 | 19% | 22% | 19% | 22% | 18% |
| North Dakota | 80 | 11% | 16% | 24% | 23% | 26% |
| Ohio | 941 | 22% | 19% | 18% | 23% | 17% |
| Oklahoma | 305 | 27% | 19% | 23% | 18% | 12% |
| Oregon | 135 | 7% | 20% | 19% | 33% | 21% |
| Pennsylvania | 696 | 19% | 21% | 18% | 23% | 19% |
| Rhode Island | 84 | 13% | 14% | 20% | 21% | 31% |
| South Carolina | 188 | 15% | 18% | 19% | 26% | 22% |
| South Dakota | 109 | 14% | 18% | 22% | 26% | 20% |
| Tennessee | 317 | 25% | 18% | 18% | 21% | 18% |
| Texas | 1,193 | 28% | 23% | 19% | 18% | 12% |
| Utah | 99 | 16% | 11% | 22% | 27% | 23% |
| Vermont | 37 | 16% | 14% | 11% | 27% | 32% |
| Virginia | 286 | 17% | 19% | 24% | 21% | 19% |
| Washington | 221 | 10% | 19% | 19% | 26% | 26% |
| West Virginia | 126 | 23% | 23% | 19% | 25% | 10% |
| Wisconsin | 388 | 9% | 18% | 18% | 27% | 28% |
| Wyoming | 38 | 11% | 18% | 16% | 37% | 18% |

NOTES: Analysis includes only nursing homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). Percents may not total to 100 due to rounding.

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

| Appendix Table 3: Distribution of Nursing Homes, by State Health Inspection Star Rating, Nationally and by State, February 2015 | | | | | | |
|---|---|---|---|---|---|---|
| | | State Health Inspection Star Rating | | | | |
| State | Number of Nursing Homes | 1 star | 2 stars | 3 stars | 4 stars | 5 stars |
| **National** | **15,505** | **20%** | **23%** | **23%** | **23%** | **11%** |
| Alabama | 226 | 20% | 24% | 23% | 23% | 10% |
| Alaska | 18 | 22% | 28% | 28% | 11% | 11% |
| Arizona | 145 | 21% | 23% | 21% | 23% | 12% |
| Arkansas | 227 | 19% | 23% | 23% | 22% | 12% |
| California | 1,212 | 20% | 24% | 23% | 23% | 10% |
| Colorado | 212 | 20% | 23% | 22% | 26% | 9% |
| Connecticut | 229 | 19% | 22% | 23% | 27% | 9% |
| Delaware | 46 | 17% | 22% | 24% | 26% | 11% |
| District of Columbia | 19 | 16% | 26% | 21% | 26% | 11% |
| Florida | 688 | 20% | 23% | 23% | 23% | 11% |
| Georgia | 355 | 17% | 22% | 23% | 26% | 11% |
| Hawaii | 46 | 20% | 22% | 20% | 30% | 9% |
| Idaho | 78 | 19% | 22% | 23% | 26% | 10% |
| Illinois | 755 | 20% | 23% | 25% | 22% | 10% |
| Indiana | 516 | 19% | 24% | 22% | 23% | 11% |
| Iowa | 438 | 19% | 23% | 24% | 24% | 10% |
| Kansas | 335 | 20% | 24% | 25% | 21% | 10% |
| Kentucky | 281 | 21% | 21% | 23% | 24% | 11% |
| Louisiana | 280 | 18% | 23% | 25% | 24% | 10% |
| Maine | 103 | 18% | 20% | 28% | 22% | 11% |
| Maryland | 227 | 21% | 23% | 24% | 23% | 10% |
| Massachusetts | 413 | 20% | 23% | 23% | 22% | 12% |
| Michigan | 429 | 19% | 24% | 23% | 24% | 10% |
| Minnesota | 376 | 20% | 22% | 22% | 24% | 11% |
| Mississippi | 203 | 19% | 22% | 19% | 25% | 15% |
| Missouri | 509 | 20% | 22% | 24% | 24% | 11% |
| Montana | 82 | 18% | 27% | 22% | 22% | 11% |
| Nebraska | 214 | 19% | 25% | 22% | 24% | 10% |
| Nevada | 52 | 19% | 23% | 23% | 23% | 12% |
| New Hampshire | 76 | 16% | 24% | 21% | 26% | 13% |
| New Jersey | 361 | 21% | 23% | 23% | 21% | 12% |
| New Mexico | 70 | 23% | 21% | 23% | 23% | 10% |
| New York | 625 | 21% | 22% | 20% | 24% | 12% |
| North Carolina | 416 | 21% | 23% | 21% | 24% | 12% |
| North Dakota | 80 | 25% | 23% | 21% | 23% | 9% |
| Ohio | 941 | 19% | 23% | 22% | 24% | 11% |
| Oklahoma | 305 | 20% | 22% | 26% | 21% | 11% |
| Oregon | 135 | 19% | 23% | 26% | 19% | 13% |
| Pennsylvania | 696 | 21% | 23% | 23% | 22% | 11% |
| Rhode Island | 84 | 18% | 25% | 23% | 20% | 14% |
| South Carolina | 188 | 19% | 24% | 23% | 23% | 11% |
| South Dakota | 109 | 22% | 23% | 27% | 21% | 7% |
| Tennessee | 317 | 21% | 22% | 21% | 22% | 13% |
| Texas | 1,193 | 21% | 24% | 23% | 22% | 11% |
| Utah | 99 | 17% | 22% | 23% | 28% | 9% |
| Vermont | 37 | 19% | 24% | 22% | 24% | 11% |
| Virginia | 286 | 20% | 22% | 26% | 23% | 10% |
| Washington | 221 | 20% | 23% | 23% | 24% | 10% |
| West Virginia | 126 | 21% | 24% | 23% | 24% | 9% |
| Wisconsin | 388 | 20% | 24% | 23% | 23% | 11% |
| Wyoming | 38 | 18% | 18% | 24% | 29% | 11% |
| NOTES: Analysis includes only nursing homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). Percents may not total to 100 due to rounding. | | | | | | |
| SOURCE: Kaiser Family Foundation analysis of Nursing Home Compare data, February 2015 | | | | | | |

