

On the Origin of **SPEOCCUPANCIES**

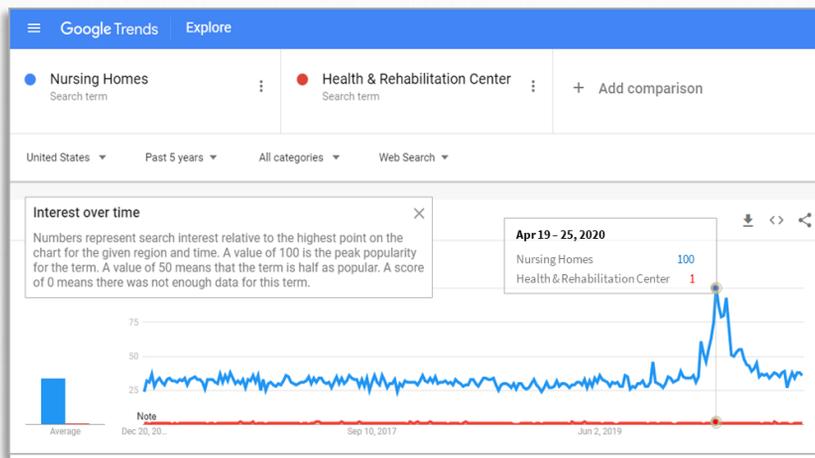
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Charles Darwin never mentioned post-acute care in his treatise on evolutionary biology, but the theory of Natural Selection is evident throughout the skilled nursing industry.

A generation ago, SNFs were on the precipice of an epigenetic shift that would carry them beyond “subacute” care. They would offer managed care organizations a cost-effective alternative to hospitalizations. Facilities were renamed; more “D/B/As” were filed in 2001 than in all previous years combined. “Nursing Homes” became “Health & Rehabilitation Centers.” SNFs would create and lead Integrated Delivery Systems to the promised land known as “Healthcare Reform.” Alas, it seems that insurance companies, not to mention nature, have rules. No matter how far the SNF model of care progresses, people still struggle to see beyond their outdated image of “nursing homes.” A comparative search on Google Trends distills the essence of public perception. What will it take for skilled nursing facilities to finally evolve?



One issue that has plagued the SNF image, “Triples & Quads,” may finally be phased out organically as the slow [decline of SNF occupancy](#) makes them unnecessary in many markets. To borrow terminology from the International Union for Conservation of Nature, high-capacity rooms are “Extinct in the Wild” in several habitats yet remain of “Least Concern” in too many others.

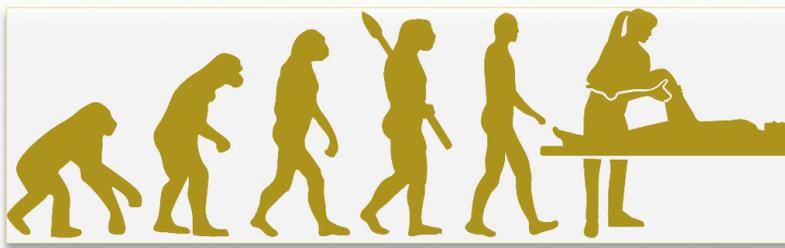
COVID-19 depressed SNF census, but it also created a paradoxical inventory problem. Isolation protocols and consumer demand drove the need for private rooms. Facilities configured with only semi-private accommodations were forced to remove beds from service. These “phantom beds” remain certified but are vestigial organs for all practical purposes.

This may be COVID’s legacy, a new species introduced into the post-acute care biome – and any new species must be named. In keeping with the many “P” neoterisms populating 2020’s vernacular (PPP, PPE, PRF), we offer “**PPC**” to the provider lexicon: ***Post-Pandemic Capacity***.



Survival of the SNFittest

I've watched enough National Geographic specials to know that nature can be cruel, and here's where it gets visceral for SNFs. Occupied or not, a certified bed carries intrinsic value, but are beds lost to PPC worth anything? Should they be decertified? Why would an operator willingly surrender a licensed bed? It may seem blasphemous, but there are subtle, significant economic reasons why capacity reduction is beneficial to the healthcare ecosystem. Of course, as with any environmental disruption, there are consequences to deliberate. The most compelling consideration, at least for providers in half the nation, is reimbursement.



While many Medicaid payment systems have evolved into “price-based” or managed rate structures, the cost report remains a fundamental rate setting instrument throughout the country. In basic terms, “cost-based reimbursement” is simple division: Allowable expenses (numerator) are divided by patient days (denominator). For example, assume that indirect operating expenses are reimbursed at reasonable cost per patient day in the following scenarios:

- A. 100 bed SNF, 100% occupied, \$1,000,000 of fixed, allowable annual expenses.
 $\$1,000,000 / 36,500 \text{ days} = \27.40 toward the rate.
- B. 100 bed SNF, 50% occupied, \$1,000,000 of fixed, allowable annual expenses.
 $\$1,000,000 / (36,500 \times 50\%) = \54.80 toward the rate.