| Appendix Table 4: Distribution of Nursing Homes, by Quality Measures Star Rating, Nationally and by State, February 2015 | | | | | | |
|---|---|---|---|---|---|---|
| | | Quality Measures Star Rating | | | | |
| State | Number of Nursing Homes | 1 star | 2 stars | 3 stars | 4 stars | 5 stars |
| **National** | **15,505** | **13%** | **20%** | **18%** | **21%** | **28%** |
| Alabama | 226 | 9% | 17% | 19% | 23% | 32% |
| Alaska | 18 | 11% | 22% | 11% | 17% | 22% |
| Arizona | 145 | 9% | 16% | 18% | 23% | 34% |
| Arkansas | 227 | 15% | 19% | 18% | 21% | 28% |
| California | 1,212 | 4% | 11% | 14% | 20% | 50% |
| Colorado | 212 | 8% | 18% | 23% | 20% | 32% |
| Connecticut | 229 | 8% | 14% | 15% | 25% | 38% |
| Delaware | 46 | 4% | 4% | 30% | 20% | 39% |
| District of Columbia | 19 | na | 11% | 21% | 16% | 53% |
| Florida | 688 | 12% | 19% | 19% | 22% | 27% |
| Georgia | 355 | 16% | 18% | 20% | 23% | 23% |
| Hawaii | 46 | na | na | 4% | 24% | 65% |
| Idaho | 78 | 8% | 21% | 21% | 21% | 31% |
| Illinois | 755 | 14% | 21% | 16% | 20% | 29% |
| Indiana | 516 | 13% | 22% | 17% | 21% | 26% |
| Iowa | 438 | 11% | 17% | 19% | 24% | 29% |
| Kansas | 335 | 19% | 26% | 20% | 14% | 22% |
| Kentucky | 281 | 29% | 22% | 19% | 18% | 12% |
| Louisiana | 280 | 25% | 30% | 20% | 13% | 13% |
| Maine | 103 | 7% | 19% | 24% | 30% | 18% |
| Maryland | 227 | 7% | 16% | 14% | 25% | 39% |
| Massachusetts | 413 | 8% | 18% | 20% | 23% | 31% |
| Michigan | 429 | 10% | 18% | 15% | 22% | 36% |
| Minnesota | 376 | 6% | 18% | 19% | 28% | 29% |
| Mississippi | 203 | 26% | 23% | 20% | 16% | 15% |
| Missouri | 509 | 14% | 20% | 23% | 20% | 23% |
| Montana | 82 | 21% | 28% | 22% | 16% | 13% |
| Nebraska | 214 | 15% | 20% | 18% | 20% | 27% |
| Nevada | 52 | 25% | 15% | 17% | 13% | 25% |
| New Hampshire | 76 | 12% | 17% | 21% | 18% | 30% |
| New Jersey | 361 | 6% | 13% | 15% | 24% | 42% |
| New Mexico | 70 | 16% | 13% | 26% | 17% | 27% |
| New York | 625 | 11% | 21% | 16% | 23% | 29% |
| North Carolina | 416 | 12% | 24% | 22% | 21% | 21% |
| North Dakota | 80 | 13% | 23% | 23% | 20% | 23% |
| Ohio | 941 | 16% | 23% | 20% | 19% | 23% |
| Oklahoma | 305 | 32% | 25% | 18% | 13% | 11% |
| Oregon | 135 | 15% | 22% | 19% | 30% | 14% |
| Pennsylvania | 696 | 10% | 19% | 21% | 24% | 26% |
| Rhode Island | 84 | 10% | 14% | 18% | 27% | 31% |
| South Carolina | 188 | 11% | 22% | 18% | 19% | 29% |
| South Dakota | 109 | 14% | 27% | 20% | 15% | 25% |
| Tennessee | 317 | 20% | 21% | 20% | 20% | 19% |
| Texas | 1,193 | 19% | 24% | 19% | 19% | 18% |
| Utah | 99 | 16% | 21% | 18% | 19% | 25% |
| Vermont | 37 | 14% | 24% | 16% | 19% | 27% |
| Virginia | 286 | 10% | 20% | 20% | 25% | 25% |
| Washington | 221 | 9% | 20% | 22% | 18% | 31% |
| West Virginia | 126 | 23% | 33% | 13% | 17% | 15% |
| Wisconsin | 388 | 5% | 17% | 19% | 22% | 37% |
| Wyoming | 38 | 16% | 26% | 24% | 18% | 13% |

NOTES: Analysis includes only nursing homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). Percents may not total to 100 due to rounding or missing Quality measures ratings (<1%).

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

| Appendix Table 5: Distribution of Nursing Homes, by Staffing Measures Star Rating, Nationally and by State, February 2015 | | | | | | |
|---|---|---|---|---|---|---|
| | | Staffing Measures Star Rating | | | | |
| State | Number of Nursing Homes | 1 star | 2 stars | 3 stars | 4 stars | 5 stars |
| National | 15,505 | 10% | 14% | 31% | 32% | 12% |
| Alabama | 226 | 1% | 8% | 37% | 46% | 8% |
| Alaska | 18 | n/a | n/a | n/a | n/a | 89% |
| Arizona | 145 | 1% | 13% | 26% | 43% | 14% |
| Arkansas | 227 | 2% | 7% | 48% | 41% | 2% |
| California | 1,212 | 2% | 8% | 32% | 40% | 15% |
| Colorado | 212 | 1% | 4% | 25% | 44% | 24% |
| Connecticut | 229 | 2% | 3% | 34% | 41% | 20% |
| Delaware | 46 | 2% | 2% | 15% | 46% | 35% |
| District of Columbia | 19 | n/a | n/a | 5% | 42% | 47% |
| Florida | 688 | 2% | 9% | 35% | 43% | 9% |
| Georgia | 355 | 32% | 23% | 31% | 10% | 2% |
| Hawaii | 46 | 2% | 4% | 13% | 35% | 28% |
| Idaho | 78 | n/a | 3% | 21% | 47% | 26% |
| Illinois | 755 | 12% | 22% | 27% | 21% | 12% |
| Indiana | 516 | 6% | 16% | 29% | 35% | 12% |
| Iowa | 438 | 3% | 14% | 29% | 38% | 13% |
| Kansas | 335 | 3% | 9% | 22% | 40% | 24% |
| Kentucky | 281 | 9% | 14% | 36% | 28% | 11% |
| Louisiana | 280 | 31% | 24% | 31% | 9% | 3% |
| Maine | 103 | 1% | 3% | 15% | 42% | 40% |
| Maryland | 227 | 4% | 8% | 37% | 35% | 14% |
| Massachusetts | 413 | 1% | 5% | 27% | 49% | 17% |
| Michigan | 429 | 3% | 8% | 33% | 38% | 17% |
| Minnesota | 376 | 2% | 6% | 28% | 49% | 13% |
| Mississippi | 203 | 6% | 13% | 32% | 36% | 10% |
| Missouri | 509 | 6% | 13% | 36% | 36% | 7% |
| Montana | 82 | n/a | 5% | 22% | 48% | 26% |
| Nebraska | 214 | 2% | 7% | 26% | 41% | 22% |
| Nevada | 52 | 2% | 13% | 31% | 27% | 19% |
| New Hampshire | 76 | 1% | 8% | 22% | 39% | 25% |
| New Jersey | 361 | 5% | 14% | 35% | 34% | 12% |
| New Mexico | 70 | 4% | 19% | 30% | 20% | 11% |
| New York | 625 | 20% | 18% | 31% | 24% | 6% |
| North Carolina | 416 | 15% | 21% | 28% | 25% | 7% |
| North Dakota | 80 | n/a | 1% | 13% | 56% | 30% |
| Ohio | 941 | 16% | 20% | 35% | 23% | 6% |
| Oklahoma | 305 | 15% | 19% | 37% | 22% | 5% |
| Oregon | 135 | n/a | 4% | 16% | 56% | 24% |
| Pennsylvania | 696 | 13% | 24% | 30% | 22% | 9% |
| Rhode Island | 84 | 2% | 10% | 31% | 43% | 14% |
| South Carolina | 188 | 6% | 8% | 37% | 32% | 14% |
| South Dakota | 109 | 1% | 13% | 33% | 33% | 18% |
| Tennessee | 317 | 17% | 14% | 42% | 21% | 5% |
| Texas | 1,193 | 35% | 22% | 25% | 12% | 3% |
| Utah | 99 | 1% | 13% | 31% | 30% | 20% |
| Vermont | 37 | n/a | 3% | 19% | 59% | 19% |
| Virginia | 286 | 13% | 18% | 33% | 20% | 14% |
| Washington | 221 | 0% | 5% | 27% | 48% | 19% |
| West Virginia | 126 | 18% | 19% | 33% | 18% | 8% |
| Wisconsin | 388 | 2% | 10% | 25% | 45% | 17% |
| Wyoming | 38 | n/a | 13% | 21% | 34% | 29% |

NOTES: Analysis includes only nursing homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). The following states have the indicated number of nursing homes with missing Staffing ratings, totaling about 2%: AL (1), AK (2), AZ (4), AR (1), CA (35), CO (3), DC (1), FL (9), GA (7), HI (8), ID (3), IL (38), IN (12), IA (8), KS (5), KY (3), LA (7), MD (4), MA (5), MI (6), MN (7), MS (5), MO (9), NE (5), NV (4), NH (3), NJ (1), NM (11), NC (16), OH (7), OK (5), OR (1), PA (9), SC (5), SD (2), TN (3), TX (39), UT (4), VA (5), WA (4), WV (4), and WI (6). N/A indicates that no nusing homes received stars at the indicated star rating. Percents may not total to 100 due to rounding or nursing homes with missing Staffing ratings.

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

| Appendix Table 6: Number of People Age 65 and Older and Percent of People Age 65 and Older with Incomes <200% of Poverty, Nationally and by State | | | | |
|---|---|---|---|---|
| State | Number of Nursing Homes, 2015[1] | Number of Nursing Home Residents, 2015[1] | Number of people age 65 and older, 2014[2] | Percent of people ≥ 65 with incomes ≤200% of Poverty, 2012-2014[3] |
| **National** | **15,505** | **1,366,044** | **44,507,600** | **33%** |
| Alabama | 226 | 22,748 | 712,900 | 38% |
| Alaska | 18 | 624 | 72,400 | 28% |
| Arizona | 145 | 11,478 | 986,700 | 34% |
| Arkansas | 227 | 17,588 | 501,100 | 43% |
| California | 1,212 | 102,370 | 4,747,900 | 33% |
| Colorado | 212 | 16,309 | 653,800 | 29% |
| Connecticut | 229 | 24,178 | 500,800 | 25% |
| Delaware | 46 | 4,284 | 157,000 | 29% |
| District of Columbia | 19 | 2,521 | 80,100 | 37% |
| Florida | 688 | 73,467 | 3,268,400 | 36% |
| Georgia | 355 | 33,923 | 1,288,200 | 34% |
| Hawaii | 46 | 3,661 | 213,300 | 27% |
| Idaho | 78 | 3,896 | 205,600 | 32% |
| Illinois | 755 | 72,277 | 1,611,400 | 31% |
| Indiana | 516 | 38,954 | 931,400 | 34% |
| Iowa | 438 | 24,775 | 429,400 | 32% |
| Kansas | 335 | 18,198 | 387,100 | 28% |
| Kentucky | 281 | 23,253 | 598,700 | 42% |
| Louisiana | 280 | 25,861 | 638,800 | 42% |
| Maine | 103 | 6,171 | 218,200 | 31% |
| Maryland | 227 | 24,445 | 862,200 | 26% |
| Massachusetts | 413 | 41,014 | 890,500 | 30% |
| Michigan | 429 | 39,353 | 1,446,400 | 30% |
| Minnesota | 376 | 26,622 | 707,400 | 29% |
| Mississippi | 203 | 16,140 | 388,700 | 43% |
| Missouri | 509 | 38,280 | 1,003,800 | 32% |
| Montana | 82 | 4,560 | 153,500 | 31% |
| Nebraska | 214 | 11,938 | 271,600 | 29% |
| Nevada | 52 | 4,830 | 386,900 | 35% |
| New Hampshire | 76 | 6,780 | 200,900 | 28% |
| New Jersey | 361 | 45,207 | 1,210,100 | 28% |
| New Mexico | 70 | 5,420 | 359,000 | 34% |
| New York | 625 | 104,411 | 2,888,800 | 37% |
| North Carolina | 416 | 36,933 | 1,417,500 | 42% |
| North Dakota | 80 | 5,603 | 83,800 | 30% |
| Ohio | 941 | 76,261 | 1,882,300 | 33% |
| Oklahoma | 305 | 18,772 | 528,000 | 33% |
| Oregon | 135 | 7,257 | 644,700 | 30% |
| Pennsylvania | 696 | 79,430 | 2,077,100 | 34% |
| Rhode Island | 84 | 8,014 | 169,200 | 34% |
| South Carolina | 188 | 16,754 | 794,400 | 39% |
| South Dakota | 109 | 6,331 | 127,100 | 30% |
| Tennessee | 317 | 28,835 | 946,700 | 39% |
| Texas | 1,193 | 93,208 | 3,000,900 | 36% |
| Utah | 99 | 5,569 | 321,200 | 31% |
| Vermont | 37 | 2,685 | 113,500 | 30% |
| Virginia | 286 | 28,440 | 1,133,400 | 26% |
| Washington | 221 | 17,128 | 1,011,800 | 27% |
| West Virginia | 126 | 9,539 | 318,300 | 38% |
| Wisconsin | 388 | 27,409 | 889,400 | 29% |
| Wyoming | 38 | 2,340 | 75,500 | 29% |
| Wyoming | | | | |

NOTES: Analysis includes only nusring homes certified by Medicare and/or Medicaid and excludes nursing homes with unavailable Overall star ratings (<1%). Percents may not total to 100 due to rounding.

SOURCE: Kaiser Family Foundation analysis of: [1]Nursing Home Compare data, February 2015; [2]Current Population Survey, 2014 Annual Social and Economic Supplement; and [3]Current Population Survey, 2012 - 2014 Annual Social and Economic Supplement.

# Endnotes

[1] Institute of Medicine, "Improving the Quality of Care in Nursing Homes." Washington: National Academy Press, 1986; Institute of Medicine, "Improving the Quality of Long-Term Care." Washington: National Academy Press, 2001; Government Accountability Office, "Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight." GAO-03-561, July 2003; Government Accountability Office, "Nursing Homes: Federal monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weakness." GAO-08-517, May 2008; Government Accountability Office, "Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tend to Be Chain Affiliated and For-Profit." GAO-09-689, August 2009; Government Accountability Office, "Poorly Performing Nursing Homes: Special Focus Facilities Are Often Improving, but CMS's Program Could Be Strengthened." GAO-10-197, March 2010; Government Accountability Office, "Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System are Met." GAO-12-390, March 2012; Department of Health and Human Services, Office of the Inspector General, "Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries." OEI-06-11-00370, February 2014; Wiener JM, Freiman MP, Brown D. "Nursing Home Quality: Twenty Years After the Omnibus Budget Reconciliation Act of 1987." Kaiser Family Foundation, December 2007; Werner RM, Konetzka RT. "Advancing Nursing Home Quality Through Quality Improvement Itself." *Health Affairs*. 1(2010): 81-86.

[2] Harrington, C., H. Carrillo, M. Dowdell, P. Tang, B. Woleslagle Blank, "Nursing Facilities, Staffing, Residents and Facility Deficiencies, 2005 Through 2010, University of California San Francisco, October 2011; IOM 2001.

[3] Kaiser Commission on Medicaid and the Uninsured, *Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011,* June 2013; Harris-Kojetin L, et al., *Long-term care services in the United States: 2013 overview*. National health care statistics reports; no 1. Hyattsville, MD: National Center for Health Statistics. 2013.

[4] The average number of Medicare-covered SNF days for a beneficiary was 27 in 2010. The Medicare SNF benefit covers up to 100 days of skilled nursing and skilled rehabilitation services per spell of illness. No beneficiary copayment is required for the first 20 days, but a daily copayment is required for the 21st through the 100th day of SNF care. Congressional Research Service, 2012 Greenbook.

[5] Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditures, 2013.

[6] IOM (2001).

[7] In 1980, as part of OBRA '80, Congress passed the Boren Amendment to require Medicaid nursing home payments to be reasonable and adequate to provide quality care consistent with federal and state standards. The Boren amendment was repealed as part of the Balanced Budget Act of '97, but the OBRA '87 amendments have remained intact.

[8] As part of the federal minimum staffing standards, nursing homes must have a licensed practical nurse (LPN)—a nurse with less academic training required than an RN—on duty at all times when an RN is not on duty. GAO (2011).

[9] Wiener (2007). IOM (2001).

[10] GAO (2008, 2009, 2010, 2012); OIG (2014).

[11] Thomas, K. "In Race for Medicare Dollars, Nursing Home Care May Lag." *The New York Times*, April 14, 2015.

[12] Center for Medicare Advocacy, "The Myth of Improved Quality in Nursing Home Care: Setting the Record Straight Again." April 2014. Thomas, K. "Medicare Star Ratings Allow Nursing Homes to Game the System." *The New York Times*, August 24, 2014.

[13] Centers for Medicare & Medicaid Services, Design for Nursing Home Compare Five-Star Quality Rating System: Technical Users' Guide, February 2015. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf

[14] Some states require a registered nurse (RN) to be on duty 24 hours a day for nursing homes with 100 or more residents—higher than the federal minimum standard which requires an RN on duty for at least at least 8 consecutive hours per day, 7 days per week, regardless of the number of residents in the nursing home.

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# Nursing Homes Are Getting Billions in COVID Aid — Where Is It Going?

## Facilities are calling for more assistance, but industry experts want answers


Boston Globe/Getty Images

En español | A Kansas nursing home recently made national headlines after disclosing that every one of its 62 residents had tested positive for COVID-19. At least 10 died. Months earlier, the facility had been cited for failing to implement federal infection control guidelines. Staff members did not consistently wear masks and said they hadn't received comprehensive infection control training.