Why does Facility B receive twice the reimbursement for being half full? After all, it may be struggling due to substandard care or poor management. Medicaid systems avoid rewarding inefficiency by setting “ceilings” on allowable costs and “imputing” occupancy for the rate equation. Imputed Occupancy is a “floor” on patient days equal to a percent of certified bed capacity (for example, 85%). Back to Facility B:

- B. 100 bed SNF, 50% occupied, \$1,000,000 of annual expenses; 85% occupancy floor.
 $\$1,000,000 / (36,500 \times 85\%) = \32.23 toward the rate.
Cost per PPD remains \$54.80, but Facility B is “penalized” \$22.57 PPD for its low occupancy.

But maybe Facility B is a highly efficient, 5-Star provider; it's just an old building...



The penalty stems from basing the denominator on available days per certified beds. If Facility B has four Triples and three Quads, converting to doubles effectively eliminates 10 beds from inventory (leaving 90 **PPC** beds). In addition, the COVID reality necessitates Facility B to convert 20 doubles to single occupancy. Our putative 100-bed facility is now effectively scaled down to 70 **PPC** beds!

The problem is that Skilled Nursing Facilities cannot be scaled down in this manner – fixed costs are simply too high. Facility B maintains all the overhead of a 100-bed provider; yet for cost-based calculations, the closest it can get to full capacity is 70%. The operator will forever be burdened by the imputed occupancy penalty... unless beds are decertified.

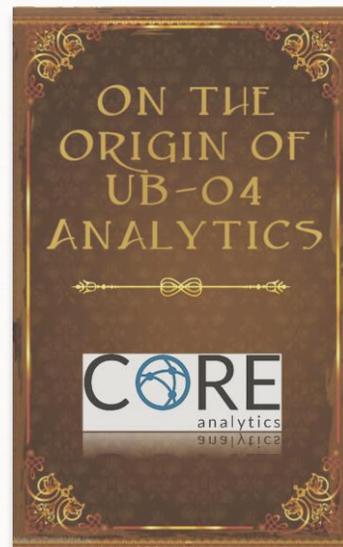


Post-Pandemic Capacity won't be fully realized until SNFs file their 2020 cost reports, but the issue extends beyond state Medicaid departments. “Per bed” pricing contracts such as software, insurance, “hotel functions,” and even rent carry an almost literal “hidden bed tax.” For those looking to invest in skilled nursing, we recommend avoiding the “Price per bed” benchmark; we now prefer to express value at “**Price per PPC bed.**”

Stakeholders are pondering what the post-COVID world holds for Skilled Nursing. While it may be too early to tell, the climate changed too rapidly for SNF operators & investors to adapt. When census recovers, PPC will stress post-acute care's ecological balance. Nevertheless, I remain optimistic that this rightsizing will ultimately strengthen the provider community, and SNFs will adapt to survive healthcare's ongoing process of natural selection.

This is a pivotal time in SNF evolution.

Charles Darwin would be fascinated.



Epilogue: Perspectives on SNF Occupancy

The “climate change” of healthcare reform has impacted SNF occupancy, but to what extent? Typical capacity reporting is misleading, often expressing market occupancy as a “simple average” of “total residents” to “total beds” per year. We refer to this measure as “Nominal Occupancy,” and it’s as dangerous as an invasive species for investors.

Year	SNFs	Beds	Census	Nominal Occupancy
2013	15,534	1,694,759	1,359,645	80.2%
2019	15,061	1,591,948	1,246,709	78.3%

Data represents Medicare certified SNF beds, courtesy of Kaiser Family Foundation

In “Nominal” terms, SNF occupancy fell 1.9 points (2.4%) from 2013 – 2019, end of story. But as a post-acute care conservationist (“Consultavationist”??), I’m more concerned with the species’ health than reclaiming lost habitat; we should not trend occupancy without the context of bed count declines.

The industry “lost” over 100,000 beds from 2013 - 2019, so the Nominal Occupancy drop does not reveal the whole story. The far more insightful utilization benchmark is “Relative Occupancy,” a common-sense measure we developed that, in this example, places all 2019 residents into the total complement of 2013 beds. This calculation reveals a more hostile environment.

Market demand deteriorated more severely than the Nominal rate of 2.4% suggests. When bed inventory is considered, we see that the Relative Occupancy decline was more than triple the Nominal Occupancy decrease: 8.3% (6.6 percentage points).

Year	SNFs	Beds	Average Census	Relative Occupancy
2013	15,534	1,694,759		
2019	15,061		1,246,709	73.6%

If census is the oxygen of our SNF environment; Relative Occupancy models future air quality.

Nominal	Relative	Outlook	Interpretation
-1.5%	> -4.0%	Negative	Utilization decreasing faster than beds closing; expect census decline
1.9%	= 1.9%	Neutral	Market is in equilibrium; expect census to remain steady
-3.1%	< 5.5%	Opportunity	Utilization growing faster than beds added; expect census to improve