Nonetheless, the Andbe Home in Norton, Kansas had received more than $300,000 in federal support through a program set up by Congress to help nursing homes and other health care providers during the pandemic. Known as the Provider Relief Fund, the program began distributing tens of billions of dollars in federal aid shortly after it was created with the passage of the CARES Act in March. Roughly $21 billion was earmarked for nursing homes — a total that doesn't include Paycheck Protection Program loans and state-specific support that many facilities received.

The government support has been described as manna by a nursing home industry upended by the coronavirus pandemic. More than 67,000 nursing home residents and staff have died from COVID-19, more than a quarter of all coronavirus deaths in the U.S. Long-term care facilities more broadly have seen more than 90,000 deaths — 40-percent of COVID-19's death toll.

And with cases surging across the country and long-term care facilities bracing for a difficult winter, nursing homes are clamoring for additional money. Two of the industry's largest trade organizations, the American Health Care Association/National Center for Assisted Living and LeadingAge, have called for an additional $100 billion to be

pumped into the Provider Relief Fund.

But many industry experts and watchdogs are opposed to distributing more federal aid without a better understanding of where the money's going. Public records show aid dollars have gone to facilities that have repeatedly been cited for health violations, insufficient care or worse. An investigation by The Washington Post found that hundreds of millions of aid dollars have been sent to facilities sued in recent years for Medicare fraud. “I am both skeptical and concerned about where that money has gone,” says Mike Wasserman, a past president of the California Association of Long-Term Care Medicine.

He and other industry critics say the federal funds have been distributed without enough transparency and with too few strings attached, potentially opening the door for large, for-profit operations to pad their bottom lines. Public records show which operators have received money — and how much — but not how that money was spent. Payments vary considerably from one operation to the next. The Brooks Rehabilitation skilled nursing facility in Jacksonville, Florida, received more than $2 million through the Provider Relief Fund, while the Lutheran Haven nursing home and assisted living facility in Oviedo, Florida — roughly two hours south of Jacksonville — received a little more than $300,000.

The federal government is expected to launch an auditing system early next year to track how facilities have spent the money they've received. But with calls for additional stimulus growing louder, experts fear that the audit will be too little, too late and that large for-profit establishments may be able to shield money from public view.

"There are billions of dollars here,” says Elaine Ryan, vice president for state advocacy and strategy at AARP. “I'm not saying that's adequate or inadequate. I'm just saying that taxpayers, residents and staff deserve answers. What has been done with those dollars?”

## 'The business is still burning cash'

Few question that the pandemic has dealt a financial blow to the nursing home industry. Many nursing facilities — nonprofit and for-profit alike — rely on Medicare payments from short-term rehab patients and Medicaid payments from long-term care residents. As elective surgeries cratered and nursing homes became less attractive to short-term patients amid the COVID-19 carnage, Medicare dollars dried up. And as residents’ families pulled them from facilities — and as residents with COVID-19 died and beds were left unfilled by new residents — homes were left with fewer Medicaid recipients as well.

A survey of nursing homes published in August by the American Health Care Association/National Center for Assisted Living found that 55 percent of facilities across the country were operating at a loss. Nearly three-quarters of industry respondents said they would not be able to sustain their operations for another year at the current pace.

At smaller nursing facilities and nonprofit operations, federal dollars have helped keep the lights on. Nursing home occupancy is down almost 30 percent since February at the Eliza Bryant Village nursing home and senior care community in Cleveland, says Marc Rubinstein, the chief financial officer. The nonprofit has received more than $1 million through federal and state support this year. But revenue is down between $150,000 and $200,000 per month. And costs have skyrocketed, Rubinstein says, rattling off personal protective equipment (PPE), supplies for outdoor visitation and tablets and other communication devices as “the tip of the iceberg."

Janet Snipes, executive director of the 133-bed Holly Heights Care Center in Denver, says the roughly $800,000 her for-profit facility received through the Provider Relief Fund has been “so very helpful” in covering expenses like testing, PPE, staffing, new filtration systems, air purifiers and more.

And federal funds have also blunted COVID-19's impact at larger for-profit operations. Genesis HealthCare, one of the country's largest health care and skilled nursing operators, estimates that the pandemic reduced the company's earnings by nearly $60 million in July, August and September — even though it received roughly $64 million in federal and state aid during the third quarter alone. Genesis received more than $250 million in relief grants and government support between April and September, according to its latest earnings report. “The business is still burning cash,” CEO George Hager Jr. said during a November earnings call with reporters.

The industry has pointed to steep losses as evidence that more money is needed to keep facilities afloat through the winter. Mike Cheek, senior vice president of reimbursement policy at American Health Care Association/National

Center for Assisted Living, says his organization supports "reasonable efforts to ensure this federal aid has been properly directed to providers to cover COVID-related costs and potential losses." But he says more funds will be needed to help nursing homes weather "a huge financial crisis, threatening access to long-term care for millions of seniors."

## 'There are just so many ways to hide this stuff'

But the aid packages to large for-profit operations have raised eyebrows among industry watchdogs. Brian Lee, executive director of the Families for Better Care advocacy group, points to Ensign Group, a publicly traded skilled nursing company that in August announced it was returning all $110 million it had received through the Provider Relief Fund. The organization enjoyed strong profitability during the second quarter of the year. "We know that there's a high degree of responsibility that accompanies government reimbursement," CEO Barry Port said on an earnings call.

Despite the pandemic, Ensign's stock price has soared to record levels. Zacks Equity Research recently ranked Ensign an "incredible growth stock," estimating its cash flow growth is up more than 18 percent over the year. "They're trading at the highest level they've ever traded at, in the middle of a pandemic in which they're supposed to be bleeding money," Lee says, suggesting Ensign's success challenges the notion that for-profit homes are struggling — and raises the possibility that other companies on comfortable financial footing received government funds and opted to keep the money.

But many publicly traded nursing home companies saw their stock prices plummet in February and March and haven't rebounded. Yet the way nursing homes are structured makes it difficult to gauge how well or how poorly for-profits are doing financially. These facilities are often set up as small nursing companies owned by larger corporations. Those corporations may own a group of separate companies that hire nursing home staff or lease real estate, keeping the day-to-day nursing home operations separate from the rest of the organization. It's a structure that allows a parent company to potentially shield many assets if a nursing home is sued for negligence.

"These big companies all have separate property companies, management companies, staffing, therapy, financing," says Charlene Harrington, a professor emeritus of sociology and nursing at the University of California in San Francisco. "If you're only looking at the operating company, you're not able to figure out what's happening with the money."

Industry watchdogs worry that some for-profit homes are funneling aid dollars into these separate companies rather than spending the money on residents' care. Nursing home companies can put federal dollars toward paying rent to their parent company, for example.

If a parent company also happens to own or have a close relationship with a medical supply manufacturer — which is uncommon but not unheard of — it can effectively charge itself a premium for personal protective equipment, using federal aid to pay. "If you spent $1 million on PPE, that doesn't tell you how much PPE you bought. Was that bought at market rates? There are just so many ways to hide this stuff," Wasserman says.

## Staffing shortages persist despite aid packages

Despite the distribution of funds, staff shortages are still commonplace, contributing to the pandemic's spread within nursing homes. A recent AARP analysis of federal nursing home data found that more than 1 in 4 nursing homes across the country had a staff shortage in the four weeks ending Oct. 18. In South Dakota and Kansas, roughly half of facilities were short-staffed.

Research has connected staff shortages to increased risk of coronavirus infection, as employees assume more responsibilities and interact with more residents than they would at higher-staffed operations. Harrington conducted a study this year that found understaffed California nursing facilities were twice as likely to have coronavirus infections as nursing homes that were sufficiently staffed.

She says residents would be better served if government aid dollars were used to hire additional workers and registered nurses, or to bolster wages to make these positions more attractive. Many of the industry's roughly 700,000 certified nursing assistants make less than $15 an hour.

"The research is so strong that if you have more total staff and more registered nurses, that's the only factor that's really protective against the COVID virus," Harrington says. "We're giving them all that money, but we don't require them to meet standards."

The nursing home industry has for years contended that facilities are understaffed in part because it is difficult to find qualified workers. Harrington contends the industry's recruiting struggles are partly self-inflicted by low wages, particularly at for-profit facilities. The median pay for nursing assistants in the U.S. is just under $30,000 annually, according to federal data. Registered nurses in nursing care facilities make a more comfortable $70,000, but they'd make considerably more in medical or surgical hospitals or outpatient care facilities.

"The shortages are caused because you could get a job as a janitor [instead]," Harrington says. "You won't need the training, and you might make more money than you would in a nursing home where you're exposed to COVID."

VIEWPOINT

# Postacute Care Preparedness for COVID-19
## Thinking Ahead

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Audio and Supplemental content

**National projections** suggest that hospitals may be overwhelmed with patients with coronavirus disease 2019 (COVID-19) infection in the coming months. Appropriately, much attention has addressed the acute challenges in caring for this surge of critically ill patients. What has received less attention, however, is what happens as patients—most of whom will recover, even in the highest-risk groups—begin to do so. Many patients with COVID-19 will need postacute care to recuperate from their infection. However, postacute care facilities currently lack the capacity and capability to safely treat patients with COVID-19 as they transition from the hospital to other care settings or to their homes. In this Viewpoint, we present the scope of the problem and outline a series of steps that may be helpful as postacute care organizations prepare for the coming increase in patients with COVID-19.

Postacute care includes rehabilitation or palliative services that beneficiaries receive following a stay in an acute care hospital.[1] Depending on the patient's needs, treatment may include a stay in a facility, such as a skilled nursing facility, inpatient rehabilitation facility, or long-term care hospital, or care in the home via a home health agency. Although data are limited regarding the proportion of patients with COVID-19 in other countries who have needed some form of postacute care, historical data from Medicare suggest that more than 30% of patients hospitalized with sepsis, a condition with inpatient mortality similar to that associated with COVID-19,[2] require facility-based care and another 20% require home health care.[3]

> However, postacute care facilities currently lack the capacity and capability to safely treat patients with COVID-19 as they transition from the hospital to other care settings....

Postacute care is also a "pop-off valve" for hospital capacity, in that moving patients to a such a setting once they recover from the most acute phase of their illness could free up hospital beds. Medicare has already loosened restrictions on criteria for transfers by relaxing the 3-day rule,[4] which requires a Medicare beneficiary to spend 3 days in the hospital to qualify for the skilled nursing facility benefit. This will facilitate faster transfer for the least-sick patients.

Projections suggest a major surge in postacute care demand will occur following the hospital surge involving patients with COVID-19. Current skilled nursing facility supply varies nationwide (see the eFigure in the Supplement), and occupancy rates average 85%,[1] signaling that current capacity is inadequate for any surge. But the problems go beyond capacity alone. The discharge of patients with COVID-19 to skilled nursing facilities is complicated. The COVID-19 outbreak at Life Care Center in Kirkland, Washington, has already led to the death of 30 residents as of March 16, 2020, approximately one-quarter of its residents.[5] The Centers for Medicare & Medicaid Services has instituted a series of rules in an attempt to prevent further outbreaks from occurring in these facilities, including no-visitor policies and no group activities or communal dining. In this context, it is not safe in some cases for hospitals to transfer patients with COVID-19 into the mainstream skilled nursing facility population because some patients may still be able to transmit disease.

Where will patients who have begun to recover from COVID-19 receive postacute care? What steps can policy makers and health care organizations take to ensure safe and appropriate postacute care services in the coming weeks and month?

As an important first principle, all patients need to be tested for COVID-19 when they are being discharged to a postacute care setting regardless of whether they were being treated for COVID-19 at the hospital. No individual who has COVID-19 should be discharged to a mainstream postacute care setting except for those rare instances in which the facility can safely and effectively isolate the patient from other residents. There is still uncertainty around how long patients remain contagious after clinical recovery, so testing guidelines may need to be revised as additional information becomes available.

Consequently, specialized postacute care environments will need to be developed to treat patients who are recovering from COVID-19 and cannot receive care at existing facilities while still potentially contagious. These specialized environments could potentially take several forms. One approach would be to dedicate certain postacute care facilities in each market to be "centers of excellence" specializing in—and exclusively assuming—the care of patients recovering from COVID-19. Because these organizations would only care for these patients, the risk of infecting other patients could be minimized. Staff would need to receive appropriate safety equipment and training to provide this care safely. Certain types of facilities such as long-term care hospitals and hospital-based skilled nursing facilities may be well-suited to adopt this specialized role initially because of their existing infrastructure for infection control and their generally higher capacity to care for complex patients.

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In other local markets, temporary capacity will need to be built due to potential postacute care shortages. Rural hospitals, many of which have occupancy rates less than 50% and some of which have skilled nursing facility "swing bed" capacity, could be important sites to provide postacute care. New York Governor Andrew Cuomo proposed the idea of using the Army Corps of Engineers to retrofit unused buildings such as military bases and college dormitories as temporary hospitals. Similar approaches could be taken to establish temporary postacute care settings, which may be more appropriate for buildings in which the infrastructure is inadequate for hospital care but could plausibly meet the less intense needs of rehabilitative care.

Given the challenges with isolation in facility-based care, another important approach is treating patients who are recovering from COVID-19 in their homes when possible. Home health agencies are paid in 30-day episodes that typically consist of a mix of therapy, nursing, and home care aide visits. The current average level of care, however, will be insufficient to manage higher acuity patients with COVID-19 transitioning from the hospital. One potential solution is increased investment in hospital-at-home models,[6] which provide institutional-level services in the home.

Regardless of which of these approaches is taken (and likely all will be needed), staffing will be key. The postacute care sector already faces issues in identifying high-quality staff willing to work in these settings.[7] This issue will be magnified in the context of COVID-19. For this reason, the support of staff is essential. Staff must have the requisite training and personal protective equipment to treat patients recovering from COVID-19 safely. Staff will need to be tested regularly to ensure that they are not spreading the virus. And additional staff may need to be recruited to perform lower-skilled tasks that can be acquired relatively quickly, perhaps in part from industries that will experience major layoffs in the near term.

Another important staffing issue is the lack of access to physicians and advanced practice providers, who may be in short supply given the increase in demand. Telemedicine might be one approach to increase access in both facility and home care settings,[8] and in the context of COVID-19 has the added benefit of helping to prevent the spread of the disease by eliminating in-person contact. The recent announcement from Medicare indicating the provision of reimbursement for all telemedicine care, across video or voice platforms and with temporary Health Insurance Portability and Accountability Act (HIPAA) waivers,[9] is a crucial step toward making this feasible.

Policy makers should consider several temporary policies to support preparedness for COVID-19. All postacute care staff should be provided with paid sick leave. This will further encourage staff who are sick to stay home and not infect vulnerable patients. In terms of payment, an enhanced Medicare rate should be implemented for providing care for patients with COVID-19 across all postacute care settings. The treatment of these cases will mean added costs in terms of isolation, infection control, and staffing. Postacute care facilities and health care personnel should be incentivized to take on these cases and be given the resources to provide these patients with high-quality care. Medicare should also reimburse hospital-at-home models at parity with institutional hospital care to encourage adoption of this model.

The US has been playing catch-up in its COVID-19 response in terms of testing, social isolation, and hospital capacity. Making changes in postacute care delivery and policy today could help contribute to having adequate capacity and capability in the coming weeks and months.

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NELSON MULLINS

## The Bankruptcy Protector

Aug. 16, 2021

# Intersection of Healthcare and Bankruptcy

### An Alternative to the Appointment of a Patient Care Ombudsman for Skilled Nursing Facilities During a Pandemic and Beyond

By Frank P. Terzo

As the pandemic marches on, the patient census figures decrease in skilled nursing facilities ("SNFs") due to significantly higher death rates among the elderly population and a near mass exodus of nurse staffing turning to more lucrative nursing positions in acute care hospitals treating COVID-19 patients. As a result, one might expect that in the absence of more direct and indirect government financial support, SNFs will soon be facing significant financial distress. With over 15,500 SNFs in existence nationally, increased SNF bankruptcies could be right around the corner. The American Health Care Association anticipates that without government aid, at least 1,600 nursing homes could close by the end of 2021.

Unfortunately, this anticipated trend only magnifies the continuing concern that the quality of care delivered in SNFs throughout the country leaves much to be desired. Why is that a concern? Many industry experts are opposed to distributing more federal aid without a better understanding of how and where the money will be deployed. Public records show aid dollars have gone to facilities that have repeatedly been cited for health violations, insufficient care or worse. An investigation by The Washington Post found that hundreds of millions of aid dollars have been sent to facilities sued in recent years for Medicare fraud. "I am both skeptical and concerned about where that money has gone," says Mike Wasserman, a past president of the California Association of Long-Term Care Medicine. A few analysts have suggested that future COVID-19 financial aid be predicated on improving the quality of care at these facilities.

The Center for Medicare and Medicaid Services ("CMS") currently has a 5-star quality rating system that calculates an overall star rating for SNFs, with 1-star being the lowest possible score and 5 being the highest based on performance in three types

of metrics. These are: (1) the results of state health inspections, (2) staffing ratios, and (3) quality measures. Statistically, there are currently 11 states that have at least 40% of all their nursing homes having low overall ratings, either 1-star or 2-stars. These states are Texas, Louisiana, Oklahoma, Kentucky, Tennessee, North Carolina, West Virginia, Ohio, Pennsylvania, New York and Georgia.

With that in mind, the filing of a SNF bankruptcy can present a daunting task of maintaining patient census, keeping medical staff and avoiding additional expenses while attempting to improve the overall quality of care. Certainly, the appointment of a patient care ombudsman ("PCO") is one such expense that must be analyzed closely. Pursuant to Bankruptcy Code, Section 333 (a)(1) states, "if a debtor is a health care business, the Court shall order not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of the patients of the healthcare business *unless the Court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case*" (emphasis supplied). In a SNF bankruptcy, debtor's counsel is faced with either accepting a PCO coming into the facility and reviewing the quality of care or alternatively, opposing the order directing the PCO appointment by suggesting that a PCO is not necessary under the specific facts of the case. Such an approach is a risky alternative for the SNF that has a poor CMS star rating. Additionally, if the government begins to dole out additional COVID-19 aid based on the quality of care, a potential life saving injection of cash could be placed at serious risk if the bankruptcy doesn't have a watchdog monitoring the care being delivered.

An alternative to the appointment of a PCO that many bankruptcy courts throughout the country have found acceptable in the past, is permitting a debtor to self-report. *See In re The Clare at Water Tower*, Case No. 11-46151 (SPS) (Bankr. N.D. Ill. Dec. 7, 2011) (ruling that the appointment of a patient ombudsman was unnecessary given that the debtor-CCRC agreed to self-report); *In re Hingham Campus, LLC*, Case No. 11-33912 (Bankr. N.D. Tex. July 28, 2011) (excusing the appointment of a patient care ombudsman for a CCRC where the Debtor agreed to self-report); *In re Lincolnshire Campus, LLC*, Case No. 10-34176 (Bankr. N.D. Tex. Aug. 19, 2010) (excusing the appointment of a patient care ombudsman for a CCRC where the Debtor agreed to self-report); *In re Laredo Urgent Care, PA*, Case No. 08-50180 (Bankr. S.D. Tex. July 11, 2008) (finding, among other things, that based upon the specific facts and circumstances of the case and the debtor's agreement with the Texas Attorney General's Office to self-report, the appointment of a patient care ombudsman under 11 U.S.C. § 333 is not necessary for the protection of patients).

The mechanism for self-reporting can be as informative and as efficient as the appointment of a PCO and far less costly. Such a self-reporting order would typically require the debtor, within 30 days from the date it is entered, and every 60 days thereafter, at least up until the time of a confirmed plan of reorganization, file with the court a verified affidavit reporting the following information: (1) a report on the number of staff members, their positions and status and standing of any licenses held by staff members and any complaints made by patients, residents or families of patients or residents concerning the care provided by the staff members at the SNF; (2) staff changes report — any increases or decreases in the number of staff members over the 60-day reporting period; (3) patient/resident records — report to the court the measures taken for the debtor to continue to secure the patient and resident records at the SNF's compliance with HIPAA; (4) vendor reports — report to the court any and all complaints by vendors regarding payment or ordering issues; (5) report all resident complaints that have been submitted to the debtor regarding the quality of care and any special care provided by the SNF to treat the patient; (6) a summary of any report of any post-petition litigation or administrative action; (7) report any plans to close the facility due to the inability to formulate a plan; (8) report any major maintenance work that needs to be done; and (9) report of any life-safety issues. The report then would be submitted and filed with the court and forwarded to the United States Trustee (the bankruptcy process watchdog), the appropriate state Department of Health, the appropriate state agency administrating the Medicaid program, CMS, any counsel of record involving any secured creditor and any family member, resident or patient who specifically requests a copy thereof.

With additional COVID-19 aid remaining uncertain for nursing homes, cost savings in health care insolvency cases will be of paramount importance and the alternative of turning to the clinical staff of the debtor to fulfill the duties usually set aside for a statutory PCO might very well appeal to the court, the economic constituencies in the case, the patients and their families and those state and federal regulatory agencies charged with the responsibility of insuring the safety and well-being of residents of a SNF.

Nelson Mullins attorneys are experienced in handling all types of bankruptcy matters and have unique experience dealing with all kinds of healthcare distress situations, including out-of-court workouts, healthcare receiverships, chapter 11 restructurings, and selling and purchasing healthcare assets in and out of bankruptcy.

# MEDICARE PROVIDER AGREEMENTS: EXECUTORY CONTRACTS SUBJECT TO 11 U.S.C. § 365?

by Holly N. Lankster, Esq.[1]

## I. What is a Medicare Provider Agreement?

Medicare is a federal program that funds medical services for aged or disabled individuals. *In re Bayou Shores SNF, LLC*, 525 B.R. 160, 162 (Bankr. M.D. Fla. 2014). The Center for Medicare & Medicaid Services ("CMS"), a component of the United States Department of Health and Human Services, is charged with administering the Medicare program. Frank A. Oswald & Howard P. Magaliff, *Transfer of Medicare Provider Numbers In Bankruptcy: Executory Contract or Saleable Asset?*, 28 AM. BANKR. INST. J. 18, 18 (May 2009).

Similarly, Medicaid provides medical assistance to low-income individuals who are disabled. *Bayou Shores*, 525 B.R. at 162. Medicaid is administered by state agencies through medical assistance programs. *See* 42 U.S.C. § 1396a.[2]

Under the Medicare system, a health care facility files an application for a provider number to evidence its enrolled status. *See* Samuel R. Maizel, Jody A. Bedenbaugh, *The Medicare Provider Agreement: Is it a Contract or Not? And Why Does Anyone Care?*, 71 BUS. LAW. 1207, 1209 (Fall 2016); Oswald & Magaliff, *supra*, at 67. Once enrolled, the facility executes a Medicare provider agreement to qualify to participate in Medicare Part A, 42 U.S.C. §§ 1395c–1395i–6. Medicare Part A authorizes the facility to receive insurance payments for the "reasonable costs" of services for eligible beneficiaries. *See* 42 U.S.C. §§ 1395x(v)(1)(A), 1395f(b); 42 C.F.R. pt. 413.

The Medicare provider agreement is a uniform document not subject to negotiation or alteration. *See* Centers for Medicare and Medicaid Services, Health Insurance Benefit Agreement, Form CMS-1561 (2001), available at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012196. It requires the provider to conform to the provisions of the Medicare Act. *Id.*

CMS contracts with fiscal intermediaries (private contractors) to process and pay Medicare claims. Payment is issued under a prospective reimbursement system, meaning payment is based on a predetermined, fixed amount for that service. Medicare providers receive periodic payments for their services on an estimated basis to ensure prompt payment. An audit is conducted after payment to determine the precise amount of reimbursement due to the provider. *See* 42 U.S.C. § 1395g; *see also* Maizel & Bedenbaugh, *supra*, at 1209; Oswald & Magaliff, *supra*, at 18.

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[1] Holly N. Lankster is a law clerk for the Hon. Gregory R. Schaaf, United States Bankruptcy Court, Eastern District of Kentucky. The following analysis is not intended to express the opinions of the Court, but merely to outline the issues and arguments raised by various courts and commentators.

[2] There are similarities between the Medicare and Medicaid provider agreements, but this discussion will focus solely on Medicare provider agreements.

Audits typically result in a "retroactive adjustment" to payment. 42 C.F.R. § 413.64(f); *see also* 42 U.S.C. § 1395g. If a health care facility is underpaid, the difference is distributed to the facility. If a health care facility is overpaid, subsequent reimbursement payments are adjusted, or arrangements are made for repayment. 42 U.S.C. § 1395g(a); 42 C.F.R. §§ 405.1803(c), 413.64(f); *see also* 42 C.F.R. § 405.371(a).

The Medicare Act prohibits a health care facility from selling its Medicare provider number. 42 C.F.R. § 424.550(a). If there is a "change in ownership" under 42 C.F.R. § 489.18(a), such as through a merger or consolidation of two or more corporations, then the new owner is required to apply for a new provider number before the change is completed. 42 C.F.R. § 424.550(b).

Although a new owner must apply for a new provider number upon a "change in ownership," the Medicare provider agreement is automatically assigned to it. 42 C.F.R. § 489.18(c). The new owner is therefore responsible for the liabilities created or incurred by the prior owner even if its approval for a new provider number is pending. 42 C.F.R. § 489.18(d). *See also Deerbrook Pavilion, LLC v. Shalala*, 235 F.3d 1100, 1103-04 (8th Cir. 2000).

## II. Bankruptcy Courts are Split on Whether a Medicare Provider Agreement is an Executory Contract.

The primary issue for the transfer of a Medicare provider agreement in bankruptcy is whether it is an executory contract subject to 11 U.S.C. § 365. Most bankruptcy courts assume a Medicare provider agreement is a contract and conclude it is executory. If a Medicare provider agreement is an executory contract, then a debtor must satisfy the cure requirements of § 365 before it can transfer the provider agreement to a new owner.

A minority of bankruptcy courts hold that a Medicare provider agreement is not a contract and § 365 does not apply. These courts rely on long-standing case law outside of bankruptcy that recognizes a provider agreement is a statutory entitlement akin to a license that is transferrable free and clear of liabilities under § 363(f).

### A. What are Executory Contracts under 11 U.S.C. § 365(a)?

Section 365(a) governs the assumption and assignment of contracts in a bankruptcy sale. Section 365(a) provides that "[the debtor] may assume or reject any executory contract or unexpired lease of the debtor." 11 U.S.C. § 365(a).

The Bankruptcy Code does not define "executory contract." Whether an agreement is a contract is governed by state law. *Butner v. United States*, 440 U.S. 48, 55 (1976). Whether a contract is executory under § 365 is examined using two different approaches: the "Countryman approach" and the "functional approach". *See Bayou Shores,* 525 B.R. at 168.

The Countryman approach is the most common. A court applying the Countryman approach starts with the conclusion that the agreement is a contract under non-bankruptcy law. The Countryman approach then requires the court to treat the contract as executory if the obligations of a debtor and counterparty are so far unperformed that the failure to complete

performance would constitute a material breach excusing the performance of the other. *Id*. If a contract is executory under this definition, then a debtor may assume or reject the agreement in its sound business judgment. *Id.*

The functional approach also starts with a determination that the agreement is a contract. If so, the functional approach requires a court to consider the objectives of the contract. *Walton v. Clark & Washington, P.C.*, 454 B.R. 537, 543 (Bankr. M.D. Fla. 2011). The court examines the benefits gained by the debtor and its estate if a contract is assumed or rejected. *Id.* If the objectives are accomplished, or if they cannot be accomplished through rejection, then the contract is not assumed.

Recently the United States Supreme Court described an executory contract as a contract "that neither party has finished performing." *Mission Prod. Holdings, Inc. v. Tempnology, LLC*, 139 S. Ct. 1652, 1657 (2019). This definition is consistent with the Countryman approach. The Supreme Court also recognized that an executory contract "represents both an asset (the debtor's right to the counterparty's future performance) and a liability (the debtor's own obligations to perform)." *Id*. at 1658. Thus, § 365(a) enables a debtor

> to decide whether the contract is a good deal for the estate going forward. If so, the debtor will want to assume the contract, fulfilling its obligations while benefiting from the counterparty's performance. But if not, the debtor will want to reject the contract, repudiating any further performance of its duties. The bankruptcy court will generally approve that choice, under the deferential "business judgment" rule.

*Id.* (citations omitted). This description is consistent with the functional approach. The Supreme Court's discussion in *Mission Product* reaffirms the vitality of both approaches. *See, e.g., Energy Conv. Dev. Liquidation Trust v. Ovonyx, Inc.* (*In re Energy Conv. Dev., Inc.)*, 621 B.R. 674, 707 (Bankr. E.D. Mich. 2020).

If a contract is assumed under § 365, then the estate is liable for the performance of the entire contract. *Gatx Leasing Corp. v. Airlift Int'l, Inc.* (*In re Airlift Int'l, Inc.)*, 761 F.2d 1503, 1508 (11th Cir. 1985). The expenses and liabilities incurred because of assumption are entitled to administrative priority. 11 U.S.C. § 503(b)(1). A debtor can assign the contract, but the assignee must give adequate assurance of future performance. 11 U.S.C. § 365(f). If a contract is rejected, then the rejection is treated as a pre-petition breach of contract claim. 11 U.S.C. § 365(g).

### B. The Majority of Bankruptcy Courts Treat a Medicare Provider Agreement as an Executory Contract Subject to § 365.

Most bankruptcy courts assume a Medicare provider agreement is a contract under non-bankruptcy law without much analysis and treat it as executory under § 365. *See In re Vitalsigns Homecare, Inc.,* 396 B.R. 232, 239-40 (Bankr. D. Mass. 2008) (citing cases). *See also MMM Healthcare, Inc. and PMC Medicare Choice, Inc., v. Santiago (In re Santiago*), 563 B.R. 467, 475 (Bankr. D.P.R. 2017)*; Bayou Shores,* 525 B.R. at 168; *In re Bethel Healthcare, Inc.,* No.

1:13-BK-12220-GM, 2014 WL 12758523, at *6 (Bankr. C.D. Cal. May 1, 2014); *Univ. Med. Ctr. v. Sullivan (In re Univ. Med. Ctr.)*, 973 F.2d 1065, 1075–79 (3d Cir. 1992); *Advanced Prof'l Home Health Care, Inc. v. Bowen (In re Advanced Prof'l Home Health Care, Inc.)*, 94 B.R. 95, 97 (E.D. Mich. 1988); *In re Memorial Hosp. of Iowa County, Inc.*, 82 B.R. 478, 480 (W.D. Wis. 1988); *In re Provident Hosp. & Training Assn*., Bankr. No. 87 B 11069, 1987 WL 383355, at *2 (Bankr. N.D. Ill. Sept. 16, 1987); *Blue Cross of Western Pa. v. Monsour Medical Med. Ctr. (In re Monsour Med. Ctr.)*, 11 B.R. 1014, 1018 (W.D. Pa. 1981).

For example, the bankruptcy court in *Monsour Medical Center* assumed the relationship was contractual and concluded that the obligations were mutual and therefore executory. 11 B.R. at 1018. The court *Provident Hospital & Training Association* relied on the same assumption and concluded that the provider agreement "fits neatly within [the Countryman approach]." 1987 WL 383355, at *2. In the more recent case of *Bayou Shores*, there was no dispute that the relationship was contractual. The court distinguished between the Countryman and functional approaches and then summarily concluded that, regardless of the approach used, most courts hold that a Medicare provider agreement is executory. 525 B.R. at 168.

### C. A Minority of Bankruptcy Courts Conclude § 365 is Not Applicable Because a Medicare Provider Agreement is Not a Contract.

A few courts have rejected the assumption that a Medicare provider agreement is an executory contract subject to § 365. Rather, these courts rely on several decades of case law issued outside of bankruptcy that recognize a Medicare provider agreement is a statutory entitlement akin to a license and, therefore an asset a debtor can transfer free and clear of obligations under § 363(f). *See, e.g.*, *In re Verity Health Sys. of Cal., Inc*., 606 B.R. 843, 848–51 (Bankr. C.D. Cal. 2019), *vacated*, 2019 WL 7288754 (Bankr. C.D. Cal. Dec. 9, 2019) (holding that provider agreements between debtors and California Department of Health Care Services were not executory contracts and distinguishing cases); *In re Ctr. City Healthcare, LLC*, No. 19-11466 (KG), 2019 WL 12496342, at *4 (Bankr. D. Del. Sept. 10, 2019) (provider agreement is not an executory contract); *In re BDK Health Mgmt. Inc*., No. 98-00609-6B1, 1998 WL 34188241, at *6 (Bankr. M.D. Fla. Nov. 16, 1998) (finding provider agreements do not create contractual rights but are statutory licenses that can be sold); *Kings Terrace Nursing Home & Health Related Facility v. N.Y. State Dep't of Social Servs. (In re Kings Terrace Nursing Home & Health Related Facility)*, No. 91 B 11478 (FJC), 1995 WL 65531, at *8 (Bankr. S.D.N.Y. Jan. 27, 1995) (same), *aff'd*, 184 B.R. 200 (S.D.N.Y. 1995).

Non-bankruptcy courts have consistently held for over thirty years that a Medicare provider agreement is not a contract. *See, e.g., PAMC, Ltd. v. Sebelius,* 747 F.3d 1214, 1221 (9th Cir. 2014); *Hollander v. Brezenoff*, 787 F.2d 834, 838 (2d Cir. 1986); *Mem'l Hosp. v. Heckler,* 706 F.2d 1130, 1136 (11th Cir.1983); *Germantown Hos. & Med. Ctr. v. Heckler*, 590 F. Supp. 24, 30-31 (E.D. Pa. 1983), *aff'd*, 738 F.2d 631 (3d Cir. 1984); *Harper-Grace Hosps. v. Schweiker*, 708 F.2d 199, 201 (6th Cir. 1983); *Southeast Ark. Hospice, Inc. v. Sebelius*, 1 F. Supp. 3d 915, 925-26 (E.D. Ark. 2014); *United States ex rel. Roberts v. Aging Care Home Health Inc*., 474 F. Supp. 2d 810, 820 (W.D. La. 2007); *United States v. Medica-Rents Co*., 285

F. Supp. 2d 742, 777 (N.D. Tex. 2003); *Greater Dallas Home Care Alliance v. United States,* 10 F. Supp. 2d 638, 647 (N.D. Tex. 1998). The issue often arises after a regulatory or statutory change to the Medicare reimbursement scheme. Providers challenge the changes on contract law grounds and the government argues against the suits on the basis that the changes are unilateral and do not constitute an impermissible taking because the provider agreements do not create contractual rights. The issue also arises in False Claims Act cases where the government is the plaintiff and posits that it has equitable, rather than contractual, claims. Maizel & Bedenbaugh, *supra*, at 1211-12.

In these cases, the government takes a position that is inconsistent with the one it advocates in bankruptcy court. The government argues that a Medicare provider agreement is not a contract because it does not create or confer substantive rights or impose obligations on the provider. Instead, the agreement merely describes the relevant statutory and regulatory provisions. Also, the agreement is non-negotiable, the government has complete control over the amount it must pay, and any remedies available for breach are not contractual remedies. *Id*. *See also* Sarah Robinson Borders and Rebecca Cole Moore, *Purchasing Medicare Provider Agreements in Bankruptcy: The Case Against Successor Liability for Prepetition Overpayments*, 24 CAL. BANKR. J. 253, 264-69 (1998).

Yet in the bankruptcy court, the government argues the Medicare provider agreement is a contract that a debtor must assume and assign under § 365. Maizel & Bedenbaugh, *supra*, at 1217-18. The bankruptcy courts have mostly accepted this characterization without testing it. *Id.* That may change as more courts recognize the inconsistency in the government's argument and the law. *See Verity Health Sys. of Cal., Inc.*, 606 B.R. at 848-51.

## III. How a Medicare Provider Agreement is Treated in Bankruptcy Affects a Debtor's Ability to Reorganize.

A debtor needs to transfer a Medicare provider agreement as part of its bankruptcy sale to bring the highest value for its assets. The process for obtaining a new Medicare provider agreement is lengthy. A facility interested in treating Medicare beneficiaries risks nonpayment for its services pending approval of a new provider agreement. Therefore, interested buyers will want to avoid this risk by purchasing the existing Medicare provider agreement from a debtor. *See* Maizel & Bedenbaugh, *supra*, as 1223.

If a Medicare provider agreement is an executory contract and § 365 applies, a debtor has several hurdles to overcome before it can transfer its Medicare provider agreement to an interested buyer. A debtor must first assume the provider agreement before assigning it to an interested buyer. Assumption under § 365 requires a debtor to cure existing overpayments. These are generally high and often a key reason a debtor has filed for bankruptcy relief. A new owner must also provide adequate assurance of future performance. Section 365 gives the government significant leverage over a debtor's reorganization process because it can demand payment of the outstanding liabilities as well as adequate assurance of future performance from the new owner. *Id.* at 1228-29.

If a debtor assumes a Medicare provider agreement and assigns it to a new owner under § 365, then the new owner also assumes liability for overpayments, duplicate payments, or payments for reimbursement claims that are subsequently denied. The government has years to review and audit cost reports. The possibility of extensive unliquidated contingent liabilities is high. This reduces the value of a debtor's Medicare provider agreement as interested buyers will account for this risk by lowering the purchase price or escrowing a portion of the purchase price to account for the unknown liabilities. *Id.* at 1223-24.

But if a Medicare provider agreement is not a contract, then § 365 does not apply. A debtor does not have to cure outstanding liabilities. An interested buyer need not provide adequate assurance of future payment to the government. A debtor can sell a Medicare provider agreement to an interested buyer free and clear of the overpayment liability under § 363(f), thereby eliminating a new owner's successor liability. *Id.* at 1230-31. This can maximize the value of a debtor's Medicare provider agreement and increase its chances of a successful reorganization.

## IV. Conclusion.

It is important to consider how a Medicare provider agreement is treated under the Bankruptcy Code and any binding authority in a bankruptcy court's jurisdiction. Most courts treat a Medicare provider agreement as an executory contract under § 365. The assumption and assignment requirements of § 365 make it more difficult for a health care debtor to reorganize because a debtor must contend with high cure costs and the risks associated with successor liability. But in some jurisdictions, a Medicare provider agreement is considered a statutory entitlement not subject to § 365 and transferrable free and clear of overpayment liabilities under § 363(f). This enables a financially distressed debtor to shed its overpayment liabilities and an interested buyer to avoid successor liability. Although these jurisdictions are in the minority, the argument that a Medicare provider agreement is not an executory contract, but a statutory entitlement, is a potential argument that a health care debtor should not overlook.

# Faculty

**Richard T. Arrowsmith** is a senior managing director with FTI Consulting, Inc. in Washington, D.C. He specializes in turnaround and restructuring advisory, including interim management appointments, concentrated in sub-acute care, laboratory and health care real estate. Mr. Arrowsmith has 25 years of creditor workout experience. Previously, he was a managing director at Alvarez & Marsal in its Healthcare Industry Group. Before that, he served as senior vice president at Hudson Americas, an affiliate of Lone Star Funds, where he managed a nine-person asset-recovery team as well as its portfolio of loan assets operating in bankruptcy. Mr. Arrowsmith spent 12 years with the leader in the health care lending space, GE Capital Healthcare Financial Services, which included client work in dental, managed care, senior living, skilled nursing and other sub-acute platforms, as well as many commercial real estate and equipment leasing portfolios. Prior to that, he was vice president and team leader in the Portfolio Management and Special Asset groups of First Union National Bank. Mr. Arrowsmith received his bachelor's degree in finance from the University of Maryland and his M.S. from American University.

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